

Improving Access to HIV and Aids Services for Key Populations in Jinja District – Uganda

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Abstract

Background: This paper details the application of knowledge and skills gained from Total Quality Management, Management Information Systems and Research Methodologies trainings from TAU in increasing access to HIV and AIDS services to key populations in Jinja district. Uganda has continued to suffer from the adverse effects of HIV and AIDS for almost three decades now, with the HIV prevalence rising from 6.4% in 2005 to 7.3 in 2011%, (UAIS 2011 Report). This was attributed to the increase in the rate of occurrence of new HIV infections, even when access to Ante Retroviral Therapy (ART) for the general population was increasing. The Uganda Ministry of Health noted that the major sources of new infections are the Key Populations.

Key Populations' are those categories of people who are most likely to be exposed to HIV infection and or most likely to transmit HIV to their sexual partners. According to studies, Key Populations in Uganda have higher HIV prevalence rates above the National HIV prevalence rate of 7.3%, sometimes often more than twice the national average. Key Populations in Uganda include; Fisher folk, Sex workers and their partners, Uniformed personnel, Long distance drivers and Men who have Sex with Men (MSM).

Methods: A PLACE (Priorities for Local AIDS Control Efforts) study conducted by Makerere University and Jinja District Local Government revealed that there were limited interventions in the district to address the challenges of access to HIV and AIDS services for the Key Populations yet they existed in the district. The Jinja district health team came up with interventions to address such challenges faced by Key Populations starting September 2015. The goal of the interventions is to reduce new HIV infections in Jinja district by providing universal access to HIV prevention, care and treatment services to Key Populations in the Jinja district. The specific objectives are; To provide factual information on issues related to HIV and AIDS among Key Populations to the general population including the health workers. To mitigate specific drivers increased HIV infection/transmission among Key Populations. To scale up delivery of comprehensive HIV prevention and treatment services to Key Populations. To build a strong enabling environment for equitable and sustainable delivery of HIV prevention and treatment services to Key Populations, and lastly is to strengthen the strategic information system for program and policy improvement for Key Populations.

Achievements: The project identified a few key populations for consultations on how best they would access and or be provided healthcare services. Venues where Key populations could easy be found were identified and sensitization of 60 managers in these venues about the intended interventions for the key populations was done. 90 leaders of the different categories of the key population were also identified for orientation and easy mobilization of their peers for services that we offer. The project also prepared 120 health workers to provide services to the key populations. Special clinics for key populations were created for easy access to the different services and to reduce stigma and discrimination. Logistical support is very vital and there was budgeting and procurement of condom dispensers, information and communication posters, and

drugs. HIV Counselling and Testing outreaches conducted and 510 key populations have been tested for HIV. Data collection tools were modified to suit the project information demands. The challenges expected when serving key populations in Uganda are mainly security agencies interference, ethical dilemmas, lack of legal framework to provide such services to key population and limited finances to meet the created demands.

Conclusion: *HIV prevention, care and treatment interventions have been limited in the Uganda health care system and introduction of such services have been observed to be key in reducing HIV transmission among the population*

Introduction

The Uganda AIDS Indicator Survey (UAIS) report 2011 revealed increased HIV prevalence in the general population in Uganda from 6.4% in 2005 to 7.3% in 2011. The report also indicated a higher HIV prevalence among women (8.3%) than among men (6.1%) and that Ugandans living in urban areas like Jinja district are more likely to be HIV-positive than those living in rural areas (8.7% versus 7.0%). The PLACE research report revealed that the urban areas of Jinja had an HIV prevalence of 7.5% compared to the rural areas of 2%. This means that interventions to address HIV transmission in the district needed to be concentrated more in the urban areas than in the rural areas.

Through application of Kaoru Ishikawa's cause and effect analysis to understand the causes, risk factors, and effects of a high HIV prevalence in the urban areas, the district health team came up with interventions to address HIV prevention, care and treatment among the key population.

