



FHI's Contribution to HIV Counseling and Testing Scale-Up

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Panel Discussion on Expanding and Diversifying HIV Testing
and Counseling: Findings from the Field
Sponsored by the Horizons Program

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Presentation Outline

- Overview of FHI key contribution to CT scale-up
- How FHI supports CT scale-up
- Accomplishments and achievement of initiating and scaling-up of both PITC and VCT services in resource poor setting
- Examples of results in countries
- Challenges
- Lessons learned



Heart to Heart

We Listen, we Care

Summary

- CT started as a prevention intervention but expanding into HIV case finding
- Expansion requires introducing CT into sites that have not historically provided testing
- No one model serves all needs
- Mobile approaches reach those most in need but require effective planning
- The VCT model of service delivery is still necessary

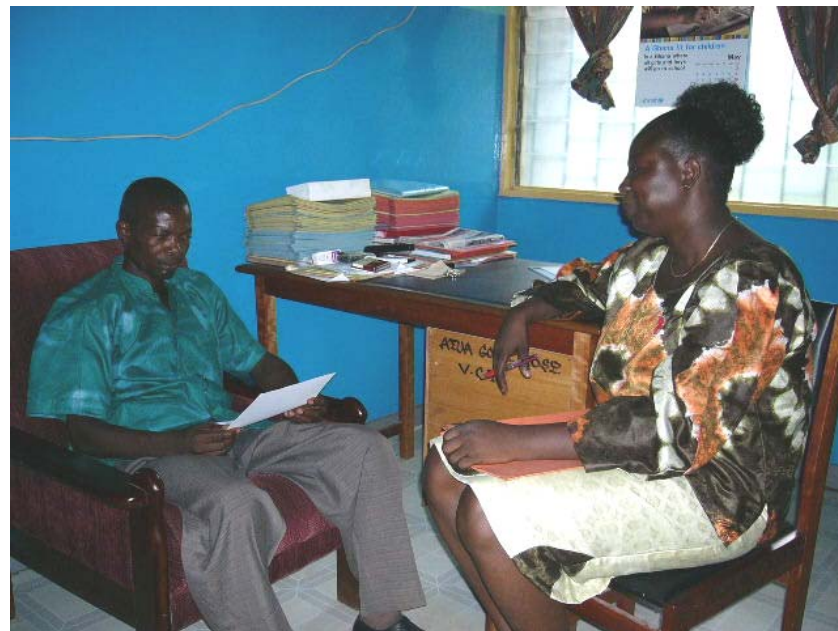


Today, in the world of CT.....

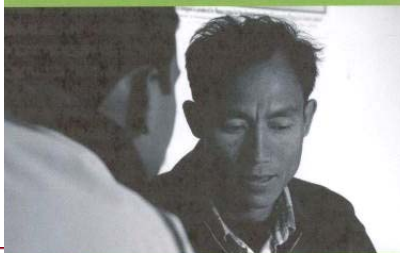
- We have the knowledge, tools and experience to implement CT
- Our hope is that getting tested for HIV infection could soon become as routine and as normal as having your temperature checked when you go the doctor.
- The big questions are –
 - Is CT as simple as that?
 - do we have the will to implement it?



What is the rethink?



