

VCT in Focus

A Quarterly Newsletter of PSI's Voluntary Counseling and Testing (VCT) Programs



New theme for the issue goes here

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Letter from the Editor

In this issue of *VCT in Focus*, we examine provider-initiated testing and counseling (PITC). As antiretroviral treatment (ART) becomes more widely available and the benefits of early treatment become clearer, countries are looking for ways to expand access to and uptake of HIV testing. PITC includes routine or “opt-out” testing, where a provider provides testing to consenting patients unless they decline testing, and diagnostic testing, where a provider recommends HIV testing to his/her patients based on symptoms consistent with HIV disease. PITC should not be confused with mandatory testing. WHO emphasizes that testing must be voluntary and that patients retain the right to decline the test. The “3 Cs” — consent, confidentiality, and counseling—must be provided to ALL clients.

This issue of *VCT in Focus* highlights several new and promising programs. PSI/ Swazi-

land is helping the government produce PITC guidelines, train providers and form a broad communications campaign to encourage testing uptake. PSI/Zimbabwe recently rolled out a pilot routine T&C program where lay counselors were trained to take the burden off of busy providers. Pilar Sebastian from PSI/Mozambique is the VCT Expert in this issue's *Ask the Expert* column, highlighting her expertise in scaling up PMTCT services in Mozambique's public sector; Uganda's basic care packages round out the *Care and Support Corner*.

We look forward to hearing from you about your programs, challenges and lessons learned.

Test on! ■

— **Dvora Joseph, Editor in Chief, VCT in Focus & HIV/AIDS Service Delivery Manager**

Routine HIV Testing Pilot in Zimbabwe

What have we learned so far?

By Dr. Karin Hatzold, PSI/Zimbabwe

Early serostatus detection increases timely care and treatment and assists in secondary prevention of HIV. Clinical settings provide an excellent entry point for patients potentially HIV-infected. In collaboration with the local health authorities, the Zimbabwe HIV/AIDS Partnership Project developed an implementation plan to transition from a VCT model to provide routine HIV testing to all consenting Murambinda Mission Hospital patients.

The results were staggering: testing and counseling increased by 300% over the first 13 days of the program, from an average of 373 clients to 1,103 clients!

Murambinda Hospital

Murambinda Hospital has a free opportunistic infections (OI) and antiretroviral therapy



A patient receives counseling at a *New Start* center in Zimbabwe.

(ART) clinic. All patients who test HIV-positive receive clinical staging at the outpatient department (OPD) and are referred to appropriate follow-on services. All HIV-positive pregnant women receive CD4 cell counts and

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Ask the Experts

By Pilar Sebastian, PSI/Mozambique, VCT/PMTCT Technical Advisor



What is the difference between VCT, provider-initiated T&C, and routine T&C?

VCT is when a client comes to the center of his or her own volition for HIV counseling and testing. Provider-initiated testing and counseling (PITC) is when a health care provider suggests HIV testing for his or her patient; in routine testing, testing is offered to all health care patients, as is done in many health facilities for antenatal care.

VCT, as a client-initiated intervention, has a focus that PITC by nature cannot. For VCT, counselors are trained to focus on client-focused prevention counseling. Health care providers have multiple concerns, of which HIV can only be one. In addition, many countries have a shortage of health care providers, so they cannot offer as much time for the counseling as VCT counselors can. As an example, in Mozambique, there are only about 400 doctors for 19 million people, which does not leave a lot of time for effective, client-focused counseling.

Under what circumstances should programs consider adding PITC to their VCT program?

