



YOUTH RESEARCH WORKING PAPER SERIES

Voluntary HIV Counseling and Testing Services for Youth and Linkages with Other Reproductive Health Services in Haiti

Youth Research Working Paper No. 6





YOUTH RESEARCH WORKING PAPER SERIES

Voluntary HIV Counseling and Testing Services for Youth and Linkages with Other Reproductive Health Services in Haiti

Youth Research Working Paper No. 6



Acknowledgments

Family Health International

Heidi Reynolds
Barbara Janowitz
Rebecca Gmach
Elan Reuben
Sarah Thomsen
Jean Robert Brutus
Magda Cheron

FOSREF

Harry Beauvais
Tania Saint Dic Viala
Fritz Moise
Johanne Philgene
Barbara Roussel

CERA

Louis Marie Boulos
Michaëlle Boulos

Constella Futures

Leanne Dougherty
Nancy Murray
Ilene Speizer
(consultant)

Family Health International (FHI)/YouthNet appreciates the many contributions of people and organizations to this study. In particular, we are grateful to our colleagues in Haiti and to our partners the Fondation pour la Santé Reproductrice et l'Education Familiale (FOSREF); the Policy Project of the Futures Group (now Constella Futures); and the Centre d'Evaluation et de la Recherche Appliquée (CERA).

We would also like to acknowledge Drs. Barbara Janowitz and Cindy Waszak Geary for their mentorship throughout the study and their reviews of this report. Of course, we are deeply grateful to the research assistants who collected the data and to the supervisors, providers, and clients who participated in the study.

Others who contributed to this study include review comments from Sarah Harbison, Mahua Mandal, and Shanti Conly at U.S. Agency for International Development (USAID). Production assistance came from William Finger of FHI.

This publication is funded through the USAID Cooperative Agreement with FHI for YouthNet, No. GPH-A-00-01-00013-00, and USAID Youth Global Leadership Priority funds through USAID Cooperative Agreement GPO-A-00-05-00022-00. YouthNet was a five-year program (2001-06) funded by USAID to improve reproductive health and prevent HIV among young people. The YouthNet team was led by FHI and included CARE USA and RTI International. The information and views contained in the publication do not necessarily reflect those of FHI or USAID.

© 2007 by Family Health International
FHI Working Paper Series No. WP07-01

Family Health International, YouthNet Program
P.O. Box 13950
Research Triangle Park, NC 27709 USA
Telephone: 1.919.544.7040
Fax: 1.919.544.7261
Web site: www.fhi.org

Table of Contents

List of Tables	4
List of Figures and Abbreviations	6
Executive Summary	7
I. Introduction	11
Study objectives	12
II. Methods.....	13
Client exit interviews	13
Mystery clients.....	15
Activity sampling.....	15
Provider interviews	16
Referral records.....	16
Data entry and analysis	17
Ethical considerations and informed consent	17
III. Results	19
1. Youth’s characteristics and risk for transmitting or acquiring HIV and unintended pregnancy.....	19
Client characteristics.....	19
Clients’ service use and reason for visit	19
Risky behaviors for HIV.....	20
Perception of risk for HIV among VCT clients	22
Risky behaviors for pregnancy	24
Dual risks for HIV and pregnancy among VCT clients.....	26
2. Clients’ reproductive health and HIV awareness and knowledge	28
3. Content, quality, and organization of VCT services that youth receive	31
VCT content.....	31
Providers’ characteristics and their readiness to offer family planning.....	34
Organization of services	39
Stockouts.....	41
Referral mechanisms.....	42
IV. Discussion and Recommendations	44
V. References.....	47

List of Tables

Table 2.1: Summary of objectives addressed by data collection methods	13
Table 2.2: Summary of data collection activities and sample sizes.....	17
Table 3.1: Percent of clients with selected background characteristics for client exit interview population, by type of clinic, client, and sex.....	19
Table 3.2: Percent of clients visiting the center for the first time and number of clients receiving services for client exit interview population, by type of clinic, client, and sex	20
Table 3.3: Percent of sexually active clients with risky behaviors for client exit interview population, by type of clinic, client, and sex.....	21
Table 3.4: Percent of sexually active clients according to risk score for client exit interview population, by type of clinic, client, and sex.....	22
Table 3.5: Youth VCT clients’ perceived risk for HIV for client exit interview population, by sex	22
Table 3.6: Percent of youth VCT clients’ perceived risk for HIV for client exit interview population, by sex	23
Table 3.7: Percent of sexually active clients with behaviors that put them at risk for unintended pregnancy for client exit interview population, by type of clinic, client, and sex	25
Table 3.8: Percent of sexually active clients at risk for unintended pregnancy for client exit interview population, by type of clinic, client, and sex.....	26
Table 3.9: Percent of clients’ reports of knowledge and awareness of HIV for client exit interview population, by type of clinic, client, and sex.....	29
Table 3.10: Percent of clients’ reports of knowledge of and beliefs toward contraceptive methods for client exit interview population, by type of clinic, client, and sex	30
Table 3.11: Number of pre-HIV test counseling elements from mystery client observations	31
Table 3.12: Number of post -HIV test counseling elements from mystery clients observations .	32
Table 3.13: Number of abstinence and condom related discussions in VCT from mystery client observations.....	33
Table 3.14: Percent of clients’ reports of providers’ HIV prevention discussions for client exit interview population, by client and sex.....	33
Table 3.15: Number of fertility and family planning related discussions in VCT from mystery client observations.....	34
Table 3.16: Professional designations for provider interview population, by type of service provision.....	35
Table 3.17: Number of providers’ reports of the dual advantages of condoms, practicing abstinence, or being faithful/reducing partners from provider interview.....	35
Table 3.18: Number of providers reporting contraindications to injectable use from provider interviews	36
Table 3.19: Number of providers reporting conditions that are not contraindications to use of combined oral contraceptive pills from provider interviews	37
Table 3.20: Number of providers with composite knowledge scores from provider interviews, by type of service provided	38
Table 3.21: Number of providers who agree with certain statements about family planning and youth and HIV from provider interviews.....	38

Table 3.22: Number of domains of providers' top three general, VCT, and family planning training needs from provider interviews	39
Table 3.23: Average and total number of client contacts from activity sampling, by center	41
Table 3.24: Average length (minutes) for VCT client contacts from activity sampling, by center	41
Table 3.25: Percent of clients' reports of referrals by client exit population, by type of clinic, client, and gender	42
Table 3.26: Number of clients visiting FOSREF youth centers between January and March, 2006 and referrals between clinical and VCT services from referral data.....	43

List of Figures

Figure 3.1: Among VCT clients with two or more HIV risk behaviors, clients' perceived risk of getting HIV, by sex	24
Figure 3.2: Dual risks for HIV and pregnancy among VCT clients, by sex.....	27
Figure 3.3: Percent distribution of VCT provider activities from activity sampling, by center ...	40

Abbreviations

CEGYPEF	Center for Gynecological Prevention and Family Education
CERA	Centre d'Evaluation et de la Recherche Appliquée
FHI	Family Health International
FOSREF	Fondation pour la Santé Reproductrice et l'Education Familiale
IUD	Intrauterine Device
MCH	Maternal and Child Health
PHSC	Protection of Human Subjects Committee
RA	Research Assistant
RH	Reproductive Health
STI	Sexually Transmitted Infection
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

Executive Summary

Voluntary counseling and testing (VCT) for HIV is an entry point to other HIV services and an opportunity for individuals to learn their HIV status, learn correct knowledge, and gain accurate risk perceptions, thereby encouraging safer behaviors. Because of this, VCT should be attracting clients with a risky profile for HIV. However, there is little information about the profile of youth VCT clients.

VCT services, especially those for youth, lack rigorous evaluations. If VCT is going to have a positive effect on clients' knowledge and risk perceptions, more information is needed to understand the content and quality of youth VCT services.

Behaviors that put youth at risk of HIV are inextricably linked to other reproductive health outcomes such as unintended pregnancy. But VCT is a discrete service, even when located with other services. Many FOSREF VCT providers are recruited specifically for VCT and do not necessarily have backgrounds in health services. Even so, when providers do not identify opportunities to link all clients with needed health services, they miss an important opportunity. Few VCT services address this more holistic view of reproductive health. More information is needed about youth VCT clients' reproductive health needs and how the organization of VCT can meet youth's broader reproductive health needs.

Haiti is an important context in which to conduct the study because of the HIV epidemic, high levels of unmet need, and youth VCT services. Of youth ages 15-24, 1.5 percent of young women and 0.5% of young men are HIV-infected. Total unmet need for contraception is among the highest in the world, 58% for 15-19 year olds. To meet the reproductive health needs of young people, Fondation pour la Santé Reproductrice et l'Education Familiale (FOSREF) has been offering specialized youth friendly services for over 15 years in Haiti. FOSREF offers education and activities as well as reproductive health services, which include family planning, screening and treatment for sexually transmitted infections (STIs), prenatal care, and other services. In July 2003, FOSREF began offering VCT in their youth centers.

Study objectives

1. To determine whether the FOSREF VCT model attracts youth who are at risk of transmitting or acquiring HIV and unintended pregnancy and whether VCT clients are at higher risk compared to youth in reproductive health services.¹
2. To document youth VCT clients' reproductive health and HIV awareness and knowledge compared to youth in reproductive health services.
3. To evaluate VCT service content, quality, and organization to assess the preparedness to offer family planning.

¹ Reproductive health services include family planning, screening and treatment for STIs, prenatal care, and other services.

Methods

Between September 2004 and March 2006, data were collected from five FOSREF facilities in Port-au-Prince, Haiti. Four study sites are “youth only” sites, where new clients are limited to ages 24 and younger. The fifth site, is a general population mother-child health center (CEGYPEF) with VCT open to clients of all ages, although about half the clients are under age 24.

The study relied on five data collection methods to answer the study objectives. We conducted 954 exit interviews with VCT and reproductive health clients, 26 mystery client observations of VCT services, 39 observation days of VCT provider activity sampling, and 34 reproductive health and VCT provider interviews. Also, we reviewed 10,518 referral records. The purpose of this multi-method approach is to triangulate results to help us converge on answers to the study objectives.

Results

VCT clients had a different socio-demographic profile than reproductive health clients. VCT clients were slightly younger than reproductive health clients, had more education, were more likely to still be in school, and were more likely to be single. Almost all clients had ever had sex.

There was some differences between VCT and reproductive health youth center clients in terms of reported risk behaviors for HIV. Female VCT clients were more likely to have multiple partners than female reproductive health clients (23% vs. 12%). Condom use at last sex was highest among men (51% of VCT clients and 46% of male reproductive health clients) and female VCT clients (46%), and lowest among female reproductive health clients (17%).

Perceived HIV risk was low among VCT clients, and their risk perception did not correspond to their reported behaviors. Among VCT clients, 81% of males and 79% of females thought they had low or no risk for HIV. Even among clients who reported two or more HIV risk behaviors about three-quarters still thought they had low or no risk for HIV.