**PROTECT YOURSELF
FROM HIV and AIDS
CONTACT: 527818**

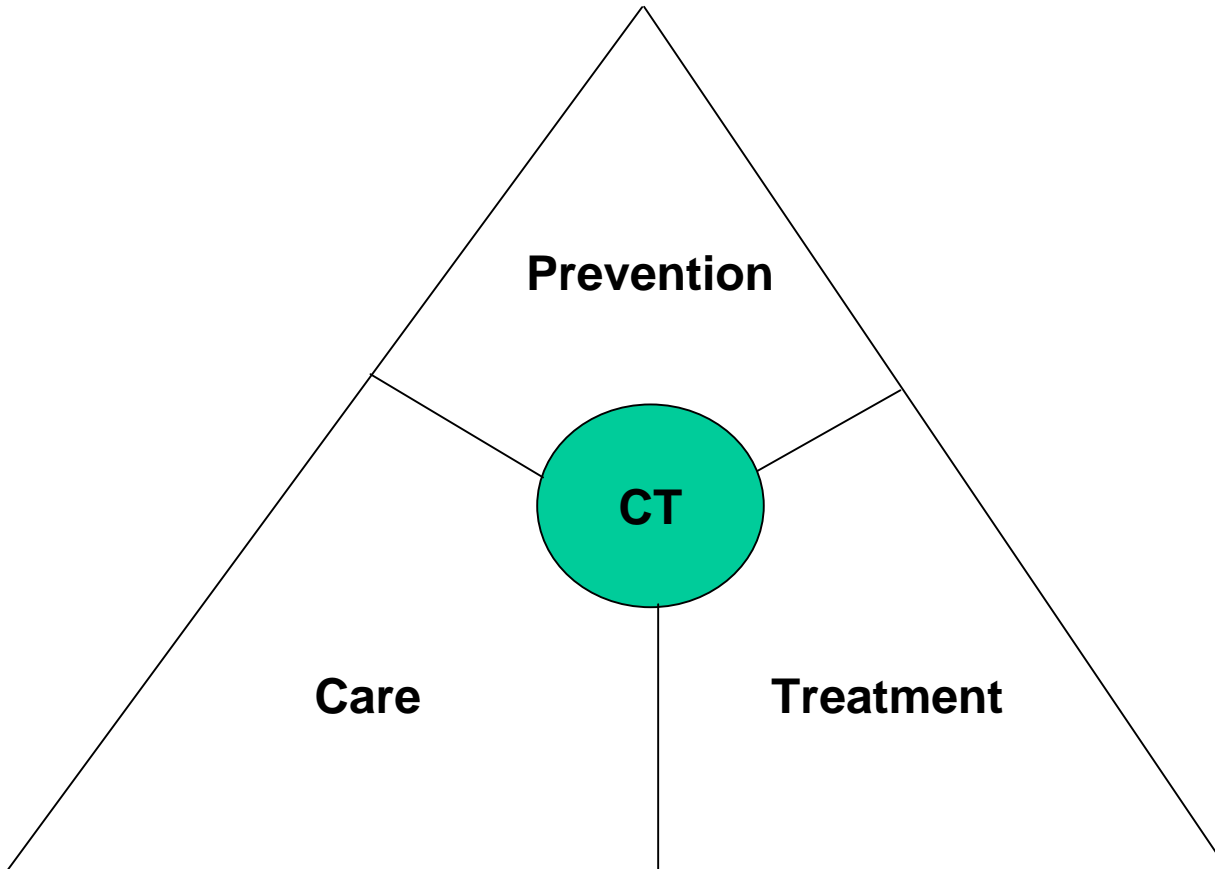


Contact us for more information on:
HIV and AIDS counselling, blood test,
care and support