Understanding of key populations and their HIV prevalence rates

The term 'Key Populations (KPs)' refers to those populations that carry a higher chance of contracting or transmitting the HIV infection because of the high risky sexual behaviours they often engage in such as; high rates of unprotected sexual practices often with multiple sex partners, engagement in high risky anal sexual practices, involvement in sexual practices for monetary benefits or other benefits, and alcohol and substance abuse, (UAC, HIV prevention strategy 2015). Key populations are defined by a high burden of HIV and sometimes they engage in stigmatizing and often illegal activities. Some of the key populations like men who have sex with men are often marginalized in ways that make access to HIV and AIDS prevention, care and treatment more difficult compared to the general populations.

According to UNAIDS, Key Populations include; men who have sex with men, sex workers, persons who inject drugs and transgender people but also recognizes prisoners as particularly vulnerable to HIV and frequently lack adequate access to services. The Uganda HIV prevention strategy defines key populations as female sex workers and their clients, uniformed forces, fisher folk, long distance truck drivers, Injection drug users and Men who have Sex with Men (MSM).

In Uganda, key populations are more at risk of HIV infection and therefore bear a disproportionate burden of HIV above the National prevalence rate. According to a 2014 Ugandan Ministry of Health and Uganda AIDS Commission report, there are an estimated 10533 MSM, 54549 sex workers, 2 million fisher folk, 0.65 million uniformed personnel, and 31588 truckers in Uganda. The HIV prevalence among Key Populations is as follows; 13.7% in MSM, 33% in Female Sex Workers, 27-40% in Fisher folks, 25-32% in long distance drivers, and 18.2% in Uniformed services, (Crane Survey report, 2008/09).

Project interventions

During the development of intervention to address the challenges of limited access to HIV and AIDS services by the key population, we applied the philosophies of Joseph M. Juran that included; identifying the targeted population, determining their needs, development of the

project goal and objectives, developing services and products that respond to their needs, establishment of infrastructure, establishment of project teams, providing the team with resources, training and having strategies for evaluating performance.

The Jinja district key populations project was as a result of the PLACE study and interventions were developed by the district health team. With support from Global Fund through Uganda AIDS Commission, the district received US \$900 to support the interventions.

Project goal and objectives

The goal of the interventions is to reduce new HIV infections in Jinja district by providing universal access to HIV prevention, care and treatment services to Key Populations in the district. The specific objectives were;

To provide factual information on issues related to HIV and AIDS among Key Populations to the general population including the health workers.

To mitigate specific drivers of increased HIV infection/transmission among Key Populations.

To scale up delivery of comprehensive HIV prevention and treatment services to Key Populations.

To build a strong enabling environment for equitable and sustainable delivery of HIV prevention and treatment services to Key Populations, and to strengthen the strategic information system for program and policy improvement for Key Populations in Jinja district.

Implementation of project activities

The project identified a few key populations for consultations on how best they would access and or be provided healthcare services, what type of services they want to access and others. This was aimed at determining the needs and kind of services to be provided to the targeted population. Venues where Key populations could easy be found were identified and sensitization of 60 managers in these venues about the intended interventions for the key populations was done. 90 leaders of the different categories of the key population were also identified for orientation and easy mobilization of their peers for services that we offer. This was aimed at establishing structures and teams for the interventions. The project also prepared the health workers to provide services to the key populations. This included training of 120 health workers from Jinja central, Walukuba, Bugembe, and Kakira health units. There was also identification of special areas to act as special clinics within the health units where key populations would access the different services from. This was aimed at reducing stigma and discrimination for the key populations. Logistical support is very vital and there was budgeting and procurement of the required drugs and other supplies. There was supply of condom dispensers and information and communication posters at places where key populations normally stay. HIV Counselling and Testing outreaches are being conducted in the places where key populations stay and 510 of them have been tested for HIV.

Information management

Information management is key and we planned not to increase on the reporting tools as this would look to be a burden to the health workers. We put some modifications on the already existing tools to capture information as noted below;

In an effort to collect quality data on the key population programme implementation, Jinja district decided to generate data using the standard Ministry of Health tools. The tools had no areas where key population information can be indicated. The project team had to modify the existing as follows. To record the category of key population served, the following abbreviations/codes were to be used;

Category of Key Population (KP)	Codes to be used
Fisher Folks	FF
Men who have sex with men	MSM
Sex Workers	SW
Uniformed Personnel	UP
Long Distance Truck Drivers	TD
Others (like; Transgender, lesbian)	Others

The programme also utilized the following source documents for data generation:

- HIV Counselling and Testing (HCT) Card
- HIV Counselling and Testing (HCT) Register
- ART Client Card
- ART Register

HCT Card: The key populations identified are filled in the **HCT entry point** section and the documented as follows: Tick sub section (h) and specify the category of the key population as elaborated in table one.