VCT clients were also at risk for unintended pregnancy. Risk for unintended pregnancy was highest among female youth VCT clients (55% compared to 15% for male VCT clients, 30% for female youth reproductive health clients, and 13% for female youth reproductive health clients at CEGYPEF). Female VCT clients were the least likely of any group to use any family planning method. When they did use a method, three-quarters relied on the male condom. But, they used it inconsistently; about three-quarters of condom users used it at last sex.

VCT clients had slightly higher HIV awareness and knowledge than reproductive health clients. For example, 97% to 98% of VCT clients knew how to prevent HIV compared to 93% of male and female youth reproductive health clients and 71% of CEGYPEF clients. Knowledge and awareness of contraceptive methods did not vary by type of client. For example, 36% to 44% of VCT clients knew the injectable is very effective at preventing pregnancy compared with 33% to 64% of reproductive health clients. Overall, however, HIV and contraceptive knowledge and awareness were low, particularly among CEGYPEF clients.

The quality of VCT counseling needs to be improved. VCT sessions were relatively short, on average a pre or post-HIV test counseling session took eight minutes. While many of the important pre-HIV test counseling elements were covered by providers, some post-HIV test elements were lacking and there was virtually no discussion of family planning or fertility desires.

Many providers gave incorrect answers to statements concerning their knowledge of reproductive health. For example, 19 of 34 providers agreed with the statement that “Before using the IUD, a young woman must have at least one child.” Eighteen providers did *not* agree with the statement, “Women who are HIV-positive and know their status have the right to have children.” Although it is impossible to know how strongly they disagreed with the statement it does suggest that training on the reproductive rights of people living with HIV is needed.

VCT providers have the time to add family planning counseling and to increase the amount of time they spend counseling clients on HIV. On average, providers spent 24% of their work day with clients. VCT providers spent a large portion of their work day on administrative (30%) and non-work related activities (25%).

Stockouts were a major problem in both reproductive health and VCT. Ten of the 13 VCT providers reported stockouts of condoms in the last six months. In the same time period, nine VCT providers were unable to conduct the HIV test because of stock outs. Fourteen of 34 providers reported that they could not provide non-condom contraceptive methods because of stockouts.

Referrals are a key mechanism to ensure that clients’ holistic reproductive health needs are met when multiple services are not available from the same provider. However, referrals were rare. Less than 24% of any type of client reported a referral to another service. One in five VCT clients were referred somewhere, the most common referral point was the VCT post-test club. Referrals from reproductive health were to other reproductive health (non-VCT) services.

Discussion and recommendations

FOSREF VCT services reach a variety of clients. Many clients are at risk for HIV and unintended pregnancy, but about one-third of sexually active VCT clients reported no risky behaviors. To increase the coverage and effectiveness of VCT, FOSREF should seek to channel clients with low HIV risk toward their non-clinical education activities while seeking to draw in clients with risk behaviors.

To address the reproductive health needs of VCT clients a number of changes are recommended. Increasing the availability of family planning can be achieved by training providers. VCT providers have time to increase their contact with clients both to improve VCT counseling and to offer family planning services. Referral mechanisms between VCT and reproductive health should be enhanced to increase linkages between services for those who need them. However, the problem of stockouts needs to be dealt with or it can undermine any improvements in provider knowledge or service organization.

Despite the fact that services need to be improved, it is important to note that FOSREF is offering services that youth need. We did not assess the other activities (clubs, education, peer education) that take place which probably have unmeasured benefits for clients. However, it does appear that many youth who need services are using them. Further, with some minimal inputs, the existing services can be organized to meet youth's reproductive health needs holistically. The largest barriers to integrated services for youth are not those within the facilities but are often external to program control – such as commodity stock out and lack of funding for reproductive health services.

I. Introduction

Youth ages 15-24 contribute up to one-half of the new HIV infections in developing countries and young women shoulder the largest burden of these infections (UN, 2006). Behaviors that put youth at risk of HIV are inextricably linked to other reproductive health outcomes such as unintended pregnancy, since HIV is primarily transmitted through unprotected heterosexual contact in generalized HIV epidemics.

In Haiti, 2.2% of the general population is HIV-infected, with urban areas experiencing a decline in HIV prevalence (Institut Haïtien de l'Enfance and ORC Macro.). Of youth ages 15-24, HIV prevalence is 1.5% for young women and 0.5% for young men. On the other hand, total unmet need for contraception is among the highest in the world, 58% for 15-19 year olds and 42% for 20-24 year olds (Cayemittes, 2001). There is very little difference in the level of unmet need by region or rural/urban residence.

To meet the reproductive health needs of young people, Fondation pour la Santé Reproductrice et l'Education Familiale (FOSREF) has been offering specialized youth services for over 15 years in Haiti. FOSREF has a network of 26 centers throughout the country, 11 of which are in the metropolitan region of Port-au-Prince. In this region, there are six youth centers, one general population center for client of all ages, and four centers that serve the needs of sex workers.

The FOSREF youth centers operate under the principle of “youth friendly services” and offer information, education, and sensitization services; clubs and activities; and reproductive health services.² FOSREF’s philosophy emphasizes high levels of youth participation at all levels of the program, which is often pointed to as a key characteristic of youth friendly programs (FHI, 2003). Across diverse settings, youth friendly programs have grown out of studies of what youth say they would like in their health programs and broadly include decision-making participation of youth, community mobilization, providers trained in youth friendly approaches, confidentiality, and convenient hours and locations.

In July 2003, FOSREF began offering voluntary counseling and testing (VCT) for HIV in three sites, and availability of VCT has since expanded to a total of 20 sites. Compared to the national youth prevalence of infection, FOSREF has documented slightly higher levels of HIV among their clients; in youth centers 1.9% of all tests were positive in the first trimester of 2006 (Beauvais et al., 2006). Among clients in the general population clinics, a large proportion of whom are under age 25, 5.9% of HIV tests in the first trimester of 2006 were HIV positive.

VCT is viewed as an opportunity for individuals to learn their HIV status, for providers to encourage safer behaviors, and to link clients with needed HIV services. Much of the promise of VCT services lies in the hands of the provider who is in an ideal position to

² Reproductive health services include family planning, screening and treatment for STIs, prenatal care, and other services.

help clients increase their knowledge, adopt accurate perceptions of their own risk, and identify options for behavior change that will decrease their risk. However, VCT as a behavior change tool has only been documented by one randomized control trial, and youth under age 18 were not included in this study (VCT study group, 2000). For those who test HIV positive, the increasing availability of antiretroviral therapy means VCT can also refer for care and treatment.

VCT should attract clients with a more risky profile than those who attend traditional reproductive health services, such as family planning. There is very little information about the profile of youth VCT clients compared to reproductive health clients.

In general, youth report relatively high levels of knowledge about pregnancy and infection prevention and can correctly identify appropriate preventative behaviors (Maswanya et al., 1999; Singh et al., 2005; Slonim-Nevo & Mukuka, 2005), yet many youth engage in behaviors that place them at risk for both STI/HIV infection and unintended pregnancy (Karim et al., 2003; Lydie et al., 2004; McCauley et al., 1995; PRB, 2001). Knowledge that is too general for an individual to actually incorporate into behavior change and/or inaccurate perception of risk or failure to admit risk may partially explain why knowledge does not translate into behavior change (Maswanya et al., 1999; Singh, 2005). More information is needed about youth VCT clients' knowledge and risk perceptions and the content and quality of VCT counseling to determine if VCT has a positive impact on behavior.

VCT is also an opportunity to identify if VCT clients have other reproductive health needs and to link these clients with those services. However, VCT is a discrete service, even when located with other services. Many FOSREF providers are recruited specifically for VCT and do not necessarily have backgrounds in health services. Even so, when providers do not link all clients with needed health services, they miss an important opportunity. Little information exists about the broader health needs of VCT clients, although one study suggests that about one-quarter to one-third of VCT clients (but not necessarily youth) are at risk for unintended pregnancy (Reynolds et al., 2006).

Study objectives

Therefore, this study has the following objectives:

1. To determine whether the FOSREF VCT model attracts youth who are at risk of transmitting or acquiring HIV and unintended pregnancy and whether VCT clients are at higher risk compared to youth in reproductive health services.
2. To document youth VCT clients' reproductive health and HIV awareness and knowledge compared to youth in reproductive health services.
3. To evaluate VCT service content, quality, and organization to assess the preparedness to offer family planning.

II. Methods

We collected data from five FOSREF facilities in Port-au-Prince, Haiti: Delmas, Lalue, Carrefour Feuille, Carrefour, and CEGYPEF (Center for Gynecological Prevention and Family Education). Four of these sites are “youth only” sites, where new clients are limited to ages 24 and younger. In addition to VCT and clinical services, these sites offer other activities such as reproductive health education, peer education, and theatre and dance clubs. The fifth site, CEGYPEF, is a general population mother-child health (MCH) center with VCT open to clients of all ages, although about half the clients are under age 24.

Prior to this study, few sites in Haiti offered VCT, much less VCT services for young people. These sites were chosen because in July 2003 four youth centers—Delmas, Lalue, Carrefour Feuille, and Carrefour—began offering VCT. These four centers are of a similar model of service delivery. Because other models of health services may also meet the reproductive health needs of youth, we added the general population maternal and child health center CEGYFEP, which had also started offering VCT services.

The study relied on five data collection methods to answer the study objectives including client exit interviews, mystery client observations, activity sampling, provider interviews, and referral monitoring (Table 2.1). The purpose of this multi-method approach was to triangulate results to help us converge on answers to the study objectives.

Table 2.1: Summary of objectives addressed by data collection methods

Objective	Data collection method
(#1 & 2) Documents VCT and reproductive health clients’ risk behaviors for HIV and unintended pregnancy, VCT clients’ perceptions of their risk for acquiring HIV, VCT and reproductive health clients’ reproductive health and HIV awareness and knowledge.	Client exit interviews
(#3) To evaluate VCT service content, quality, and organization.	Client exit interviews, mystery clients, activity sampling, provider interviews, & referral records

Client exit interviews

We conducted exit interviews with male and female VCT and reproductive health clients³ to document their risk behaviors for HIV and unintended pregnancy, perceptions

³ Through our collaboration with the Futures Group and FOSREF, data were also collected from “condom clients”—those clients who did not use other clinical services but came to pick up condoms. Data from these clients were outside the scope of FHI/YouthNet’s study objectives and thus are not included in this report. However, those results can be found in a Futures Group and FOSREF report titled, “Insights into

of their risk for acquiring HIV, HIV awareness and knowledge, and reports of services received. *VCT clients* had pre-test counseling, testing, and post-test counseling. *Reproductive health clients* had used STI services, prenatal care, pregnancy testing, gynecologic procedures, and FP services (regular and emergency contraception), or prevention of gynecologic cancer.

Clients participated in the interview if they were exiting reproductive health or VCT services, if they were between the ages of 15-24, and if they consented to participate. Questionnaires were developed specifically for this study and questions were in translated into both French and Creole. Most interviews were conducted in Creole.

There were difficulties collecting data for reasons of political insecurity that affected CEGYPEF more than other facilities. This primarily affected our ability to interview VCT clients. Due to the small number of VCT clients interviewed at the CEGYPEF clinic (seven men and nine women) and the small number of male reproductive health clients at CEGYPEF (n=4), these data were excluded. Our client exit interview population consists of 954 male and female VCT and reproductive health clients at youth centers and female reproductive health clients at CEGYPEF.