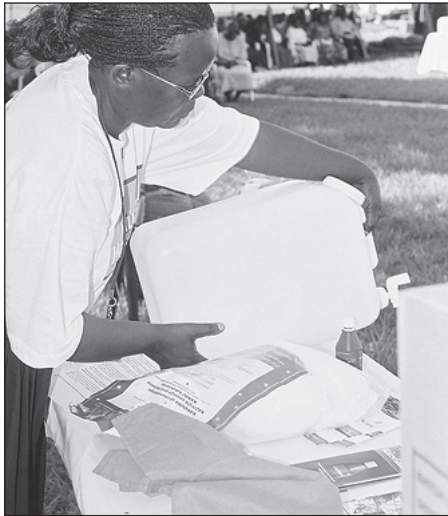
PITC is best integrated within health services but requires enough trained providers to cover the patient load. Lay counselors can be trained to help provide

Expert, continued on page 2

Basic Care and Prevention Kits in Uganda

Lilian Sekabembe, PSI/Uganda

PSI, with funding from the U.S. Centers for Disease Control and Prevention, is implementing an HIV Basic Care and Prevention Package (BCP) program for people living with HIV/AIDS (PLHA) in Uganda. An estimated 900,000 people or more die of HIV-related illness each year in Uganda, but a simple, comprehensive intervention can significantly decrease these life-threatening illnesses. The BCP program goal is to reduce morbidity and mortality from opportunistic infections (OIs) and reduce HIV transmission by PLHA. According to a CDC study from April 2006, use of the BCP is over 75% in Uganda, and there is a significant decrease in OIs, diarrhea disease and malaria among the PLHA using the kit.



PSI's medical detailer, Robina Kayondo, displays some of the contents from the Basic care package.

The program started in September 2004 with an IEC campaign primarily targeting PLHAs with their families. In April 2005, the campaign expanded to include health commodities distribution, including 2 long-lasting, insecticide-treated bednets (ITNs), Water Guard, and condoms. Existing HIV care and support organizations implement the program across the country. To date, PSI is working with 49 implementing partners, 43 of which are distributing condoms to their adult clients (other partners are either FBOs or deal with young infected children, so their kits do not carry condoms). As of April 2007, 113,341 kits have been distributed, of which 8,507 were given to children. Initial clients received 76,162 new bottles of WaterGuard and 1,248,500 condoms pieces as refills. Program funding increased from \$2.3 million in its first

year to \$3 million in the second year, enabling program scale-up and enlistment of additional implementing partners.

A corresponding multi-channeled communications campaign educates the target group on family planning OI prevention such as Cotrimoxazole prophylaxis to prevent pneumonia, diarrheal disease prevention using safe water systems, use of ITNs for malaria prevention, and prevention of HIV transmission to others, including from mother to child. PSI has trained service providers, peer educators and drama groups who now implement activities to reinforce these messages. Other small group activities included the staging of the BCP drama "Lucy's Choice." A total of 95 drama performances reached over 18,000 participants. In partnership with Straight Talk Foundation (STF), PSI has produced and aired radio spots in 8 local languages on 17 radio stations and Parent Talk program in 3 local languages on 6 radio stations across the country

PSI has received significant acclaim about the BCP program and has launched programs in the following countries:

KENYA: Launched a large-scale BCP program with USAID/PEPFAR support.

ETHIOPIA: BCP launched in association with Save the Children targeting HIV-infected and affected children and include point-of-use water purification, oral re-hydration salts and insecticide-treated mosquito nets.

COTE D'IVOIRE: BCP program targeting rural populations linked with PSI's rural, mobile VCT services.

ZAMBIA and HAITI: Currently waiting to hear on private donor funds to launch BCP projects.

TANZANIA: In November 2006, PSI/Uganda hosted a team from Tanzania composed of CDC, USAID, Pathfinder, FHI and MOH. They plan to implement a BCP program and wanted to learn from Uganda. Likewise, the PSI/Uganda BCP team traveled to Nairobi to assist International Medical Corps with training.

SUDAN: BCP program launched in February 2007 with funding from CDC. ■

Lilian Sekabembe is ?? for PSI/Uganda.

Please see "Name of story" on page 4 for more about basic care packages and how they can improve lives.

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counseling within a health facility. PITC will add a large number of clients, so there must be trained counselors to meet the demand. If providers will do the counseling themselves, they must be convinced of the value of HIV counseling. Measures must be taken to ensure strict confidentiality; post-test counseling, in particular, must happen on an individual basis in order for it to be effective. A good procurement chain is also crucial; without steady availability of test kits, it's better to not offer testing routinely.

