

VCT in Focus

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



New Start for VCT: Targeted social marketing and service provision

Volume I, Issue 4 • November 2006

VCT Progress to Date

Letter from the Editor

Voluntary counseling and testing (VCT) has taken on increasing importance in the global response to HIV/AIDS. In 2001, it is estimated that only 8.6 million people in the developing world had received VCT services. In only 4 years, the number of persons receiving VCT has almost doubled to an estimated 16.6 million people in the developing world by 2005. Despite this rapid increase, VCT remains relatively uncommon worldwide with less than 1% of all adults 15-49 tested for HIV. To have an impact on both HIV prevention and treatment uptake requires sustained and growing investment in increasing access to both client initiated counseling and testing (VCT) and routine offer or provider initiated testing and counseling (T&C).

In 1999, PSI launched the first VCT Social Marketing project in Zimbabwe. New Start VCT was used as a model for PSI's expanding VCT program that now includes 18 country programs, mostly focused in Sub-Saharan Africa (13 country programs), Asia (4 country programs) and Haiti, testing over 1.4 million individuals and over 68,000 couples since 2002, with the number of clients increasing 48% from year to year on average.

However, we still need to do more. PSI programs have found that despite this



Increasing access to VCT among rural, underserved populations through mobile VCT in Zimbabwe (and 13 other countries)

rapid scale up, barriers and obstacles to VCT still exist. Social marketing campaigns have helped normalize testing and motivate those who would not normally test (such as couples or vulnerable populations such as sex workers and truckers) to seek out VCT services. Further, innovative techniques have helped increase access to VCT through community based outreach, satellite VCT sites (reaching rural health care facilities) and workplace VCT services.

What have we learned over the past 7 years of implementing VCT programs?

1. Partnerships are essential: PSI partners with international, local and public sector partners to scale up VCT and

increase capacity to implement services. In countries where PSI manages franchises of VCT service delivery, we have seen the number of clients tested increase as well as the capacity of service delivery and have seen the quality improve significantly.

2. Innovative techniques for service delivery are needed: Stand alone or health facility-based VCT sites alone are insufficient in meeting demand for or increasing access to VCT. Innovative techniques like mobile VCT, community based VCT and satellite or workplace VCT have been extremely effective in increasing access to VCT among under-served groups such as rural and at-risk populations.

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VCT logos that are used to promote standardized, high quality services in (left to right) Mozambique (Renacer), Togo (Centre L'Eveil and CDVA), India (Saadhan), throughout southern Africa (New Start), Rwanda (Centre Dushishoze), Myanmar (QC), and Vietnam (Chan Troi Moi)

Taking It to the Streets

PASMO Reaching Sex Workers with Innovative VCT in El Salvador

By Michael Holscher, Central America and Gerardo Lara, El Salvador

March 2005: A commercial sex worker named Lucia in a remote area of El Salvador recently decided to get tested for HIV at a public clinic after learning about her risk for HIV from a PASMO educator. When she discovered that she was HIV+, however, she felt helpless. Lucia had no idea what to do, where to go, how to care for herself and her four children, or how to protect others.

A growing number of stories like Lucia's prompted PASMO/ El Salvador to initiate critical counseling services for CSW and other marginalized groups.

PASMO began by training five BCC staff to conduct pre and post counseling, in coordination with the Salvadoran Ministry of Health. These trained counselors then hit the streets to seek out CSW and their clients, MSM, and other high-risk groups who wanted VCT services. Counseling takes place in locations such as brothels and nightclubs where these groups are already known to gather. HIV testing is conducted in collaboration with the MOH.

During the period March to August 2006, PASMO tested over 500 sex workers and 100 MSM. The HIV prevalence among those tested was 3%, significantly higher than the national prevalence of <0.5%, indicating that the project is successfully targeting high-risk populations in El Salvador.

"It is one of the most innovative and targeted VCT interventions I have seen to date," said PSI's VCT Specialist, Dvora Joseph, who visited the project for the first time last month. On a whirlwind 5-day tour, she also led a VCT training and capacity building activity for sixteen senior PASMO staff members including Country Reps Michael Holscher and Monte Achenbach.