SECTION B
 Pre-test counseling done/information given: Yes -1 No-2

Counseled as: Individual-1 Couple-2 Group-3

Approach: CICT PHTC

HCT Entry Point: (a) Facility based (b) Work place (c) HBHCT (d) For PEP

(e) PMTCT (f) HCT for PEP (g) HCT for Circumcision (SMC) (h) MARPS

Marital status: Married/cohabiting Divorced/separated Widowed Never married

Have you ever tested for HIV before? Yes-1 No-2

How many times have you tested in the last 12 months.....

Number of sexual partners in the last 12 months.....

What was the test result the last time you tested: Positive Negative

Has your spouse/partner been tested for HIV before? Yes-1 No-2

Do you know-3

What were the results?

Figure 1: HCT Register: Check section column 17 and indicate as per examples here under; MARPs-SW, MARPs-TD

(12) Received HIV Results (Y/N)	(13) HIV Test Results (+ve / -ve)	(14) Counseled & Tested as a Couple (Y/N)	(15) Received Results as a Couple (Y/N)	(16) Discardant Results (Y/N)	(17) HCT Entry Point (Facility, Work place, MARPs, Comm, Outreach, HBHCT/SMC, PEP/PMTCT, TB)	(18) TB Suspected (Y/N)	(19) CD4 Count Indicate early de- C, T & S & Lab de- L, if < 350/mm ³	(20) Current Care and treatment

Figure 2: ART Client Card: Check section of entry care point, tick others and specify the as per examples here under; KP-SW, KP-TD

The image shows a form titled 'HIV CARE/ART CARD No.' with various fields for patient information. In the 'Care Entry Point' section, there are several checkboxes: eMTCT, TB, YCC, and Other (specify). The 'Other (specify)' option is circled in red.

Figure 3: ART Register: Use column 3 written in as TI/eMTCT. Document as indicated in the ART Client Card above

The image shows 'HMIS FORM 081: ART REGISTER' with a table for 'Registration and personal information'. The table has six columns: (1) ART start date, (2) Unique ID number, (3) TI / eMTCT, (4) Patient clinic ID, (5) Name (Surname, Given name), and (6) Sex. The header for column (3) is circled in red.

Figure 4: The documentation has helped us to monitor progress and achievements of the project.

Using the management information systems skills a web based reporting of ministry of health called the District Health Information System 2 (DHIS2) is being used and advocacy for any modifications in the system and the tools has started.

Challenges

Health workers are seen as unfriendly and judgmental towards some key populations like the sex workers and MSM. Some health workers do not provide accurate specific information to different categories of key populations because of their religious beliefs. Lastly some health workers do not respect clients' confidentiality due to negative attitude toward the MSM. The laws in Uganda condemns the sexual acts of MSMs and this affects access and legal framework to provision of health care services to such individuals.

Other challenges include; Interference by security agencies as some times we provide services at night, limited finances to meet the created demands, lack of transport means for movement of staff and logistics during outreaches.

Conclusion

Application of learnt skills is key but challenging given the environment we work in. Key populations project interventions were meant to address the challenges of limited access to HIV and AIDS services to key population. The goal of the interventions in Jinja is to reduce new HIV infections in Jinja district by providing universal access to HIV prevention, care and treatment services to Key Populations in the district. Situational analysis was done and interventions that address the challenges of access to health care for the key population were identified and implemented. Over 500 key populations have access such services and capacity and structure establishment have been made. Information management is key, and data collection tools were

modified to suit the project information demands. The challenges expected when serving key populations in Uganda are mainly security agencies interference, ethical dilemmas, lack of legal framework to provide such services to key population and limited finances to meet the created demands. The project is still ongoing and more results will be communicated in the subsequent reports.

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