Two measures were created in an effort to quantify clients' risk for HIV and risk for unintended pregnancy. To quantify clients' potential *risk for HIV*, we created a score ranging from 0-3 with one point for each risk factor clients had. A client who had been sexually active in the last 12 months was assigned one point each time s/he reported a risky behavior that included: two or more partners in the last 12 months; no condom use at last sex; or had an STI diagnosis in the last 12 months.

These indicators were selected to measure HIV risk because of previous indicators put forth by UN Agencies and others, "condom use among young people who had higher-risk sex in the preceding year," where "higher-risk sex" refers to sex with a non-cohabiting, non-marital partner (Slaymaker, 2004; UNAIDS/Measure Evaluation, 2001; WHO, 2004b). STI diagnosis was added because monitoring STI prevalence is considered a way of monitoring levels of risky behavior (WHO, 2004b). We did not include all the risk factors that were measured in the score because we were attempting consistency with existing indicators including one put forth by UN Agencies and others (Slaymaker, 2004; UNAIDS/Measure Evaluation, 2001; WHO, 2004b). While a score is useful to describe youth by risk behaviors, it's predictive value has not been evaluated.

To measure the proportion of clients at *risk of unintended pregnancy* we created a variable based on the definition of unmet need for modern contraceptive methods (Sonfield, 2006). Sexually active clients at risk of unintended pregnancy were defined as those who had sex in the last year, desired to wait more than two years to have children but were not using modern contraceptive methods.

Mystery clients

We used the mystery client technique to evaluate the content and quality of VCT services offered at the five FOSREF sites. This technique uses research assistants (RAs) who are trained to act like VCT clients and to document their experiences. After the VCT session, RAs recorded what happened in the VCT session using a data collection form in French designed specifically for this study. Mystery clients participated in the VCT session in the language that was most natural for them, and this was usually Creole. RAs were at least age 18, two were female, four were male, two were HIV-positive, four were HIV-negative, all were or had been sexually active, they knew their HIV status, and they were willing to be tested again.

RAs stuck to their “true” story with providers so that they could act as natural as possible with the provider. An exception was made for the number of times they had been HIV tested. RAs were instructed to tell the provider this was their first HIV test, since this would reflect the situation for most VCT clients. Moreover, it might have raised providers’ suspicions if they were honest about the number of tests. The only other exception was that RAs were also instructed to wait and see if the provider mentioned condoms and contraceptive methods. If this did not occur, RAs asked the provider for this information.

RAs did not reveal the data collection instrument to the provider. Instead, after the VCT session, RAs went immediately to a private location to fill in the instrument. At the end of each day, the supervisors looked over their responses, asked any clarifying questions, and made any adjustments as necessary.

The supervisor of each VCT center was notified in advance about the study. They were given a block of time, but they did not know specifically when data collection would take place. Supervisors were responsible for notifying providers about the study.

The six RAs made 26 mystery client visits to five VCT centers. Each RA made between four and five visits but never to the same VCT center. Although the six RAs who served as mystery clients made 26 mystery client visits to five VCT centers, two visits were not completed. In one case, the mystery client was turned away because she was “too old”. In the other, the observation was not completed due to an RA error. Thus, the results are based on observations made during 24 mystery client visits.

Activity sampling

Activity sampling is a technique that provides information about how VCT services are organized and assess the preparedness of providers to offer family planning. Specifically, activity sampling measures how VCT providers spend their time during a full day on the job. An RA followed one provider per day. RAs used a watch that beeped every three minutes, and at that moment, the RA checked off the activity that was being performed by the provider using a form developed specifically for this study. The form had a list of 41 activities, but when necessary, the observer could add activities. The activities were re-coded into six categories:

- With a client (provider in consultation room with a client),
- Attending group-work related activities (e.g., health discussion, group education, etc.),
- Carrying out administrative tasks (e.g., filling out records, attending a work related meeting, etc.),
- Engaging in personal activities (e.g., lunch, toilet),
- Non-work related activities (e.g., personal telephone call, reading newspaper, etc.),
- Not at the clinic during provider's regular work hours (e.g., not present when shift began, left early, or attending personal matter outside clinic), and
- Unknown.

We used this information to determine the number of minutes spent in these activities over the course of an average provider work day. We present the percent of providers' time spent on each of the activities. Results also include the number, duration, and types of all provider-client contacts.

Two providers of VCT services were selected from each of the four youth clinics (CEGYPEF excluded). Either the primary VCT counselor or the assistant counselor was observed, since these providers have different designations and therefore different roles in the clinic. In total, 39 observation-workdays of data were collected from 8 providers.

Provider interviews

Interviews with providers provided information about the quality of services they offer and assess providers' preparedness to offer family planning. We sought to interview all providers in the five FOSREF sites who provided VCT and/or reproductive health services. Thirty-four providers from five health facilities participated in the survey. The majority of providers (14 of 34) were providers at CEGYPEF, while six were from Delmas, five each from Carrefour and Carrefour-Feuille, and four from Lalue.

Referral records

Referral records provide insight into how common referrals between services are. At the time of study initiation, FOSREF was developing a referral database in Microsoft Access. The database was refined and expanded to the four youth centers in this study. This system tracks clients using a unique identifying number. At their first visits, clients are given an identification card that has the identifying number, the date the card was issued, the client's name, and his/her sex. Clients cannot use their cards at different FOSREF centers.

All clients' first point of contact in the FOSREF centers is the reception. At the reception, the receptionist records the date of the client's visit, client's name, age, sex, place of residence (in or out of catchment area), and what service or activity the client is referred to.

Providers in clinical services/reproductive health and VCT also kept records of the clients they served. All providers recorded the client’s code, date, place of referral from, and place of referral to. Clinical services record services received and family planning method received if applicable. VCT records whether the client received the pre-test counseling, HIV test, and post-test counseling. The reception and providers collect this information, and at the end of each day it is entered into the computer.

Although all four centers were collecting referral data by the end of December 2005, centers started at different times. We decided to standardize by analyzing the data for the first quarter of 2006. During the first quarter, January to March 2006, clients made 10,518 visits to the four youth centers.

There were a number of issues that call into question the quality of the referral data. We had to eliminate many cases that were missing information or had irrational information (e.g., dates of visits later than the year 2006). Political upheaval, electrical shortages, and issues with supervision affected the quality of the data.

Table 2.2 summarizes the data collection activities described above including the facilities and services that participated, the dates of data collection, and sample sizes.

Table 2.2: Summary of data collection activities and sample sizes

Data collection technique	Facilities participating	Services included	Dates of collection	Total sample size collected
Client exit interviews	All 5 study sites	VCT and RH	Sept.-Dec. 2004	954 interviews
Mystery clients	All 5 study sites	VCT	Jan.-Feb. 2005	26 observations
Activity sampling	4 youth sites	VCT	Feb.-Mar. 2005	39 observation days
Provider interviews	All 5 study sites	VCT and RH	January 2005	34 interviews
Referral records	4 youth sites	All youth visiting center	Jan.-Mar. 2006	10,518 client visits*

*includes youth who made multiple visits

Data entry and analysis

Data were entered, consistency checks performed, and data were cleaned in Haiti by staff from FOSREF or Centre d’Evaluation et de la Recherche Appliquée (CERA; the local research organization). For the client exit interview, data were entered using CSPro 2.5, developed by the U.S. Census Bureau, Population Division International Programs Center (IPC). For this report, data were analyzed in North Carolina using SPSS version 13. For the mystery client data, the activity sampling data, and provider interview data were entered into EpiInfo version 6. As mentioned previously, the referral data are entered in Microsoft Access. For this report, data were analyzed in North Carolina using SPSS version 13.

Ethical considerations and informed consent

FHI’s Protection of Human Subjects Committee (PHSC) and the Ethical Committee of the Ministry of Public Health and Population in Haiti reviewed and approved the study.

For all participants, RAs informed participants of their rights and risks of participating in the study according to a standardized informed consent process. No names or identifying information were obtained from participants. For data collection activities with adolescents 15-17, we obtained parental consent and adolescent assent if adolescents specifically attend VCT or reproductive health services with their parent/guardian.

III. Results

1. Youth's characteristics and risk for transmitting or acquiring HIV and unintended pregnancy

Client characteristics

VCT clients were younger than reproductive health clients. They had more education, were more likely to still be in school, and were more likely to be single (Table 3.1). Slightly under half of the VCT clients were female, while reproductive health clients were almost all female. CEGYPEF clients were older than other youth reproductive health clients, had slightly less education, were less likely to be in school, and were more likely to be in union.⁴ Since youth do not typically attend health services for preventative services or education alone, it is not surprising to note that almost all youth who participated in the study had ever had sex at the time of the interview. Given their young age, many youth center clients were still in school and not in union, although clients were well educated relative to youth of similar characteristics in the general population, an observation that has been noted elsewhere (Murray et al., 2005).

Table 3.1: Percent of clients with selected background characteristics for client exit interview population, by type of clinic, client, and sex

	VCT		Youth		CEGYPEF
	Male N=186	Female N=158	Male N=27	Female N=395	RH Female N=188
Age	%	%	%	%	%
15-19 years	55	51	33	37	21
20-24 years	45	49	67	63	79
Education level					
None or primary	2	2	0	16	35
Secondary	91	87	78	77	60
Superior	7	11	22	8	3
Still in school	82	83	100	62	28
Marital status					
Married/ Placed*/	25	28	34	52	80
Cohabit					
Not in union	76	72	67	48	20
Ever had sex	98	89	93	91	94

*In Haiti, "placed" is a type of union that is less formal than marriage.

Clients' service use and reason for visit

Many clients had been to the facilities before, although a majority of female VCT clients were making their first visit to the facility (Table 3.2). As expected, because VCT is a discrete service, VCT clients almost exclusively received HIV testing and no other services.

⁴ Across groups, almost all clients in the group "married, placed or cohabiting" were actually cohabiting or placed (results not shown). In Haiti, "placed" is a type of union that is less formal than marriage.

Unlike VCT clients, reproductive health clients received a variety of services, particularly the youth reproductive health clients, although few received VCT (Table 3.2). The exception is that about 12% of male reproductive health clients received VCT, probably because they were mainly STI clients. The majority of female CEGYPEF clients were seeking family planning compared to only one-third of female youth reproductive health clients. Men and women received different services.

Table 3.2: Percent of clients visiting the center for the first time and number of clients receiving services for client exit interview population, by type of clinic, client, and sex

	Youth				CEGYPEF
	VCT		RH		RH
	Male N=186	Female N=158	Male N=27	Female N=395	Female N=188
First visit to the center	% 26	% 57	% 42	% 39	% 41
Services received*					
HIV test	92	94	12	1	0
Family planning	0	0	8	36	51
Test/treatment STI	0	0	62	23	2
Pregnancy test, prenatal care, or postnatal care	0	1	0	17	16
Education or condoms	4	1	0	2	1
Other	0	2	19	22	16

* Column adds to more than 100% because more than one response was possible

^{||} “Other” services mainly include non-specific gynecologic services

As expected, almost all VCT clients (92%) reported having had an HIV test (most likely because these were exit interviews). Although less than half of reproductive health clients (36% to 41%) reported ever being tested (results not shown), this was much higher than the general population in Port-au-Prince (7% for women and 13% for men) (Cayemittes et al., 2002).

