



## EDITORIAL

HIV assessment and testing for hospital in-patients:  
still a weak link in the cascadeCollins C. Iwuji,<sup>1</sup> Richard J. Lessells<sup>2</sup><http://dx.doi.org/10.5588/pha.17.0111>

Since 2007, the World Health Organization has recommended that in countries with generalised human immunodeficiency virus (HIV) epidemics, HIV testing and counselling should be offered to all adults and adolescents seen in a health facility.<sup>1</sup> This recommendation had been policy in Uganda since 2005.<sup>2</sup> However, evidence suggests that translation of this policy to practice in real-world settings has been patchy and that missed opportunities with HIV testing in the in-patient setting are still contributing to HIV-related deaths.<sup>3,4</sup>

In this issue of *Public Health Action*, Cummings and colleagues have assessed the effectiveness of a multi-modal quality improvement programme on HIV status assessment in western Uganda.<sup>5</sup> The quality improvement (QI) programme included a one-week instructional course on the early recognition of severe illness and HIV status assessment as an important part of management of sick individuals, followed by site-specific QI interventions: audits, performance assessments and mentoring. HIV status in adults and adolescents admitted to medical wards was assessed before and after the intervention. Of the total 5759 hospitalised patients evaluated, less than half (42.6%) had their HIV status assessed. Although HIV status assessment was higher post-intervention (44.8%) than pre-intervention (36.5%), the difference was not statistically significant. There was inconsistency in effect between the sites, and the facility with the poorest performance prior to the intervention did achieve a significant improvement in HIV status assessment, although this remained below 50%. The importance of proper assessment of HIV status was highlighted in this study by the observations that HIV prevalence was four times higher than that in the general population, at 16%, and that in-hospital mortality was also substantially higher in HIV-positive patients.

Data on HIV test offer were not reported, making it difficult to differentiate between failure to offer HIV testing and refusal of HIV testing in the majority of individuals whose HIV status was not established. As a result, it is difficult to comment as to whether the QI programme was intrinsically ineffective or the fidelity of implementation was poor. It was also not possible to ascertain the number of new testers amongst those whose status was reported as HIV-positive. The underlying di-

agnoses for the severe illness conditions resulting in higher mortality in HIV-positive individuals were also not reported. As neither antiretroviral treatment status nor CD4 counts were reported in those ascertained to be HIV-positive, the contribution of late presentation in this study to the observed higher morbidity and mortality in HIV-positive individuals could not be established.<sup>6</sup> There is also the increased risk that those unaware of their HIV-positive status will continue to transmit the virus. It would be interesting to know whether the QI intervention did lead to other positive changes, as this might suggest that there was insufficient focus on HIV assessment within the QI programme or that there were specific barriers to improving HIV testing. The authors allude to some of these limitations.

Informing all patients that an HIV test will be routinely added to their investigations may improve testing rates by reducing the amount of time spent on pre-test counselling. Signs advertising this approach should be displayed in strategic places at the point of admission and on the wards. Using point-of-care HIV tests that provide results in 1 minute (INSTI™ Rapid HIV Test; bioLytical Laboratories, Richmond, BC, Canada), rather than the usual 20 minutes, could also encourage the offer of a test by health care providers.

## References

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