PASMO plans to build on this pilot VCT activity in partnership with Georgetown University's Institute for Reproductive Health (IRH). Under PSI's USAID HIV/AIDS Prevention Project for Central America and Mexico—a four year, \$11 million dollar cooperative agreement— PASMO and IRH will support VCT providers, monitor service delivery and update VCT training and support activities through the

region. Developing materials that include interpersonal BCC modules with supporting print materials, PASMO will promote the benefits of knowing one's HIV status and encourage target groups, such as CSWs & clients and MSM & partners to access VCT services.

The El Salvador VCT initiative is meeting a critical need among target groups for high quality counseling and support and is an excellent example for the region and other regions with concentrated epidemics. The program is still a work in progress, as there is still a need to fine-tune certain aspects such as improving quality of counseling, collecting, analyzing, and reporting on data, and sharing experiences throughout the region. PASMO's future plans include implementing rapid HIV lab tests, which are still controlled by the MOH.

PASMO country manager for El Salvador, Gerardo Lara, and BCC coordinator Susan Padilla, deserve special recognition for their efforts. Though this program is still developing, PSI has no doubt about its potential impact—on the region and with PASMO staff. This is a valuable addition to improving essential health services in Central America, but also to motivating PASMO program staff who say they feel they are making a real difference. We look forward to seeing how this program evolves and, as the saying goes in Central America, ¡Va pue! ■

Michael Holscher is country representative for Central America, and Gerardo Lara is PASMO country manager for El Salvador.



Providing counseling and testing to sex workers with the Ministry of Health in El Salvador

VCT in Focus

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Chanuka! Get Smart in Kenya: Promoting VCT Nationwide in Kenya

By Gwen Morgan, PSI/Kenya

Mass Media Campaigns for VCT Promotion in Kenya

PSI/Kenya has implemented VCT campaigns since 2002, effectively increasing targeted demand for VCT nationwide.

In 2000, the Government of Kenya (GoK) committed to the rapid scale up of VCT and by June 2005, registered VCT sites had increased from 3 sites (in 2000) to 585 sites. In order to complement the growth in VCT services, a national communications committee was formed (MoH, NACC, USAID, CDC) and a multi-stage promotional campaign was included in the national plan. PSI was contracted by FHI and CDC as the implementing agency to support the scale-up of VCT services and to increase public demand.

Four mass media campaigns have been used to promote VCT in Kenya, using a variety of media channels. A simple, easily recognizable logo was designed and used on all advertising and print materials. Logo signboards were also provided to registered VCT sites which encouraged sites to meet quality assurance standards or else face de-registration. The logo has become widely recognized in Kenya, with unregistered sites trying to display hand painted copies.

Campaign 1: Building Confidence in VCT Services (May to September 2002)



The initial campaign utilized commonly-asked questions identified through formative research. The objectives of the campaign were to build knowledge of and confidence in VCT services, create links between consumers and VCT centers, and launch the VCT logo. The target audience was 15-39 year-olds in urban and peri-urban communities where the majority of VCT centers were located.

Campaign 2: "Chanuka" (August 2002 to January 2003)



"Chanuka" - Get Smart about your life by knowing your VCT status

This campaign targeted 15-24 year olds in urban and peri-urban settings. The aim of the campaign was to encourage youth to "get in control of their life" by knowing their HIV status. The campaign worked with popular Kenyan entertainers to encourage youth and used the slang term "chanuka" ("get smart") which became widely associated with HIV testing.

Campaign 3: "Chanukeni Pamoja" (July to December 2003)



"Chanukeni Pamoja" - Get Smart Together by knowing your VCT status to plan your lives together

The third campaign targeted urban/peri-urban 18-28 year olds. The objective was to establish a norm among young couples to know each others' HIV status during key life events such as marriage or starting a family. Taking advantage of the popular and widely-used phrase "chanuka", the third campaign used "chanukeni pamoja" which means "get smart together."

Campaign 4: "My Family Knows I'm HIV Positive and They Are Grateful I Found Out" (January to April, 2005; March to September, 2006)

Beginning in late 2004, antiretroviral treatment became available at provincial hospitals while access to VCT and other HIV clinical care services increased in

rural areas. The fourth VCT promotional campaign overtly discussed HIV and aimed to increase the understanding that, while most people test negative, there is hope and treatment available for people who test positive. This campaign targeted low income urban and rural male family decision-makers and established couples ages 18-35. It retained the "Chanukeni" phrase and also added "Onyeshya mapenzi yako" which means "show your love."