Risky behaviors for HIV

In order to compare youth VCT and reproductive health clients’ risk for transmitting or acquiring HIV and unintended pregnancy, we examine their reported behaviors in the client exit interview.

While VCT clients who have never had sex may be curious about the service or seeking HIV test results for some sort of employment, marriage, or religious requirement, they are not at risk of being HIV infected through sexual intercourse. Thus, for the rest of this section and where otherwise noted, clients who have never had sex are excluded from the denominators.

Many clients, regardless of whether they were VCT or reproductive health clients, and men more than women, reported risky behaviors for HIV. In the last year, most clients

were sexually active, and the majority of men had multiple partners (Table 3.3). Female VCT clients were more likely to have multiple partners than female reproductive health clients. Condom use at last sex was highest among male VCT clients, followed by female VCT clients and male reproductive health clients, and lowest among female reproductive health clients. Male reproductive health clients were most likely to have had an STI in the last 12 months.

Another indicator of risk for HIV is sex in exchange for money, favors, or gifts (otherwise known as “transactional sex”). Transactional sex increases risk because it introduces economic and power differentials which may reduce one person’s ability to negotiate for safer sex or expose them to the risk of forced sex (Luke and Kurz, 2002). Contrary to the traditional transactional sex pattern where women receive money and men give money for sex, we found men to be more likely to report both giving and receiving money for sex compared to women (Table 3.3).

Table 3.3: Percent of sexually active clients with risky behaviors for client exit interview population, by type of clinic, client, and sex

Of clients who’ve had sex...	VCT		Youth		CEGYPEF
	Male N=183	Female N=139	Male N=25	Female N=355	RH Female N=176
	%	%	%	%	%
< 12 months since last sex	83	93	84	92	93
Two or more partners in last 12 months	57	23	56	12	6
Condom used last sex	51	46	46	27	14
Had STIs in last 12 months	8	9	48	17	9
Ever gave money, favors, gifts for sex	19	1	32	1	0
Ever received money, favors, gifts for sex	13	2	24	2	1

The majority of clients had at least one risk factor for HIV (Table 3.4), but there are no differences in HIV risk scores between VCT and reproductive health clients. The average number of risk factors, however, was relatively low. About one-third of VCT clients had no risk factors. This finding raises the question about why they were using VCT (which, unfortunately, we did not explore). Male reproductive health clients followed by male VCT clients were the most likely to have two or more risk factors. Female reproductive health clients at CEGYPEF were the least likely to have two or more risk factors.

The high proportion of female reproductive health clients with one risk factor is mostly explained by the fact that the majority of these clients were married or in union and they did not use a condom at last sex (results not shown). However, condom use was lower among female VCT clients compared to male VCT clients and these clients were less likely to be married.

Table 3.4: Percent of sexually active clients according to risk score* for client exit interview population, by type of clinic, client, and sex

	VCT		Youth		CEGYPEF
	Male N=183	Female N=137	Male N=25	Female N=353	RH Female N=176
Of clients who've ever had sex, clients with:	%	%	%	%	%
0 risk factors	33	38	24	27	17
1 risk factor	38	45	36	56	73
2 risk factors	25	15	20	17	10
All 3 risk factors	4	3	20	1	1
Mean number of risk factors	1	0.84	1.36	0.93	0.96

*In order to score a point on the scale, clients had to have been sexually active in the last 12 months *and* reported a risky behavior that included: Two or more partners in the last 12 months, no condom use at last sex, or had an STI diagnosis in the last 12 months.

Perception of risk for HIV among VCT clients

High perceived risk may suggest the potential for behavior change following VCT. Few VCT clients felt they had a high or moderate risk of getting HIV (Table 3.5); in fact about one-half of both women and men felt they had no risk. On the other hand, most VCT clients said that they desired another HIV test (85% to 86% of VCT clients) (results not shown). These results raise the question as to why these clients are seeking VCT. More research is needed to understand why VCT clients perceive they have no HIV risk yet have a high demand for VCT services.

Table 3.5: Youth VCT clients' perceived risk for HIV for client exit interview population, by sex

	Youth VCT	
	Male N=174	Female N=137
Self assessed risk of getting HIV	%	%
High risk	5	6
Moderate risk	11	7
Small risk	29	33
No risk	52	46
Don't know	5	8

Women more than men credited condom use for their low perceived risk; women were equally likely to acknowledge condom use and faithfulness (Table 3.6). Despite 83% to 93% reporting they were sexually active in the last year (Table 3.3), 31% of male VCT clients cited sexual abstinence as their reason for small or no risk of HIV (Table 3.6). This observation raises questions about these clients' understanding of abstinence, which unfortunately we did not investigate.

For the few clients who thought they had high or moderate risk of acquiring HIV, male VCT clients cited “sex with many partners” and female VCT client cited “not faithful” as the main reasons (Table 3.6). These reasons were closely followed by “no condom use.”

The results also indicate a knowledge gap of how HIV is transmitted. About 15% of VCT clients had “other” reasons for their risk perception, a category which mainly included “don’t know” and “consult a traditional healer.” A similar proportion cited “risky” contacts which mainly included contacts which are not actually risky (e.g., hugging, kissing, etc.).

Table 3.6: Percent of youth VCT clients’ perceived risk for HIV for client exit interview population, by sex

	Youth VCT	
	Male %	Female %
Reasons for self assessed <u>small or no risk</u> *	N=138	N=81
Use condoms	57	62
Faithfulness	23	62
Abstain from sex	31	14
Limit sexual partners	9	41
Avoid risky sex †	7	4
Avoid risky contact ‡	18	17
Other^^	11	14
Reasons for self assessed <u>high or moderate risk</u> *	N=26	N=18
Not faithful	46	44
Do not use condoms	46	39
Sex with many partners	50	22
Have risky sex †	12	0
Have risky contact ‡	8	17
Other ^^	27	17

* Columns add to more than 100% because multiple responses were possible

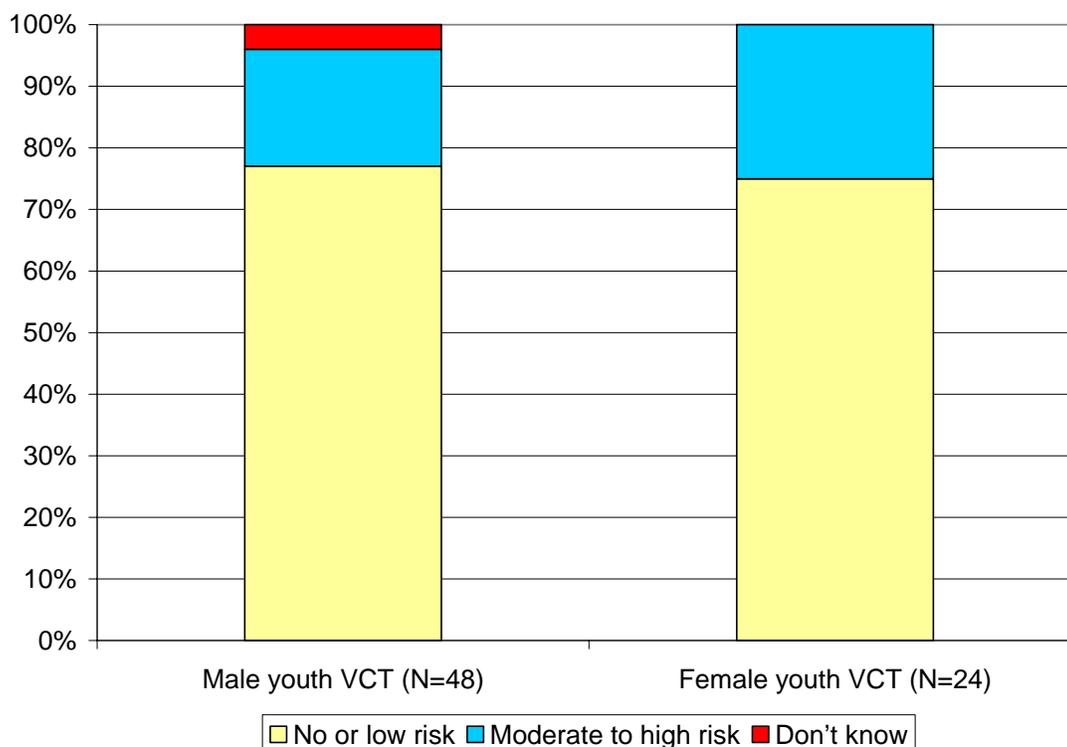
† People with risky behavior include promiscuous individuals, prostitutes, homosexuals, injecting drug users

‡ Risky contacts include blood transfusions, injections, kissing, hugging, sharing razors

^^This includes individuals who consult a traditional healer and said they don’t know the reason of their risk perception

Inaccurate perception of risk may be linked to lack of behavior change and may indicate needed improvement in VCT to increase accuracy of risk perceptions. We compared VCT clients’ perceived risk of getting HIV with their reported risk behaviors. Figure 3.1 demonstrates that less than one-quarter of VCT clients who reported two or more risk behaviors thought their risk of getting HIV was “moderate” to “high.” The reasons clients who scored higher on the risk assessment gave for why they considered themselves as at low or no risk for HIV were not different from the reasons in Table 3.6.

Figure 3.1: Among VCT clients with two or more HIV risk behaviors, clients' perceived risk of getting HIV, by sex



Risky behaviors for pregnancy

Many clients who have ever had sex had previous unintended pregnancies (or their partners did) (Table 3.7). The majority of female reproductive health clients had ever been pregnant, and at least two-thirds of those pregnancies were not desired. VCT clients were less likely to have had previous pregnancies, but around one-quarter of males and females had been pregnant or gotten their partner pregnant. Over three-quarters of these pregnancies were undesired.

Many clients were also at risk for future unintended pregnancies. Almost all VCT and reproductive health clients wanted to wait two or more years before their next pregnancy (or their partner's next pregnancy) (Table 3.7). As expected, female reproductive health clients were more likely to be using contraception than female VCT client given the type of services they're using. Also, VCT clients, particularly men, were most likely to be using condoms as their method of contraception compared to female reproductive health clients who were primarily using injectable methods.

Results for female VCT clients underscore an important opportunity to prevent unintended pregnancies by increasing the use of any method or increasing the use of consistent condom use. Female VCT clients were the least likely of any group to use any

family planning method. Of female VCT clients who used a method, three-quarters relied on the male condom. But, they used it inconsistently; about three-quarters of condom users used the method at last sex.

