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
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 to the doctor.

• The big questions are –
  – Is CT as simple as that?
  – do we have the will to implement it?
What is the rethink?
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

Diagram:
- Prevention
- Care
- Treatment

CT
### Broadening entry points to testing

<table>
<thead>
<tr>
<th>Past / current</th>
<th>Moving toward</th>
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<tr>
<td><strong>limited VCT</strong></td>
<td><strong>Care &amp; support</strong></td>
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<tr>
<td><strong>PMTCT</strong></td>
<td><strong>OVC</strong></td>
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<td><strong>ART</strong></td>
<td><strong>Prevention</strong></td>
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- **Bottleneck?**
  - VCT
    - Diagnostic for symptomatic
    - Routine offer
    - STI, TB, ANC
  - Care & support
  - PMTCT
  - OVC
  - Prevention
  - ART
“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
- 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
GHAIN CT Strategy in a snapshot

**Goal:** PREVENTION AND ACCESS TO CARE

**HIV Counseling and testing**

Different models for different needs in different settings

- **Donor Clinics**
  - Routine testing
  - STI, ANC, TB

- **Provider Initiated**
  - Clinical settings
  - HBC, symptomatic

- **Client Initiated**
  - Youth, MARP

**Mobile Services**

**Community**
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

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<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>Total No</th>
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<tr>
<td></td>
<td>No</td>
<td>%</td>
<td>No</td>
</tr>
<tr>
<td>Clients pre-test counseled</td>
<td>240,911</td>
<td>42.2</td>
<td>329,884</td>
</tr>
<tr>
<td>Clients accepting test</td>
<td>215,195</td>
<td>44.1</td>
<td>273,051</td>
</tr>
<tr>
<td>Clients post-test counseled</td>
<td>210,499</td>
<td>46.0</td>
<td>247,365</td>
</tr>
<tr>
<td>HIV+</td>
<td>24,180</td>
<td>35.7</td>
<td>43,558</td>
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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