Extending VCT promotion to rural Kenya through hopeful messages

Challenges/lessons learned in implementing national VCT campaigns on behalf of the government and VCT community include:

1. Without an adequate national system for quality assurance, clients can lose confidence in VCT as a brand.
2. There has been inadequate regulation of VCT site registration and provision of official signage by the GOK, thus there are many unregistered sites with fake logos and branding, providing variable quality services in Kenya (PSI has no control over VCT as a brand).
3. It is difficult to reach the 35% of the population who have no/low access to mass media.
4. Test kit availability is unpredictable and can often delay airing of campaigns and affects campaign impact.
5. Due to a lack of national MIS for VCT, it has been impossible to collect national-level VCT data from sites in Kenya to determine campaign impact. ■

Gwen Morgan is communications and research technical advisor for PSI/Kenya.

Program Challenges

Promoting VCT among At-Risk Populations in Vietnam

Dr. Trinh Thu Hang, PSI/Vietnam

PSI launched the first VCT communications campaign in Vietnam in March, 2006 in response to the increased access to VCT nationwide. The Ministry of Health of Vietnam (MoH) rapidly scaled up VCT with support from the Center for Disease Control (CDC) and in just over three years more than 50 VCT sites in 40 provinces are fully operational. However, most sites remain underutilized and operate well below their maximum capacity. Low client flow is exacerbated by a poor understanding of VCT by target populations and stigma-related barriers.

To address this issue USAID and CDC turned to PSI in 2005 to design and implement a VCT communications program to promote VCT services to the most at risk populations—IDUs, Men who have Sex with Men (MSM), CSWs, and their sexual partners.

The campaign relies on outdoor media, posters, and IEC materials such as brochures and marketing cards to promote VCT sites as welcoming, confidential,

and high quality that can provide clients with non-judgmental and reliable results — all elements that research showed to be key motivators for VCT.



PSI/Vietnam utilizes bus stop advertising to promote “*Tran Choi Moi*” (“New Horizon”) VCT centers.

Interpersonal communicators reinforce key messages and distribute materials directly to target audiences. Images emphasize the value of professional and compassionate counseling, and the role friendly counselors play with clients in discussing fears, hopes, challenges and concerns. The generic campaign utilizes a logo also shown on signs at select high quality sites. *Chan Troi Moi* (“New Horizon”) branded sites are seen as offering important services that improve quality of life and healthier living that comes with knowing one’s HIV status.

Impact of campaign

After just 6 months of implementation client flow has increased between 5% and 50% in target provinces compared to the same period last year and 60% of VCT clients stated they had seen or heard an advertisement related to a New Horizon Center. More clients stated they had learned about VCT through a PSI advertisement than any other source, including a health worker or friend.

Challenges of promoting VCT services

1. Measuring program impact continues to remain a challenge in assessing program effectiveness. Future monitoring and evaluation steps include conducting further analysis to evaluate the impact of the campaign on VCT uptake, knowledge of VCT and perception of service quality.

2. Client flow at sites that PSI does not manage is affected by external factors beyond the control of both PSI and, at times, the sites themselves. For example, a site with some of the country’s highest client flow located in a province PSI supports recently had to relocate to a neighboring location. PSI, in partnership with the local province, attempted to redirect client flow, which dropped for some months but is rebounding.

3. Other challenges stem from the capacity gap between high-quality sites that receive sustained support, resources, and training, such as the CDC/MoH sites, and those sites that lack the resources to assure consistently high quality. PSI has worked closely at the national as well as provincial level to direct the campaign to support sites that operate to under MoH quality standards. ■

Dr. Trinh Thu Hang is senior program manager for PSI/Vietnam.



PSI/Vietnam’s bus stop advertisement by night.

Ask the Experts

Dr. Karin Hatzold, PSI/Zimbabwe



Karin manages PSI's largest VCT and post-test care program in Zimbabwe that tests over 18,000 clients per month.