Table 3.7: Percent of sexually active clients with behaviors that put them at risk for unintended pregnancy for client exit interview population, by type of clinic, client, and sex

Of clients who've had sex.....	Youth				CEGYPEF RH Female %
	VCT		RH		
	Male %	Female %	Male %	Female %	
Even been pregnant or gotten partner pregnant	N=183 22	N=139 25	N=25 28	N=355 61	N=176 82
Last pregnancy not desired	N=38 76	N=35 80	‡	N=218 74	N=144 63
Wants to wait more than two years until next pregnancy/partner's pregnancy	N=183 94	N=139 91	N=25 86	N=326 91	N=158 93
Current use of contraception[†]	78	45	68	59	69
Type of method in current use[†]	N=137	N=61	N=17	N=193	N=109
Condom	87	77	88	26	6
Injectable	1	2	0	64	87
Pill	1	2	0	8	2
Implant	0	0	0	0	4
Other*	12	20	18	6	1
Contraceptive use at last sex[†]	N=183 46	N=139 52	N=25 54	N=349 62	N=173 57
% using condoms at last sex (of clients use condoms as contraception)[†]	N=119 61	N=48 72	N=15 67	N=50 66	‡

* Includes rhythm method, periodic abstinence, abstinence, traditional methods

[†]These variables exclude the 40 pregnant women seeking prenatal care

[‡] N=7, results not presented

As expected, the clients most at risk of unintended pregnancy were female VCT clients (Table 3.8). These results underscore the fact that VCT clients, particularly female VCT clients, are at risk of unintended pregnancy.

We may have underestimated clients' risk of unintended pregnancy because, as we noted above in Table 3.7, a large proportion of clients, particularly VCT clients, rely on condoms for contraception but did not use condoms at last sex. In order to assess the magnitude of the effect that inconsistent condom use has on the risk of unintended pregnancy, we created a second pregnancy risk variable. Clients who used condoms as

contraception but who did not use condoms at last sex were classified as at risk of unintended pregnancy. Table 3.8 shows that among groups that rely on condoms for pregnancy prevention and who use condoms inconsistently, such as the male VCT clients, traditional measures of unmet need may underestimate the risk of unintended pregnancy by as much as 20%.

Table 3.8: Percent of sexually active clients at risk for unintended pregnancy for client exit interview population, by type of clinic, client, and sex

Of clients who've had sex.....	VCT		Youth		CEGYPEF
	Male N=183	Female N=139	Male N=25	Female N=326	RH Female N=158
Risk of unintended pregnancy*†	% 15	% 55	% 24	% 30	% 13
Risk of unintended pregnancy (w/ clients who did not use a condom at last sex)†‡	35	61	32	34	14

*Clients at risk of unintended pregnancy are those clients who had sex in the last 12 months, are not using a modern method of contraception, but do not want a pregnancy for more than two years (of all clients who have ever had sex).

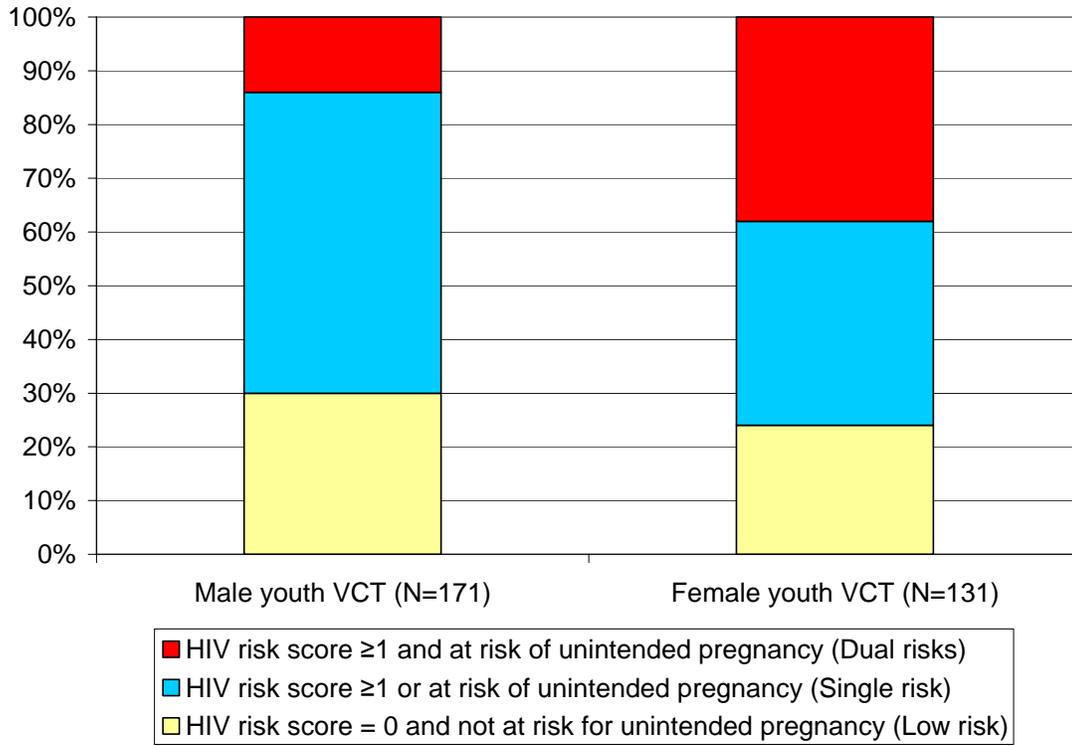
†These variables exclude the 40 pregnant women seeking prenatal care.

‡This indicator of “risk of unintended pregnancy” is defined as those clients who had sex in the last 12 months, are not using a modern method of contraception or use condoms but did not use condoms at last sex, and they do not want a pregnancy for more than two years (of all clients who have ever had sex).

Dual risks for HIV and pregnancy among VCT clients

To assess the extent to which VCT clients have dual HIV and pregnancy risks, we combined their HIV risk score and the risk for unintended pregnancy measures in Figure 3.2. “Single” risk for HIV or unintended pregnancy was defined as a VCT client with a HIV risk score of one or more (see Table 3.4) *or* were considered at risk of unintended pregnancy (see Table 3.8). A client with “dual” risk is, of course, a client who meets both criteria. Results suggest that female VCT clients are the more vulnerable than male VCT clients in terms of single and dual risks for HIV and pregnancy.

Figure 3.2: Dual risks for HIV and pregnancy among VCT clients, by sex



2. Clients' reproductive health and HIV awareness and knowledge

In this section we examine VCT clients' family planning and HIV awareness and knowledge and compare this information to that for reproductive health clients. VCT clients should have better HIV knowledge as they are exiting VCT if VCT is doing what it is supposed to. Reproductive health clients' family planning knowledge gives us a picture of the information that VCT clients would get if they attended reproductive health services. Finally, low levels of awareness and knowledge of HIV may explain some of the inaccurate risk perceptions observed in the previous section. Data come from the client exit interview and include all clients.

Almost all clients knew there were actions one could take to avoid contracting HIV; this was slightly higher among VCT clients (Table 3.9). CEGYPEF clients had the lowest knowledge; 29% of CEGYPEF clients did not know any behaviors that would reduce HIV risk.

We assessed how many of the "ABC" prevention strategies were mentioned (i.e., Abstain from sex, Be faithful, or use Condoms). The most commonly cited action to prevent HIV was condom use, followed by abstain from sex and be faithful (Table 3.9). Knowledge of ABC elements was no different between VCT and youth reproductive health clients, CEGYPEF clients had the least knowledge of all three ABC strategies. Few clients named all three strategies.

Correct knowledge that HIV cannot be transmitted through sharing food, shaking hands, and kissing was highest among youth VCT clients and CEGYPEF clients compared with other youth reproductive health clients (Table 3.9). However, depending on the group and the question, 20% to 60% of clients held incorrect beliefs.

In general, VCT clients were more likely to have correct knowledge about HIV transmission than youth reproductive health clients which suggests that VCT clients may be receiving this information in VCT. However, these results could simply be a reflection of the underlying differences between VCT and reproductive health clients that led them to seek VCT in the first place. Regardless, knowledge was low across the board suggesting room for improved HIV risk counseling in both VCT and reproductive health services.

Table 3.9: Percent of clients' reports of knowledge and awareness of HIV for client exit interview population, by type of clinic, client, and sex

	Youth				CEGYPEF
	VCT		RH		RH
	Male N=186	Female N=188	Male N=27	Female N=395	Female N=188
	%	%	%	%	%
Personally know someone who has HIV or died of AIDS	55	41	63	39	39
Know how to prevent HIV/AIDS	97	98	93	93	71
Actions to prevent HIV/AIDS	N=175	N=149	N=25	N=361	N=129
Use condoms	90	82	100	80	80
Abstain from sex	54	54	60	54	24
Be faithful	34	32	32	53	43
Limit sexual partners	10	12	20	21	9
Avoid risky sex *	5	5	5	8	12
Avoid risky contact †	26	28	8	18	14
“ABC” actions mentioned					
None	1	2	0	1	3
Any one	41	46	28	40	65
Any two	43	37	56	39	21
All three	15	15	16	20	12
Client believes...	N=186	N=188	N=27	N=395	N=188
Sharing food with HIV+ person <u>not</u> dangerous	57	60	41	40	68
Shaking hands with HIV+ person <u>not</u> dangerous	70	71	56	46	79
Kissing a HIV+ person on the cheek <u>not</u> dangerous	62	67	41	41	74

* Risky sex includes sex with “promiscuous individuals,” prostitutes, homosexuals, injecting drug users.

† Risky contacts include blood transfusions, injections, kissing, hugging, sharing razors.

Relatively low knowledge levels of the effectiveness of injectables, pills, and condoms at preventing pregnancy and STIs suggest family planning services need improvement (Table 3.10). Less than one-half of male and female VCT clients believed that the injectable is very effective at preventing pregnancy, and this is slightly lower than female reproductive health clients' knowledge. Most clients knew that the injectable was not at all effective at preventing STI/HIV, though this was not universal and lowest among CEGYPEF clients despite the injectable being their predominant method.

The knowledge of the effectiveness of the condom to prevent both pregnancy and STIs/HIV was higher, although knowledge was not higher among VCT clients as one would expect, especially since they were just exiting a VCT center when they were interviewed (Table 3.10). Some youth clients did not know the effectiveness of the condom, and lack of knowledge was greatest among CEGYPEF clients.

Table 3.10: Percent of clients' reports of knowledge of and beliefs toward contraceptive methods for client exit interview population, by type of clinic, client, and sex

	Youth				CEGYPEF
	VCT		RH		RH
	Male N=186	Female N=188	Male N=27	Female N=395	Female N=188
Client believes...	%	%	%	%	%
Injectable is <u>very</u> effective at preventing pregnancy	44	36	33	64	56
Injectable is <u>not at all</u> effective at preventing STIs/HIV	93	87	93	88	70
Efficacy of condom in pregnancy prevention					
Very effective	57	54	52	57	47
Somewhat effective	33	34	44	30	35
Not effective at all	6	3	4	3	4
Don't know	4	7	0	8	11
Efficacy of condom in STI/HIV prevention					
Very effective	49	46	48	49	43
Somewhat effective	37	40	44	37	32
Not effective at all	11	8	7	6	10
Don't know	3	5	0	6	13

3. Content, quality, and organization of VCT services that youth receive

We have documented that many clients who use VCT services have behaviors that put them at risk for HIV and unintended pregnancy, but their HIV risk perceptions do not accord with their reported behaviors, and their knowledge of HIV prevention, transmission, and pregnancy is poor. Health service providers armed with accurate information can serve as “cues to action,” or in other words they can improve clients’ knowledge, increase the accuracy of clients’ risk perception, and influence behavior change. This section assesses the content, quality, and organization of services that youth receive and applies this information to understand how prepared VCT services are to offer family planning services and to make recommendations about how VCT services can improve to meet youth’s dual health (HIV and family planning) needs.