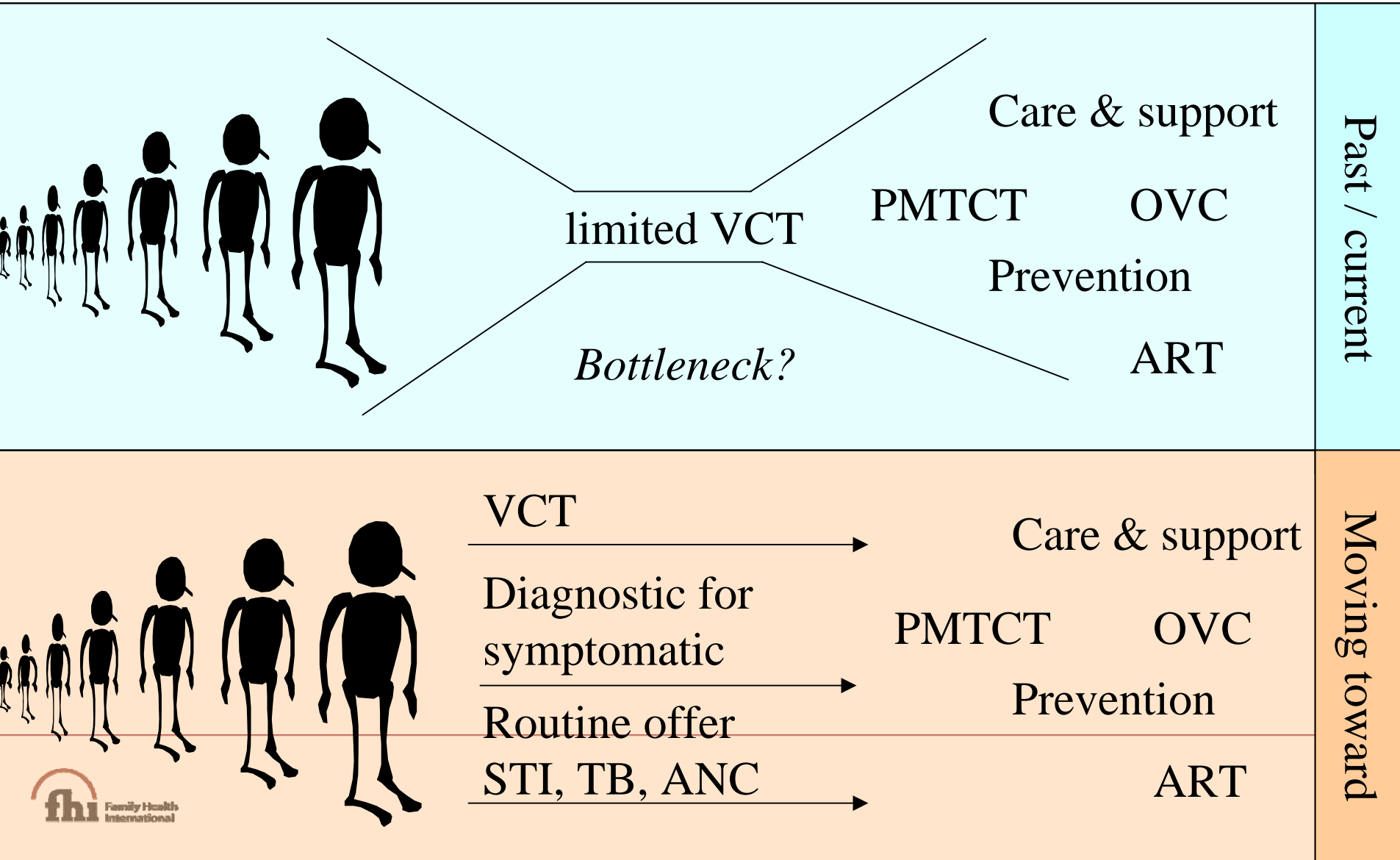
The Need to Increase Access

- 180 Million people in need of HIV Testing and Counselling Annually
 - 100 Million to prevent mother to child transmission
 - 12 Million in need of clinical care
 - 67 Million in need of prevention services

Integrated Management of Prevention Treatment and Care



Broadening entry points to testing



“Not Throwing the Baby Out with the Bath Water!”

- Benefits of VCT are well known
- Not blaming VCT; not replacing VCT
- Rather, broadening and adding new approaches in addition to VCT



Overview of FHI Contribution to CT (1)

Global/Regional Level

- **CT Multi-center Randomized Controlled Study**
 - 1995 – 1998 (Kenya, Tanzania, Trinidad and Tobago)
 - Release of study results promoted strong support for CT (USAID, UNAIDS, WHO, etc.)
- **Development of tools**
 - Guide to Establishing VCT Services for HIV
 - Reference Guide for Counselors and Trainers
 - Skills Training Curriculum Facilitators Guide with CDROM
 - Planning Guide for Commodity Management in VCT Programs

Overview of FHI Contribution to CT (2)-Country/Program Level

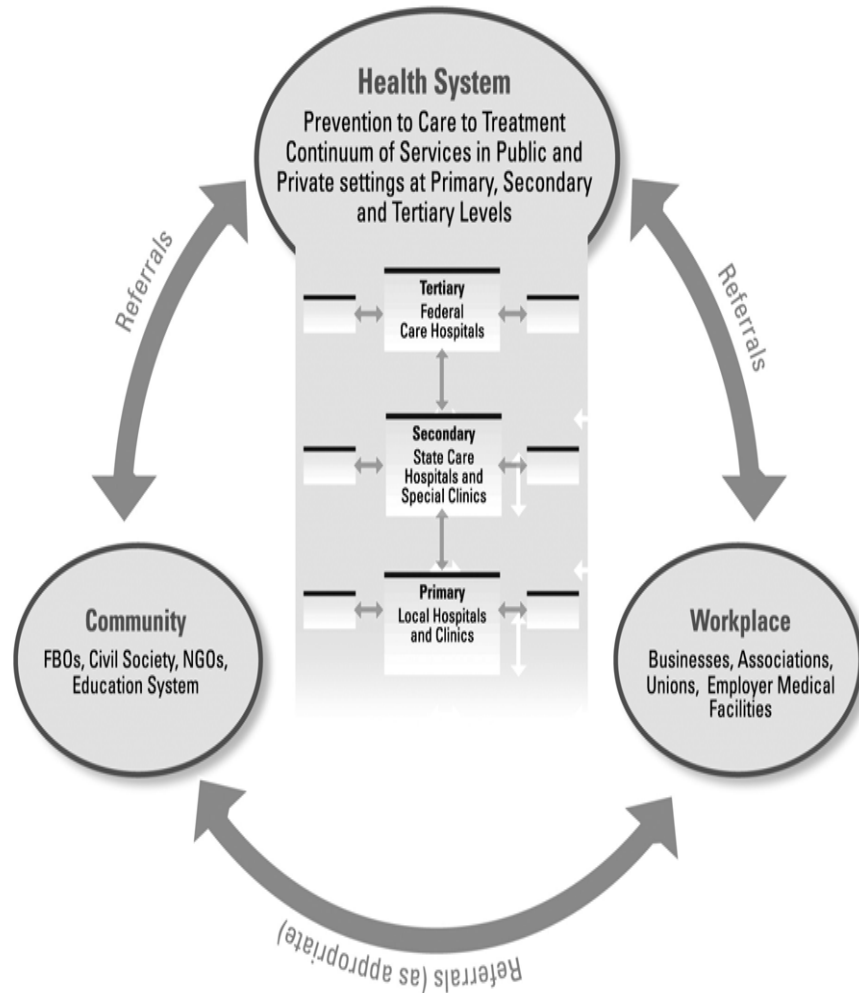
- In collaboration with international sponsors and partners especially USAID and other USG partners
- Intensified and expanded our CT support
 - From 5 sites in five countries in 1999, to > 1000 sites in 25 countries
 - Served > 1.4 million clients from 2004- Mid 2006
- Working with a wide range of partners
 - Government, FBOs, NGOs, etc