What has motivated PSI/Zimbabwe to move into routine offer of testing and counseling (T&C)?

Since the introduction of *New Start* VCT in 1999 over 722,000 clients (representing 12% of the adult population in Zimbabwe) have accessed the services offered through the network of 20 VCT sites and extensive outreach covering all districts in Zimbabwe. While this represents an outstanding achievement, many more Zimbabweans need to know their status in order to effectively scale up access to care and treatment.

Based on this need, the approach of routine offer of T&C to all clients accessing public health services has been adopted by the Ministry of Health and Child Welfare (MOHCW) to scale up T&C in Zimbabwe. Success of routine T&C has been demonstrated in Botswana, one of the first countries to introduce routine HIV testing in 2004.

The positive collaboration between PSI and the MoHCW, and PSI's technical experience, led to MoHCW's decision to partner with PSI to introduce and scale up routine T&C. PSI is also involved in the development of an integrated and comprehensive HIV services communication strategy and campaign. The communication strategy is expected to reduce HIV-related stigma and increase acceptance of both client-initiated and provider-initiated T&C.

How is PSI going to shift from VCT to routine T&C? How do the two complement each other?

PSI will increase the coverage of T&C outreach especially in high risk areas such as mining areas, resettlement and commercial farming areas. PSI has also changed from direct implementation of VCT services to take on a more capacity building role in service delivery. PSI has established two Centers of Excellence to train and mentor staff from partner organizations and the MoHCW in T&C.

Both models of T&C are complementary, as patients in health care facilities will benefit from routine T&C, while clients who are motivated to know their status will continue to seek services at New Start centers. Client initiated New Start outreach services will also ensure that vulnerable population groups and those at high risk of HIV infection will continue to be reached.

What are the challenges to date in routine T&C service delivery?

1. **Lack of human resource capacity** to provide routine T&C to each patient accessing health care services. With very high levels of staff attrition and health care staff leaving Zimbabwe to neighboring countries or overseas, staff is limited. This especially affects the counseling capacity at the health care facilities.

2. Primary counselors are the cornerstone of the provider initiated T&C program. Although the MOHCW has introduced a cadre of lay counselors who receive a 6 month training in HIV counseling, **the policy currently preventing these cadres from performing rapid HIV testing will not be revised until the end of 2006.**

3. **Increased numbers of patients in need of ART and other treatment and care services**, representing a major challenge in the current health care context with shortages in ART, limited lab capacity (CD 4 cell count and other lab facilities to monitor patients on ART) and a limited human resource capacity to provide ART and follow up patients on treatment. Scaling up of both provider initiated T&C as well as treatment, care and support services must happen in tandem to yield maximum health impact. ■

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

Debunking VCT Myths

By Clancy Broxton, PSI/Washington

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

MYTH: "False positive test results are common." (Mali)

TRUTH: PSI VCT centers use government and WHO approved HIV rapid testing algorithms that minimize the risk of false positives and false negatives. The tests typically have a less than 1% chance of a false positive or false negative result (i.e., the tests are highly sensitive and specific). A serial testing algorithm typically uses one rapid test and then a confirmatory test if the first test is positive, while a parallel testing algorithm includes two

rapid tests at the same time. In both testing algorithms, a third test can be performed as a tiebreaker if the first two are discordant (occurs less than 1% of the time). This assures that counselors, lab technicians and clients have confidence in the results that are given.

Tests that are highly *sensitive* reduce the odds of reporting a false negative when HIV antibodies are present, assuming you are being tested beyond the three month window period and have not engaged in activities that put you at risk for HIV. The high sensitivity of the test creates a slightly lower *specificity*. This means the result could (infrequently) be a false positive. To compensate for this, test results are *automatically* confirmed with a second test to confirm the first positive test.

MYTH: "Once you visit a VCT center, you start losing weight and you die." (Namibia)

TRUTH: VCT centers provide a gateway to care and support services that can extend clients' lives. PSI supported VCT centers emphasize ensuring that HIV positive clients access appropriate referral services, including antiretroviral treatment (ART), treatment for opportunistic infections, post-test care groups, and other psycho-social support services. Although VCT clients who test positive may eventually get AIDS, most access care and treatment that enables them to live for a long time before becoming ill. ■

Clancy Broxton is program manager for Asia at PSI/Washington.