Information obtained during mystery clients’ observations of VCT and client exit interviews assess the content and quality of VCT counseling. Interviews with providers documented what providers said they do and their family planning knowledge. Knowledge affects the quality of information and care providers give and their readiness to provide family planning. To understand how to re-organize services, we use the activity sampling and referral data.

VCT content

The mystery client technique was used to evaluate the amount and quality of the core VCT counseling and if any reproductive health information or services were provided in VCT. Mystery clients reported that the providers and staff were generally welcoming and that most providers covered basic information about VCT (Table 3.11). The relative lack of discussion about the HIV testing process is probably due to the fact that, in the FOSREF youth center model, HIV testing was conducted in the laboratory and not by the counselor.

Table 3.11: Number of pre-HIV test counseling elements from mystery client observations

	Yes N=24
<i>Did the counselor...</i>	<i>(n)</i>
Discuss the meaning of being HIV negative with you?	24
Enquire about your reason for attending?	23
Explain what would happen during the visit?	22
Discuss the meaning of being HIV positive with you?	20
Explore your knowledge about HIV and modes of transmission?	19
Ask you questions about exposure to HIV (risk assessment)?	19
Give you information concerning the testing window?	15
Ask you to sign (or orally consent to) an informed consent form?	12
Give you information concerning the HIV testing process?	11
Enquire if you had experience with HIV counseling and/or testing before?	8

Because clients do not receive HIV testing in the same session with the VCT counselor, not all clients received their HIV test results on the same day as the pre-test counseling session (Table 3.12). Seven clients received them the next day, one client received the result two days later, and two did not get their HIV test results at all (results not shown). One client did not get their results because after sticking her four times they could not find her veins saying she was “anemic.” The other client could not return when they told him to. Of the clients who did get the results on the same day, the waiting time ranged from 10 to 95 minutes with an average of 42 minutes.

VCT providers were less consistent in their post-HIV test counseling than in their pre-test counseling. Providers were most likely to explain the HIV test results simply and clearly (Table 3.12). Most clients were told to come back for another HIV test or additional counseling and to come back in three months. In 13 of the 15 cases, when the provider told them to return for HIV retesting or counseling, the provider also counseled them on the incubation period of a new HIV infection (results not shown). This finding could explain why so many clients said in the client exit interview results presented earlier that they wanted to be retested.

For those clients who tested HIV positive, the providers were most consistent at explaining the results simply and clearly and discussing how to “live positively” (results not shown). However, in only three of the six observations of HIV positive clients did the provider discuss the type of support that was available or make a referral to other services.

Table 3.12: Number of post -HIV test counseling elements from mystery clients observations

	Yes (n)
Did you get your test results on the same day?	15 (N=24)
<i>Did the counselor....</i>	
Explain your results simply and clearly?	22
Discuss the meaning of the results with you?	16
Ask you to come back for another test or additional counseling?	15
Ask you if you understood the results?	13
Discuss how to “live positively?”	12
Discuss strategies for disclosing your status to family and friends?	2
Discuss the types of support that you could have access to?	6
Refer you to any services (other than FP) or support groups (including post-test clubs)?	7
	(N=22) ¹

¹ 2 mystery clients never got their HIV results

Condoms were not discussed in one-quarter of the VCT sessions participated in by mystery clients (Table 3.13). For mystery clients who received condom counseling, the message was basic: “always use condoms.”

Mystery clients reported that messages around discussing condom use with partners and dual protection were rare (Table 3.13). Discussions about abstinence occurred in a minority of interactions.

Table 3.13: Number of abstinence and condom related discussions in VCT from mystery client observations

	Yes N=24 (n)
During the entire session, did the counselor talk about condoms without your prompting?	18
Did the counselor discuss negotiating condom use with partner?	3
Did the counselor discuss simultaneous use of condoms and other contraception for dual protection?	5
Did the counselor discuss abstinence as a way to prevent HIV/AIDS?	10

In contrast to the mystery client results, clients' reports from exit interviews were more positive (Table 3.14). However, female VCT clients were less likely, on the order of 13 to 16 percentage points compared to male VCT clients, to report that providers discussed condoms or reducing partners.

Table 3.14. Percent of clients' reports of providers' HIV prevention discussions for client exit interview population, by client and sex

	Youth VCT	
	Male N=186	Female N=188
Client reports that provider discussed:		
That condoms help prevent HIV	82	66
That condoms help prevent other STIs	82	68
Reducing partners helps prevent HIV	73	60

According to mystery client observations, fertility and family planning-related discussions were virtually absent in VCT sessions despite the fact the mystery clients were sexually active (Table 3.15). This is not surprising given that the provider interview suggests that the majority of VCT providers (9 of 13) have non-medical backgrounds, and they may not view counseling on these topics as part of their job.

Table 3.15: Number of fertility and family planning related discussions in VCT from mystery client observations

	Yes N=24
<i>During the entire session, did the counselor...</i>	<i>(n)</i>
Ask you if you have any children?	4
Ask you if you wanted any (more) children?	0
Ask you how long you wanted to wait until your (next) child?	0
Ask you if you were using a method to prevent pregnancy?	0
Discuss abstinence as a way to prevent pregnancy?	3
Talk about any other contraceptives (other than condoms) without your prompting?	2
Did you receive a referral to a family planning provider or clinic?	4

Providers’ characteristics and their readiness to offer family planning

What providers currently offer and their readiness to offer new services is influenced by their attitudes and knowledge. First, we present information on providers’ characteristics, then we describe their knowledge of and attitudes toward specific methods, and finally we evaluate providers’ attitudes toward family planning for youth and HIV infected women.

Most providers interviewed were auxiliary nurses (15 of 34) because the Haitian health system relies heavily on this cadre to provide health services (Table 3.16). All auxiliary nurses were reproductive health providers. There were two doctors and two nurses providing both VCT and reproductive health. The doctors and nurses served as either the principal VCT providers or the medical supervisors (results not shown).

Most VCT providers were of “other” designation (9 of 13) (Table 3.16). They were mainly students, although one was a sociologist, one a journalist, and one an electrician (results not shown). The existence of non-medically trained VCT provider points to FOSREF’s efforts to engage senior peer educators (those who have long term positions at FOSREF) as VCT providers.

The majority of providers participating in the interviews were female (19 of 34). Female providers were more likely to provide reproductive health services (16 of 25 reproductive health providers). Most female providers were auxiliary nurses (13 of 19). Men were more likely to be VCT providers (7 of 13 VCT providers).

Not all providers trained in VCT were offering VCT. While 13 providers reported providing VCT, 21 providers interviewed reported being trained in VCT (results not shown). Seven of the 21 had even received refresher training.

Table 3.16: Professional designations for provider interview population, by type of service provision

	Types of services provided			<u>Total</u>
	Only RH (not VCT)	Only VCT	Both VCT and RH	
Professional designation	N	N	N	N
Doctor	6	0	2	8
Nurse	0	0	2	2
Auxiliary nurse	15	0	0	15
Other (mainly students)	0	9	0	9
Total	21	9	4	34

We now turn from providers’ characteristics to their knowledge and beliefs about two methods to prevent HIV and pregnancy, condoms and abstinence, and we assess their knowledge about faithfulness. Beginning with condoms, few providers expressed beliefs that may prevent them from discussing or providing condoms to their clients:

- Eight (of 34) providers agreed with the statement that “condoms, even when used correctly for every sex act, cannot be relied on to reduce the risks of some of the most common sexually transmitted infections to an acceptable level.”
- Three (of 34) providers thought it was not worthwhile to try to convince youth to use condoms.
- One (of 34) provider thought that condoms encourage promiscuity.

Providers’ knowledge of dual protection was strongest for condoms, followed by abstinence (Table 3.17). Faithfulness or partner reduction was also mentioned for prevention of STIs or HIV by a majority of providers, but curiously there were five providers who also said that faithfulness can prevent pregnancy, and this, of course, is incorrect. No additional information was obtained to explain how “faithfulness” might also prevent pregnancy.

Table 3.17: Number of providers’ reports of the dual advantages of condoms, practicing abstinence, or being faithful/reducing partners from provider interview

Advantages of... (n=34)	Condoms	Abstinence	Faithfulness/ partner reduction
Prevent pregnancy	30	22	5
Prevent STIs	31	24	22
Prevent HIV	30	18	17

We now turn to methods with the single purpose of preventing pregnancy. Starting with injectable methods, nine providers said that injectables were contraindicated⁵ in women testing HIV positive and women who are breastfeeding (Table 3.18). According to the

⁵ The questionnaire did not actually use the word “contraindication,” but rather asked about the characteristics of people who “should not use” the particular method.

World Health Organization (WHO) Medical Eligibility Criteria, none of these conditions in Table 3.19 are actually contraindications to injectable use⁶ (WHO, 2004a).

Table 3.18: Number of providers reporting contraindications to injectable use from provider interviews

Number of providers who believe that injectables should not be used by women with certain conditions	All N=34
Women who are breastfeeding (within 6 months of delivery)	9
Women testing HIV positive	9
Women who smoke	6
Women over 35	2
Women less than 18	1
Women who have never been pregnant	5
Women with sexually transmitted infections	3
Women with multiple sex partners	4
Don't know/not sure	4

Most providers, but not all, thought that injectables could be safely used by youth:

- 24 (out of 34) providers agreed with the statement that injectable contraceptives can be safely used by young women.
- 20 (out of 34) providers agreed that a woman who is at least 10 days late for her injection should be told to use a barrier method for one week. (Actually, women have a two week window in which they can safely get their re-injection without fear of pregnancy [WHO, 2004c]).

There were providers who would restrict use of the IUD by women, although these conditions were not based in evidence (Hatcher et al., 1997; WHO, 2004a). The most common barrier to IUD provision was a parity requirement:

- 12 (of 34) providers would restrict youth who have never had children from getting the IUD
- 19 (of 34) providers agreed with the statement that “Before using the IUD, a young woman must have at least one child.”
- Nine (of 34) providers agreed with the statement that “For young women between the ages of 15 and 24, the IUD is not a good contraceptive option.”

Providers were asked to name up to five contraindications⁷ for combined oral contraceptive pill use where we defined “contraindication” based on the medical eligibility checklist in the Essentials of Contraceptive Technology and the WHO medical eligibility criteria (WHO, 2004a). Many providers (23 of 34) correctly named hypertension as a contraindication, but few named other conditions that are considered contraindications (results not shown).

⁶ With the exception of women who are less than six weeks post-partum, there are no contraindications for women who are breastfeeding. For women who are less than six weeks post-partum, the injectable is considered “category 3” which means that in general use is not advised unless the provider has clinical competencies and there is access to clinical services.

⁷ For this question we did use the term “contraindication” after an explaining that “some women have health conditions or characteristics that mean that they should not use combined oral contraceptives.”