Current strategies

- Rapid scale up to increase access to care and ART
 - Broaden entry points for testing
 - Target MARPs and clinical sites likely to have ART patients
- Increase CT for prevention
 - Broaden geographical coverage
 - Expand range of services provided and Increase numbers of clients seen in existing sites
- Use different models for different needs-
 - Traditional VCT; Provider-initiated CT (At ANC; Diagnostic CT in clinical settings and Outreach and mobile CT

Scaling Up Through an Integrated Network Model



- Bridging the urban–rural divide through the establishment of a care system that utilizes all levels including rural health posts.
- Ensuring comprehensive HIV care through family oriented care centers within a referral network that links clinical with social services.

Doing this through different ways e.g.

- **Branding services**
- Using different models for different needs
- Building local capacity (strengthening national systems, training, national guidelines, protocols, SOPs, etc.) and foster ownership (working closely with NACPs, FBOs, NGOs, etc.)
- Improving procurement and supplies management
- Creatively addressing Human resources shortages a
- Creating linkages with other services (prevention and care services)
- **Adapting tools**

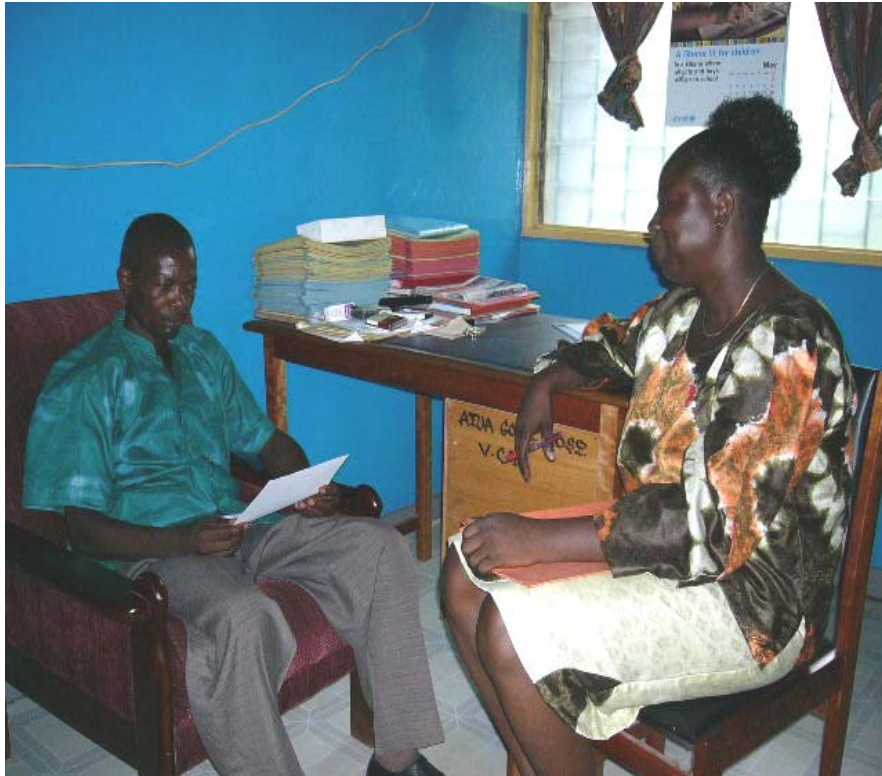


Real life process of scale-up (1)

- Form national CT task force
- Develop national CT guidelines
 - confidential HIV testing, with informed consent
 - pre- and post-test counseling
 - risk assessment and risk-reduction planning
- Develop training manual
- Training service providers
 - (varies from 40- 124 hours of training required)
- Disseminate CT guidelines to health care workers
- Developing QA protocols



Real life process of scale-up (2)



- Sensitization of key stakeholders
- Sites selection
- Training of counselors and technicians
- Renovating/re-modeling and equipping counseling room(s)
- Launching of CT services
- Mass communication campaign focusing on what CT is, benefits of CT, and where services are available

While the demographics in typical SSA would look like this.....