What are the benefits and challenges of routine testing and counseling?

Benefits: PITC can help increase testing as providers encourage testing within other health services. There may be less stigma associated with provider-initiated testing; going to the doctor may involve less stigma than going for VCT. This can help decrease barriers around testing including that some are afraid of testing or don't think they need to get tested for HIV, and the provider will help encourage uptake. And for clients who are already very sick, they have immediate access to care and treatment.

Challenges: PITC has multiple challenges. Providers are extremely busy and may not have the time to spend with their patients to ensure client-focused counseling. Hospitals are likely to need either increased staffing or hire lay counselors. Providers may have trouble disclosing positive results sensitively, and they may not see the need to spend time with an HIV-negative patient for prevention-reduction counseling. Confidentiality is more difficult to maintain in medical situations, particularly for patients who need follow-on care. Systems must also be established before PITC can be implemented including: counseling and lab quality control, lab and test procurement, community communications, and referral systems all need to be worked out prior to roll-out. ■

VCT in Focus

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Debunking VCT Myths

By Julianna Kohler, PSI/Washington

Debunking VCT Myths is a column to clarify common misperceptions about VCT and HIV.

Myth: “There is a vaccine to prevent HIV.”

Fact: There are several vaccine candidates under study, but no vaccine has been proven to prevent HIV. Even vaccine trial participants are at risk of HIV so they are encouraged to continue using condoms and protecting themselves and should speak to the research team before undergoing any HIV test.

Myth: “HIV is spread by VCT staff who use the same needle on all their patients.”

Fact: Counselors at New Start and other VCT centers take many precautions to ensure that no one acquires HIV while undergoing testing. These precautions include using new needles and syringes with each client, immediately disposing of all sharps in biohazard containers, proper disposal of biohazard materials, and use of latex gloves and frequent hand-washing. VCT labs are consistently supervised to ensure adherence to these standards.

Myth: “New Start tests cannot be trusted because they do the tests themselves and don’t send it to an external lab.”

Fact: All of our staff, whether they are lab technicians or counselors (in certain countries) are fully trained to perform the HIV rapid tests that are approved by the Ministry of Health. By doing our tests in the same location, we can get the results back to the client faster.

Myth: “PSI VCT sites work for the government, and they want to report who is infected.”

Fact: PSI VCT sites work *with* governments in a partnership to provide high-quality VCT services to everyone who wants it. No government can access our confidential patient information. Our counselors are well-trained to provide high-quality, confidential counseling and to maintain that confidentiality for all of our patients whether in workplaces, mobile VCT or among the military. ■

Julianna Kohler is the VCT consultant for AIDSMark.

Shifting to Provider-Initiated Testing in PSI/Swaziland: What’s it all about?

By Victoria Masuku, PSI/Swaziland and Erin Stuckey, PSI/Washington

Despite the ravaging effects of HIV on Swaziland, only 12% of the population has tested for HIV. Acknowledging the grave need to scale up HIV testing, the Government of Swaziland is rolling out provider-initiated HIV testing and counseling services (PITC). PSI has partnered with the Ministry of Health (MoH) since 2004 in the provision of VCT through the New Start franchise country-wide and is now developing the training curriculum for PITC roll out.

Partnership with the MOH: PSI/Swaziland is assisting the Swazi government in developing post-test care and generic HTC communications and a coordinated, national monitoring and evaluation (M&E) plan. PSI/Swaziland also partners with University Research Cooperation (URC) in training the first group of HTC master trainers for training rollout to the country’s four regions.

Communications Promoting Provider-Initiated Testing: PSI/Swaziland is participating in the creation of Swaziland’s national health communications framework, which will guide all HTC communications throughout the country. PSI shared

results from the 2005 research and client data from the New Start VCT database to inform development of target groups and behavioral objectives. This campaign will focus on the benefits of learning one’s status, namely that by accessing HTC, clients can access individualized and targeted prevention, treatment, care and support services to lead healthier lives regardless of their HIV-status.