Some providers named conditions that are not actually contraindications to pill use (Table 3.19). Slightly less than half of providers named women older than a certain age (age was not specified), which is not a contraindication in the absence of other conditions. These results suggest that some providers may limit pill use according to criteria that are not based in evidence.

Table 3.19: Number of providers reporting conditions that are not contraindications to use of combined oral contraceptive pills from provider interviews

	All providers N=34
<i>Conditions that are not contraindications</i>	
Women older than a certain age	15
Women younger than a certain age	1
Women who may be pregnant	2
Women who have never had children	2
Others	5
Don't know	8

We created a composite family planning knowledge score with ten knowledge questions (some results not shown). Thus, the maximum score possible was 10 points (no partial credit possible). A provider could score one point if s/he knew:

- The three benefits of condoms (i.e., prevent pregnancy, STIs, and HIV)
- The three benefits of abstinence
- The two benefits of faithfulness
- One of two ways to rule out pregnancy if a client wants to start a method but is not menstruating
- Contraindications to injectable use (i.e., none according to the way the question was asked)
- Contraindications to condom use (i.e., none according to the way the question was asked)
- The three lactational amenorrhea criteria
- Five contraindications to pill use
- Methods that require a gynecological exam for safe provision
- That a woman can be 10 days late for her re-injection

Twelve out of 33 providers answered correctly on four of the 10 knowledge questions (Table 3.20). No one scored more than eight points and only one provider got eight correct (results not shown). Interestingly, VCT providers were slightly more knowledgeable than reproductive health-only providers (six out of 13 VCT providers [46%] scored five points or more compared with six out of 20 reproductive health providers [30%]). This is not immediately explained by providers' professional background. Most of the reproductive health providers were auxiliary nurses while most of the VCT providers were of the 'other' category (e.g., mainly students).

Table 3.20: Number of providers with composite knowledge scores from provider interviews, by type of service provided

Composite score	VCT providers ¹	RH providers	Total
≤3	2	7	9
4	5	7	12
≥5	6	6	12
Total N	13	20	33

¹Providers could be VCT providers only or VCT and RH providers.

We assessed providers' values and beliefs regarding contraceptive provision for youth. Almost all providers agreed with the statement that it was worthwhile to talk with youth about family planning (Table 3.21). Few providers held any feelings that sex education or contraception would result in promiscuous behavior. No providers thought contraception was reserved for married youth.

There were no providers who believed asking married women about HIV/STI risks was insulting (Table 3.21). Four providers felt that young women who are infected with HIV should not have sex, but many more providers felt that women with HIV have the right to have children. We do not know how strongly the remaining providers disagreed with the statement.

Table 3.21: Number of providers who agree with certain statements about family planning and youth and HIV from provider interviews

	All providers N=34
Family planning and youth	
Number of providers who agree that...	
It is worthwhile to speak to youth about family planning	29
Contraception encourages promiscuity among youth.	2
Sex education encourages promiscuity among youth	1
Contraception should not be provided to non-married youth	0
HIV	
Number of providers who agree that...	
Asking married women about STD / HIV risk is insulting to them.	0
A young woman infected with HIV should not have sexual relations	4
Women who are HIV-positive and know their status have the right to have children	16

Despite the relatively low level of contraceptive knowledge, most providers had been trained in family planning (28 of 34) according to provider reports. However coverage of family planning drops off quickly from there as only three providers had been trained to provide all modern methods. There is a particular gap in youth centers of providers trained in family planning:

- 25 of 34 providers had been trained to provide any method

- 3 of 34 providers had been trained to provide *all* modern methods (condoms, female condoms, pills, injectables, IUDs, and implants).
- 2 of 13 VCT providers offer all available methods
- 16 of 25 reproductive health providers offer all available methods
- 1 provider in each of Lalue, Carrefour, and Carrefour Feuilles (youth centers) regularly provide family planning methods
- 2 providers at Delmas (youth center) regularly provide family planning methods

We asked providers specific questions about their training needs in general, in family planning, and in VCT. Providers reported a broad range of needs for additional training (Table 3.22); those that scored in the top three (or tied) are presented here. It is interesting to note that providers' top HIV/VCT and family planning training needs were: "How to help an individual assess her/his risk of acquiring HIV/AIDS" and "How to screen clients for unintended pregnancy risk/unmet need for contraception." These are the same as those gaps that we identified based on client interview results.

Table 3.22: Number of domains of providers' top three general, VCT, and family planning training needs from provider interviews

	<u>N=34</u>
General training needs	
Listening skills	31
General counselling skills	30
How to feel comfortable/ less uncomfortable discussing sensitive topics/ topics related to sexual relations with youth	29
HIV/VCT training needs	
How to help an individual assess her/his risk of acquiring HIV/AIDS	30
How to help an individual understand how he/she can reduce his/her risk to acquire HIV/AIDS	29
Up-to-date knowledge of all of the modes of transmission of HIV/AIDS	29
How to discuss the risk of transmission to babies with HIV positive clients	29
How to prepare an individual mentally for an HIV test	28
The client-centred counselling model (helping the client to develop an individualized plan)	28
Talking about issues of sexuality with youth	28
Family planning training needs	
How to screen clients for unintended pregnancy risk/unmet need for contraception	29
How to address the family planning needs of HIV infected clients	28
How to assist youth to select a contraceptive method	26
How to demonstrate the use of the female condom	26
When (the point at which) to introduce family planning information/discussion	26

Organization of services

In this section we assess VCT provider time, supplies of stocks, and referral mechanisms, which would be needed if VCT providers are enlisted to meet VCT clients' reproductive health needs. To determine if VCT providers have time to address youth's reproductive health needs, we rely on results from the activity sampling data. To assess the adequacy of supplies we rely on providers' reports and mystery client observations. Finally,

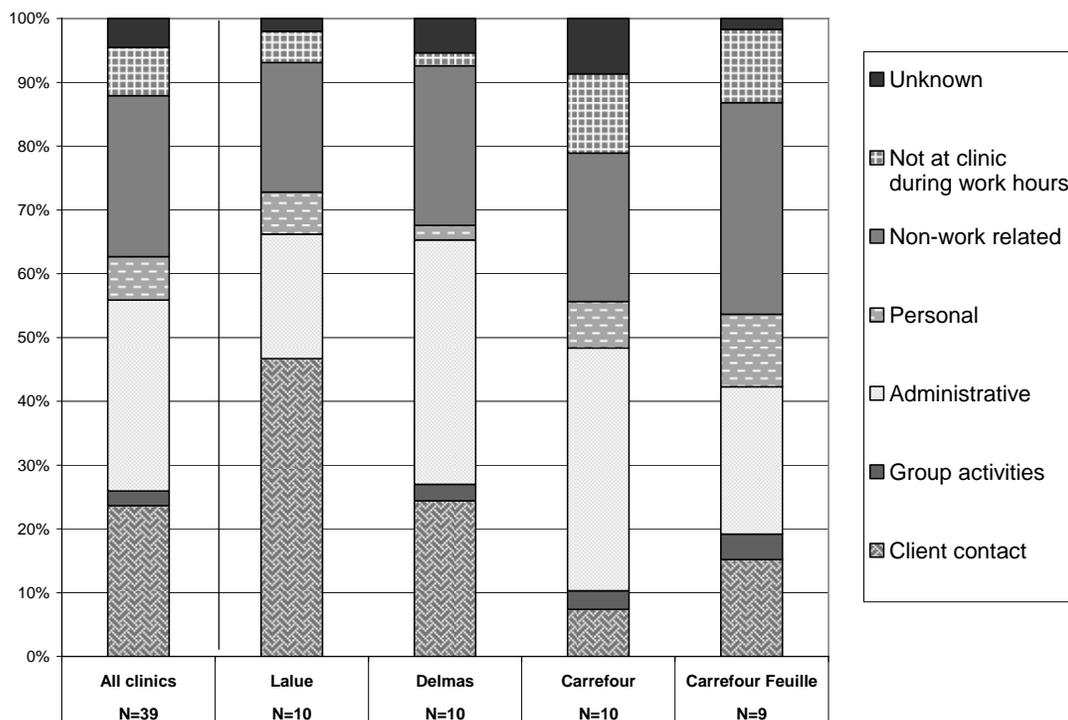
referral mechanisms are assessed using client exit interviews, referral data, and provider reports.

Activity sampling data gives us a picture of how VCT providers spend their day in the four youth clinics. Providers had variable schedules ranging from five to eight hour long shifts (results not shown). Figure 3.3 shows how VCT providers in each clinic distributed their work day across various categories of activities (their schedule differences were accounted for in the analysis). On average, providers spent 24% of their work day with clients. This includes all client contacts (n=449), of which 435 were VCT contacts.

VCT providers also spent a large portion of their work day on administrative and non-work related activities (Figure 3.3). The average percent of time spent in administrative activities was 30% and ranged from 20% at Lalue to 38% for both Delmas and Carrefour. Carrefour Feuille providers spent the most amount of time on non-work related activities and they were the most likely to not be at the clinic (44%).

Two other studies of VCT provider time in Zimbabwe and Kenya have also documented that client contact time and administrative time were inversely associated (Hatzell Hoke & Reuben, 2006; Reynolds et al., 2003). One possible explanation for the inverse relationship between contact time and administrative time is that providers may be trying to fill time on other duties that would otherwise be spent with clients.

Figure 3.3: Percent distribution of VCT provider activities from activity sampling, by center



The 449 different client contacts VCT providers had resulted in an average of 12.5 client contacts per provider per day, as can be seen in Table 3.23.

Table 3.23: Average and total number of client contacts from activity sampling, by center

	All clinics	Individual clinics			
		Lalue	Delmas	Carrefour	Carrefour Feuille
Average number of client contacts	12.5	19.6	14.7	8.3	5.1
Total	449	196	147	58	46

Analysis of the length of a VCT visit was eight minutes on average and ranged from four minutes at Carrefour to 15 minutes at Carrefour Feuille (Table 3.24). This was also similar to the client contact time observed by mystery clients (results not shown).

The reason for the relatively short contact time is, in part, due to how services are organized at FOSREF. The length of VCT is actually the length of the pre- or post-test counseling session. Actual blood draw for HIV tests were done in the lab and were not observed. However, eight minutes is a particularly short amount of time with a client and may not be enough to convey important information. Further, another study documented 44 minutes on average for the VCT counseling session that includes pre-test counseling, HIV testing (rapid test), and post-test counseling (Reynolds et al., 2003).

Table 3.24: Average length (minutes) for VCT client contacts from activity sampling, by center

	All clinics	Individual clinics			
		Lalue	Delmas	Carrefour	Carrefour Feuille
Average contact length (minutes)	8	7	7	4	15
Total	435	194	143	57	41

Stockouts

Stockouts of supplies appears to be a problem. In the VCT setting, 10 of the 13 VCT providers reported that during the last six months (from July to December 2004), they were unable to provide condoms to their clients because of stock outs (results not shown). Nine VCT providers also said that during that same period they were unable to conduct the HIV test because of stock outs. Fourteen of 34 providers reported that they could not provide non-condom contraceptive methods because of stockouts.