- **48 -74 % will be women**
- **HIV Prevalence ranging from 1.4 %- 70% depending on setting and age group**
 - **1- 4 % - < 14 years**
 - **7.8 % - 15- 29 year old**
 - **30 % - 20-24 year olds**
- **10-16 % - of Couples session will be in discordance situation**

Clients Demographic profile in concentrated and/or low prevalence setting would be different

For examples:

Of about 10,000 clients FHI served last FY in Vietnam

- 76% are male
- 23% HIV positive (70% male- 30% female)
- Average age: 28 years old
- 67% with high school degree or higher

Examples of achievements

Counseling and Testing Zambia



Provider and Client Initiated CT services in Zambia

- ZPCT supports 86 CT sites
 - about half are providing both client and provider- CT services
- Provider-initiated CT has helped increase access to ART and Care; TB patients through “opt-out”
- Clinicians are providing CT services.
- Establishing testing corners to facilitate same day results
- Broaden entry points for CT, with a focus on testing corners in TB units
- Train health care workers and community (lay) counselors in provision of CT - MOH and KCTT

Zambia- ZPCT results

- From May 2005 to January 2006:
 - 88,913 clients received test results in CT
 - 59% are females,
 - ~ 6 % are aged 14 years and below;
 - 15 % are HIV positive with no gender difference
 - 550 health care workers trained in CT as follows:
 - 316 - basic CT
 - 50 - refresher training in CT
 - 160 - CT supervision skills (KCTT)
 - 24 - couple counselling
 - 186 lay counsellors trained in CT
 - 25 of the 186 an additional three-day in HIV testing