To complement quantitative research from 2005, the team conducted qualitative research to explore the issue of self-efficacy, which was shown to be a barrier to HTC:

1. Most respondents did not test because they fear an HIV+ result; respondents fear their family’s reaction and forced unemployment.

2. Respondents who did test almost universally had a friend or family member who had tested and encouraged them to do the same; respondents who had not tested noted a lack of awareness about positive living.

Based on this research, PSI, with input from the National HTC technical working committee, developed the following campaign:

Goal: To reduce the fear associated with testing among non-testers

Behavioral Objectives:

Intention: a) Promote a more proactive attitude towards HTC services; b) Highlight the product at the end of the process, i.e. knowledge of one’s status

Self-efficacy: a) To reduce stigma associated with being HIV+; b) Provide tangible benefits of knowing one’s status; c) Position HTC as the doorway to post-test services

Tagline: “Kusite mine kwati simo sami sengati,” which roughly means “It helps me to know my status.” All campaign materials, which include posters, billboards, and radio spots, will communicate through the theme of testimonials:

- a) What benefits you, as an individual, will receive from accessing HTC
- b) You can now access HTC through a VCT center and also from health clinics, hospitals, private doctors, and community outreach.

PSI/Swaziland is in the progress of developing an M&E plan to measure impact and further guide this national effort and will share results later this year about the program launch and success. ■

Victoria Masuku is VCT network manager for PSI/Swaziland and Erin Stuckey is associate program manager for Southern Africa in Washington.



PSI’s collaboration highlighted in local newspaper *The Swazi Observer* (March 28, 2007)

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start on ART if eligible.

Routine Testing Intervention

Training: Training guidelines were developed and trainings conducted on routine HIV testing, including lay counselors to avoid an increased provider workload. Despite the nursing staff's initial reservations to conduct post-test counseling to HIV-positive patients, nurses have accepted their new responsibilities and have improved their prevention counseling skills.

Implementation: The pilot was launched in March 2007 using all patient entry-points, including the OPD, the well-baby clinic, the antenatal clinic, all in-patient departments, and the maternity ward. HIV testing is also routinely offered to all TB patients.

Step 1: Group Education & Testing Offer:

All patients receive group education sessions from Primary Care Counselors at registration. The sessions cover HIV-related health information, the importance of HIV testing and the routine nature of HIV testing. The nurses remind the patient of the group education session and ask the patient if he/she agrees to HIV-testing. If the patient declines HIV-testing, the student nurse offers individual pre-test counseling to the patient. If

he/she refuses HIV testing, the nurse attends directly to his/her health problem for which he accessed the hospital.

Step 2: Consent: All patients who opt-in receive HIV rapid testing after written, informed consent.

Step 3: Testing and Post-Test Counseling: If a patient tests HIV-positive, he/she immediately receives post-test counseling and is advised about treatment choices based on both his/her initial health problem HIV-positive status. If indicated, clients are referred to the OI clinic. Other referral options include the home-based care program, the PMTCT program and PLHA support groups. Patients who test HIV-negative receive medical treatment then are referred to receive their HIV test results and intensified post-test counseling.

Initial Results: Out of the total number of patients tested for HIV at the hospital, 66% were through the OPD, 22% through the well-baby clinic, 9% pregnant women and 0.2% male partners through ANC, and 2.6% were in-patients. After group education sessions, HIV testing was accepted by 44% of patients in the three sections of OPD. Acceptance rate among general OPD patients, well-baby clinic patients and ANC was 41%, 46% and 93%, respectively.



Peer educators enter a New Start clinic.

Future of Pilot: Final analysis of the quantitative data from the pilot site will be conducted after 3 and 6 months and will include data on sexual risk behavior and referrals. The findings will guide the national roll out plan for PITC in additional clinical settings. ■

Dr. Karin Hatzold is senior HIV advisor for PSI/Zimbabwe.

Best of VCT Photos!

Share your favorite VCT photos in *VCT in Focus!* Please send submissions to Dvora at djoseph@psi.org.



Mobile VCT program at the Nwala Ceremony in an eastern province of Zambia.

Uganda Human Interest