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3. Social marketing campaigns help fight stigma surrounding HIV and VCT in communities:

Social marketing is essential in normalizing testing and destigmatizing VCT and HIV at the community level. In countries where PSI has implemented VCT, rates of testing have increased along with recognition of the importance of VCT.

4. Routine and provider initiated T&C complements VCT and is needed to meet the need for HIV testing in high prevalence settings in health care facilities.

5. Ensuring quality counseling and testing is crucial: Standardized operating manuals, supervision and training guidelines and protocols have helped improve the quality of both counseling and testing in PSI-managed sites (considered “Centers of Excellence” in many countries) and in partner sites. Quality is essential in ensuring both behavior change and access to care and treatment as well as increasing confidence in test results by the general community.

PSI’s fourth *VCT in Focus* newsletter shares articles that highlight PSI’s lessons learned and success in the field of VCT service delivery. Articles come from Kenya, where PSI has implemented social marketing for nationwide VCT services since 2001; from Zimbabwe, PSI’s flagship VCT program that is now moving into provider initiated T&C; El Salvador, PSI’s newest, targeted VCT intervention; and Vietnam, PSI’s newest VCT social marketing program that targets the most at risk populations in Vietnam. Read on and please share your stories of VCT expansion, obstacles or success stories. ■

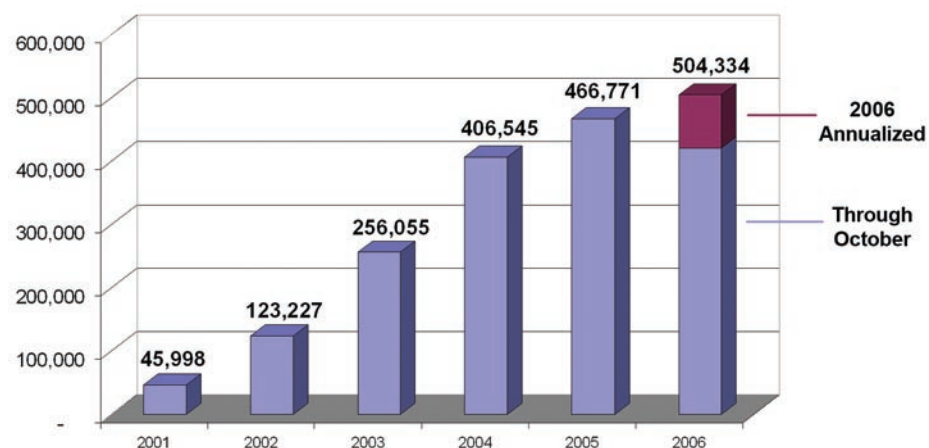
— **Dvora Joseph, VCT in Focus Editor and PSI’s HIV/AIDS service delivery manager (djoseph@psi.org)**

This newsletter was made possible through support provided by the Global Bureau of Health/HIV/AIDS, U.S. Agency for International Development, under the terms of Award No. HRN-A-00-97-00021-00. The opinions expressed herein are those of the author and do not necessarily reflect the views of the U.S. Agency for International Development.



Dvora Joseph (left), PSI’s HIV/AIDS service delivery manager, with staff of the Sun Quality Health franchise that offers VCT in Cambodia

Figure 1: PSI VCT clients (2001-2006)



PSI programs increased access to and demand for high-quality VCT services through innovative combinations of social marketing (using both mass media and IPC to increase motivation and decrease barriers around testing), and diverse service delivery models (including stand-alone, mobile, integrated in the public sector, and partner-managed/franchised models).

Figure 2: Percent increase in VCT clients

Date	Total tested	% increase	# of countries
2000	11,384	n/a	1
2001	45,998	75%	5
2002	123,227	63%	10
2003	256,055	52%	13
2004	406,545	37%	18
2005	466,771	13%	17
Through Oct 2006	420,278		18
Annualized 2006	504,334	24% (est)	

In 2005 PSI launched VCT in 3 countries: Cambodia, Myanmar and South Africa. PSI programs tested over 460,000 people in 2005, an increase of 13% over 2004.