COUNSELING AND TESTING IN NIGERIA- GHAIN

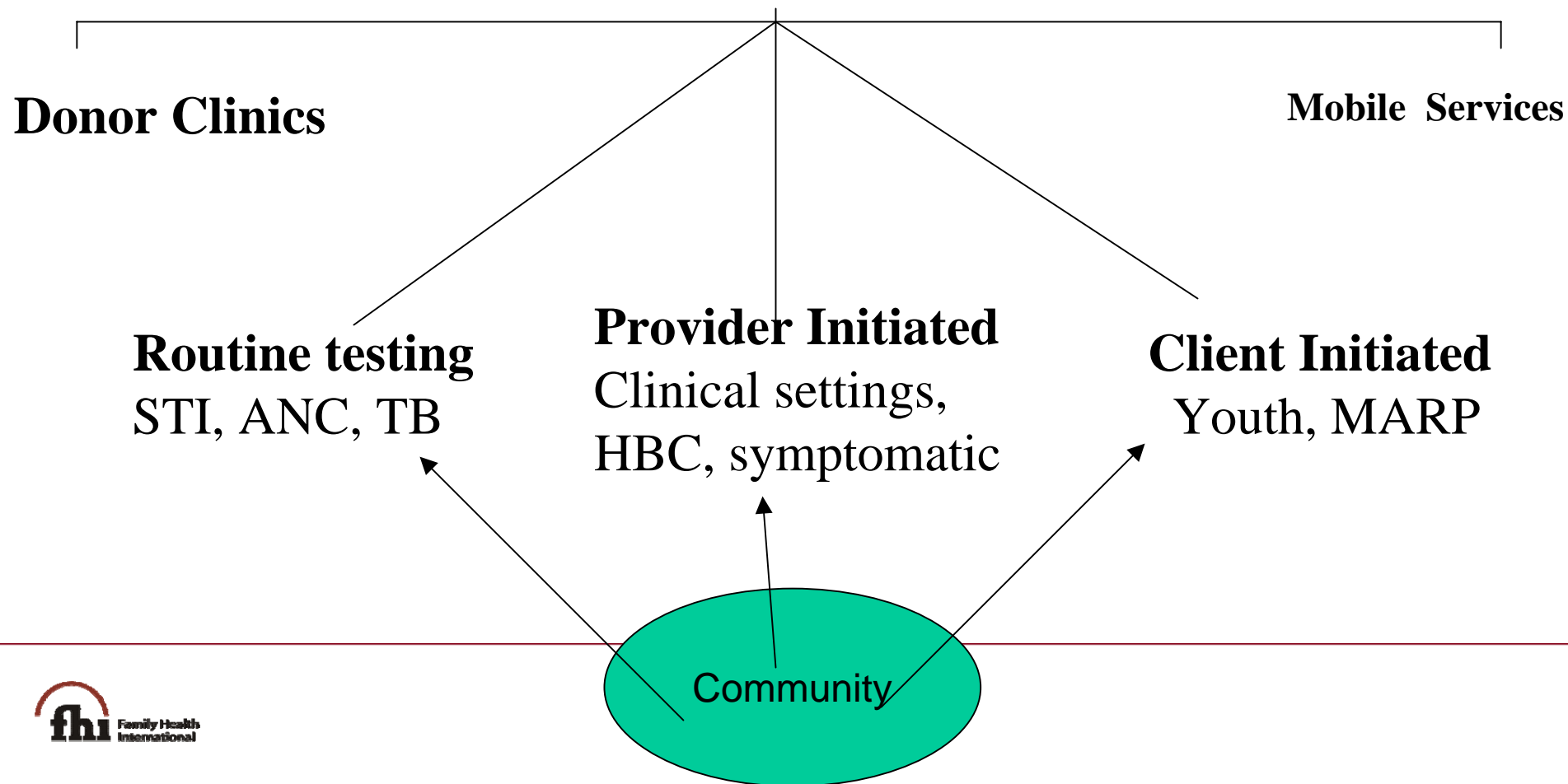


GCHAIN CT Strategy in a snap-shot

Goal: PREVENTION AND ACCESS TO CARE

HIV Counseling and testing

Different models for different needs in different settings



Provider-initiated CT activities- Nigeria

- Concept of PICT started in 2005 in at least 25 health facilities
- Goal Case Finding
- PICT specific activities include:
 - Advocacy to policy makers to support PITC
 - Review of national guidelines to include PITC
 - Sensitization of care providers in HF
 - Training of care providers on provider initiated at every POS
 - Identification of various point within facility
 - Facility upgrade- renovation, furniture and equipment
 - Logistics support- test kits and consumables
 - Orientation of staff on provider initiated

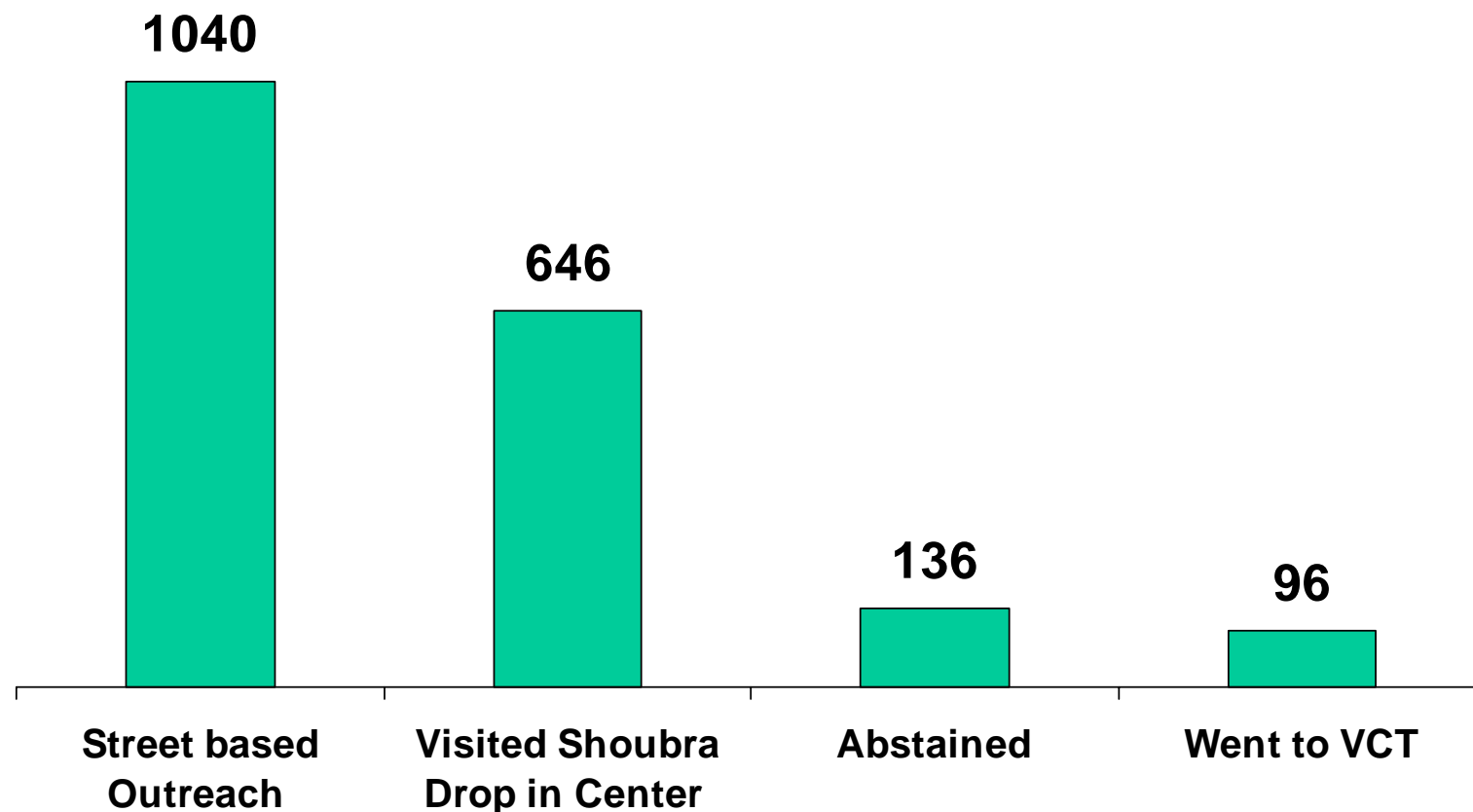
Clients served through GHAIN-supported CT Services, 2005-2006

	Male		Female		Total No
	No	%	No	%	
Clients pre-test counseled	240,911	42.2	329,884	57.8	570,795
Clients accepting test	215,195	44.1	273,051	55.9	488,246
Clients post-test counseled	210,499	46.0	247,365	54.0	457,864
HIV+	24,180	35.7	43,558	64.3	67,738

Innovative work around CT

Reaching different groups like

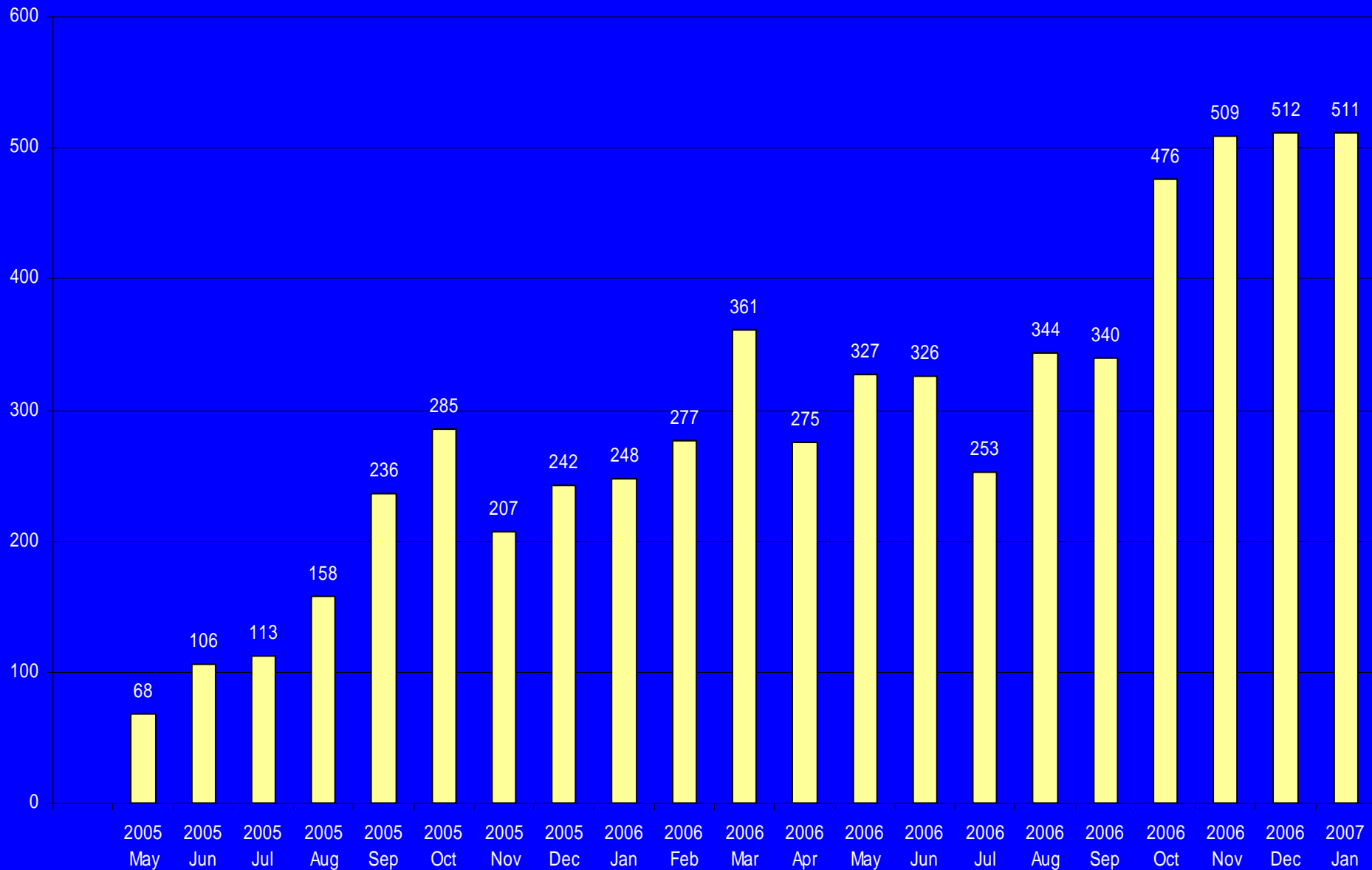
Linking IDU Outreach Program to VCT in Egypt



Number of Outreached IDUs

September 2003 – June 2005

Routine offer of CT for children in care-Zambia- ZPCT

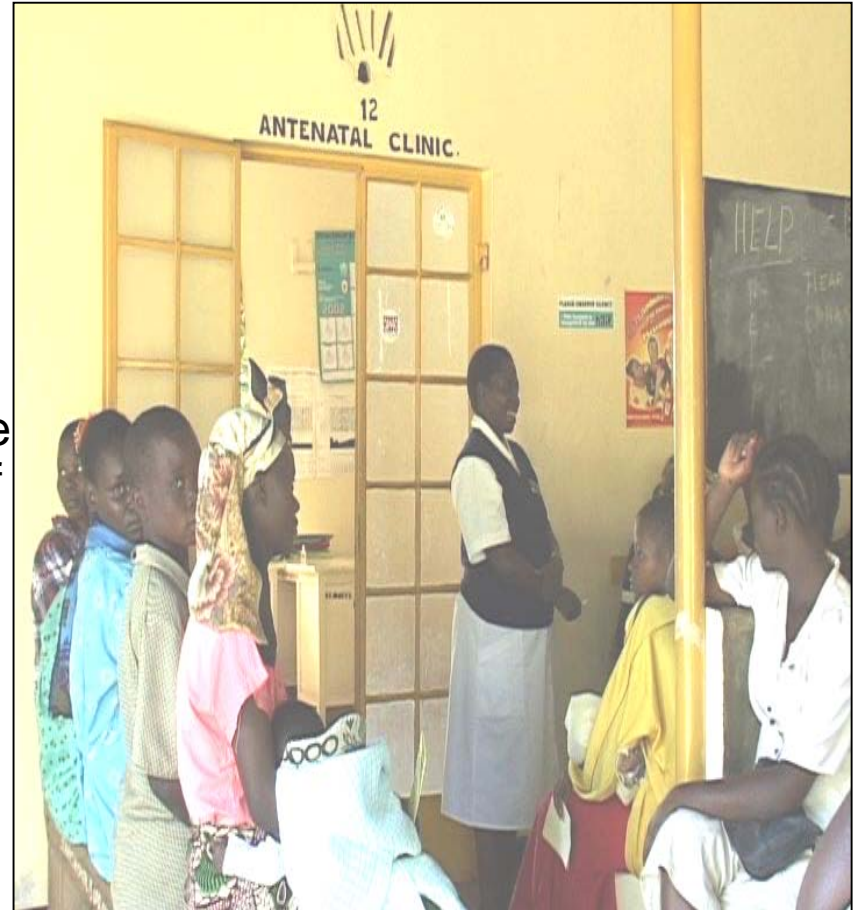


Testing Corner, Mansa General Hospital, Luapula Province



Other Creative and innovative solutions

- Use of alternative cadre of staff (e.g. lay counselors , retired nurses, sessional counselors, off-duty staff ,PLHWA as implementers)
- Routine, “opt-out”
- Group pre-test information +/- individual counseling
- VCT linked to ARV services are using the family approach to reach the members of patients on ARV.
- Rapid testing with same day/hour result
- Development of training centers with nursing and midwifery(In Nigeria)
- On site TA and training
- Door- to- Door Testing



Many constraints exist (1)

- At the macro level
 - How do we ensure that clients get longitudinal care from CT to other care and treatment programs
 - How can we effectively address stigma and discrimination?
 - **Sustainability of self-standing CT sites**
 - **How to operationalize the shift in paradigm (VCT to CT) without jeopardizing consent**
- Gender-related
 - How to promote increased access to CT for women in a safe environment that respects human rights issues, especially those of the women ?

Many constraints exist (2)

- Health systems related:
 - Unequal distribution of access (urban bias)
 - Lack of trained staff
 - Commodities and supplies
 - Lack of linkages and tools between domestic violence workers and CT providers
 - PICT still in preparatory stages
- Service delivery challenges
 - How to seize the primary prevention opportunities?
 - Disconnect between TB and HIV services and between PMTCT and Clinical care for adults and children
 - Fees for services
 - Inadequate support for counsellors

Lessons Learned

- With appropriate support, countries are able to rapidly scale up CT services
- Creating national/local ownership is critical to the success of CT program
- There is need for intensive technical assistance (handholding) to countries in the process of scale-up
- Effective promotion and demand creation must be part and parcel of CT program design and implementation
- Instituting same day CT significantly reduce the number of people who do not receive their test results
- Setting up different models of CT helps meet the needs of various potential users of the services
- CT targeted to MARPs and clients in clinical settings will be more cost effective in low prevalence settings
- Community counselors have been critical in facilities with inadequate human resource.
- Introduction of incentives to community counselors has boosted their work morale and increased client flow

Quick summary

- A dramatic and strategic expansion of HIV Counseling and Testing is essential to the provision of high-quality
 - prevention,
 - care,
 - and treatment services
- The optimal mix of approaches will depend on local
 - assets,
 - needs,
 - infrastructure,
 - and priorities

FINALLY

THANK YOU FOR LISTENING