Another indication of the problem of stockouts comes from mystery client observations. Many mystery clients had difficulties even getting to see the VCT provider. In seven of 24 instances there were no syringes available for the HIV test and the RA was obligated to purchase the syringe at 12 gourdes (about \$0.35). In four cases there were no syringes

and purchasing the syringe was not an option according to the provider, so the RA had to return to the clinic at another time. For a typical client faced with this situation, this would be a barrier for them to receive services.

Referral mechanisms

Referrals are a key mechanism to ensure that clients' holistic reproductive health needs are met when multiple services are not available from the same provider. However, clients' reports suggest that providers made few referrals (Table 3.25).

When referrals were made they were not between VCT and reproductive health or vice versa. Referrals tended to be from VCT to center activities (e.g., clubs) and from reproductive health to other reproductive health (non-VCT) services. While about one in five VCT clients were referred somewhere, the most common referral point was the VCT post-test club (results not shown). The next most common referral point for VCT clients was the laboratory followed by family life education and another club in the center. Reproductive health clients were receiving few referrals as well. Reproductive health clients (mainly female) were most likely to be referred to gynecology followed by the laboratory.

Table 3.25: Percent of clients' reports of referrals by client exit population, by type of clinic, client, and gender

	VCT		Youth		CEGYPEF
	Male N=186	Female N=158	Male N=27	Female N=395	RH Female N=188
Client received referral from provider	23	18	16	17	18

The referral database is another resource to examine the referrals within the facility. Between January and March 2006, 4,172 clients made 10,518 visits to the four youth facilities (Table 3.26). Clients flow through the youth FOSREF facilities by first registering themselves at the reception. From the reception, only 6% and 11% of clients were referred to clinical services (i.e., reproductive health) or VCT. The fact that the majority of clients (72%) were referred from the reception to sensitization classes (a prerequisite at FOSREF facilities for participation in education and clubs), demonstrates the intensity of and popularity for FOSREF's non-clinical related activities (results not shown).

During the three months of referral data, 1,436 clients visited reproductive health and other clinical services (excluding VCT). Only 12% of these clients were recorded as having been referred from VCT, and only 18% of reproductive health/clinical clients were referred to VCT (Table 3.26). Most reproductive health/clinical clients referred from reproductive health services to other reproductive health services (not VCT) (81%) (results not shown).

During the same time period there were 287 VCT clients. Similar to reproductive health clients, 85% of VCT clients were referred by the reception (results not shown), while referrals from reproductive health services were low 15% (Table 3.26) (information about where VCT clients were referred is not available).

Table 3.26: Number of clients visiting FOSREF youth centers between January and March, 2006 and referrals between clinical and VCT services from referral data

	N(%)
Reception	
Total number of client visits	10,518
Total number of clients	4,172
From reception, clients referred to clinical services	665 (6%)
From reception, clients referred to VCT	1159 (11%)
Reproductive health and other clinical services	
Total number of clinical clients	1,436
Clinical clients referred from VCT to clinical services	174 (12%)
Clinical clients referred from clinical services to VCT	261 (18%)
VCT	
Total number of VCT clients	287
VCT clients referred from clinical services	43 (15%)

IV. Discussion and Recommendations

Many FOSREF youth VCT clients have risk behaviors for HIV. But, most VCT clients who reported risk behaviors for HIV do not perceive they are at risk for HIV. Lack of consistency between VCT clients' reported behavior and perception of risk for HIV may be due to gaps in youth's HIV knowledge which should be addressed in VCT services.

To make good use of scarce resources, all clients who use VCT services should be at risk of HIV. However, in FOSREF youth centers, about one-third of VCT clients reported no risky behaviors. There are also many clients who reported low or no perceived risk of HIV, yet they had a high demand for subsequent HIV testing. If client reports are accurate, these results raise the question about why low risk clients are seeking VCT in the first place. If these clients are simply seeking education and information, FOSREF has other activities in place that can address these needs.

The evidence provides a mixed picture as to whether the introduction of VCT has increased access to health services for youth. While VCT clients are different from reproductive health clients on socio-demographic characteristics, they are similar to reproductive health clients in reported risk behaviors for HIV. Efforts to decrease use of VCT by youth not at risk while simultaneously increasing use by those at risk will increase the coverage and effectiveness of VCT services.

VCT clients also have risks for unintended pregnancy, which are not currently addressed in VCT or through referrals. Female youth VCT clients were most vulnerable; the majority were at risk for unintended pregnancy. When they did use contraceptive methods, they mainly relied on the male condom, and use was sometimes inconsistent. Female VCT clients need access to other family planning methods.

Meeting VCT clients' broader reproductive health needs can be achieved by training existing providers, although both VCT and reproductive health providers will need significant additional training. In the youth centers, few providers were available to offer family planning and those who were offered a limited method mix. Further, their knowledge of contraception was poor, and some providers disagreed with statements related to the sexual and reproductive rights of women with HIV.

VCT providers need to increase their sensitivity to their female clients' needs. The poor counseling female VCT clients received combined with the fact that the majority of VCT providers are male suggest that gender and power dynamics may affect interactions between male providers and female clients. Women generally tend to prefer discussing sexual issues with female. In the presence of male providers they are less likely to seek services or ask questions when they do (Barnett & Stein, 1998). Addressing this need could be accomplished by providing training or increasing the number of female VCT providers.

The frequency of stockouts is a problem. Stockouts of HIV test kits and syringes mean some clients could not receive services on the day they attended. Stockouts of condoms and other contraceptive commodities were also common. Improving providers' skills in family planning will be insufficient if steps are not taken to address the problem of supply stockouts.

VCT providers have time to increase their contact with clients both to improve VCT counseling and to offer family planning services. Providers can redistribute some of the "non-work related" or administrative time to gain more time with clients. In order to not increase client waiting time at peak client load times, it may be necessary to spread out client visits over the day by the use of appointments, or providers could be available during times desirable to adolescents (e.g., early morning, late afternoon, or weekend).

Referral mechanisms between VCT and reproductive health should be enhanced to increase linkages between services. In a setting like FOSREF's where all clinical services are co-located, a referral may be as simple as providers identifying clients who need additional services, providing some basic counseling, and making the referral. However, FOSREF should ensure that providers are working at the same time on the same days so that a client does not have to leave and come back to see the provider as this may result in some clients not returning.

A referral system is not always the preferred solution. One specific case where the referral imposes barriers for clients is HIV testing. With the widespread availability of rapid HIV tests, VCT providers do the HIV tests. This change will reduce the number of clients who fail to return for post-HIV test counseling.

While some recommendations can be implemented without incurring additional costs, many recommendations will need financial support. In the current environment, generating support for more holistic VCT services faces challenges. In Haiti, as in other countries (UNFPA, 2005), the growing emphasis on HIV has coincided with decreased support for family planning services (Verbal communication, results interpretation meeting participant, May 24, 2006). This situation has led to a decrease in the availability of family planning services in youth centers.

The following are recommendations to FOSREF to help improve clinical services in youth centers:

- Implement and improve efforts to educate clients about reproductive health and HIV. This should include providing updates for providers and supervision to ensure providers' counseling messages are adequate.
- Increase VCT providers' knowledge and skills to increase gender equity in service delivery.
- Implement screening for reproductive health needs and simple referrals to reproductive health services from VCT. Ensure that VCT providers know how to accurately identify clients at risk of unintended pregnancy and that reproductive health services are available at the same time as the referral.

- Identify the root causes of stock outs, especially for condoms, syringes and test kits, and contraceptive commodities.
- Implement same-day HIV testing and feedback by the VCT provider rather than HIV testing in the lab.
- Assess why sexually inexperienced youth and youth with no behavioral risks are attending VCT so as to refine marketing strategies to attract youth who are at risk.
- Continue advocating and educating donors about youth's dual risks for HIV and unintended pregnancy.

Despite the areas for improvement, FOSREF is offering services that are important for youth. It appears that many youth who need services are getting them. Further, with some minimal inputs, the existing services can be organized holistically to meet youth's reproductive health needs. The largest barriers to integrated services for youth are not those within the facilities but those such as commodity stockouts and lack of funding for reproductive health services that are often external to program control. Thus, continued advocacy is needed to raise awareness of and support for the reproductive health needs of youth.

V. References

Barnett B, Stein J. *Women's Voices, Women's Lives: the Impact of Family Planning. A Synthesis of Findings from the Women's Studies Project*. Research Triangle Park, NC: Family Health International, 1998.

Beauvais HJ, Roussel B, Alzuphar C. *Programme de Conseil et Dépistage Volontaire du VIH. Résultats du Programme. Analyses et Perspectives. Période Juin 2003 à Décembre 2005*. Port-au-Prince, Haiti: FOSREF, 2006.

Cayemittes M, Placide F, Barrère B, et al. *VIH/Sida et Infections Sexuellement Transmissibles en Haïti: Résultats de l'Enquête Mortalité, Morbidité, et Utilisation des Services (EMMUS-III), Haïti 2000*. Calverton, MD: ORC Macro, 2002.

Cayemittes M, Placide MF, Barrere B, et al. *Enquête Mortalité, Morbidité et Utilisation des Services, Haïti 2000*. Calverton, MD: Ministère de la Santé Publique et de la Population, Institut Haïtien de l'Enfance and ORC Macro, 2001.

FHI Focus on Voluntary Counseling and Testing (VCT) and Youth. Arlington, VA: Family Health International, 2003.

Hatcher RA, Rinehart W, Blackburn R, et al. *The Essentials of Contraceptive Technology*. Baltimore, MD: Johns Hopkins Bloomberg School of Public Health, Population Information Program, 1997.

Hatzell Hoke T, Reuben E. *Assessment of How Family Planning and HIV Services Can Be Integrated in Zimbabwe, Final Report*. Research Triangle Park, NC: Family Health International, 2006.

Institut Haïtien de l'Enfance and ORC Macro. *Enquête Mortalité, Morbidité et Utilisation des Services EMMUS-IV: Haïti 2005–2006*. Pétion ville, Haiti and Calverton, MD: Institut Haïtien de l'Enfance and ORC Macro, 2006.

Karim AM, Magnani RJ, Morgan GT, et al. Reproductive health risk and protective factors among unmarried youth in Ghana. *Int Fam Plan Perspect* 2003;29:14-24.

Lydie N, Robinson NJ, Ferry B, et al. Adolescent sexuality and the HIV epidemic in Yaounde, Cameroon. *J Biosoc Sci* 2004;36:597-616.

Maswanya ES, Moji K, Horiguchi I, et al. Knowledge, risk perception of AIDS and reported sexual behaviour among students in secondary schools and colleges in Tanzania. *Health Educ Res* 1999;14:185-96.

McCauley AP, Salter C, Kiragu K, et al. Meeting the needs of young adults. *Popul Rep J* 1995; 1-43.

Murray N, Buek C, Dougherty L, et al. *Insights into Young People: Findings from a Survey of Youth Clients of VCT and other Reproductive Health Services at FOSREF Clinics in Haiti*.

Adolescent Working Group, *POLICY Project Paper*. Washington DC: Port-au-Prince, Haiti: Futures Group and FOSREF, 2005.

Population Reference Bureau (PRB). *Youth in Sub-Saharan Africa: A Chartbook on Sexual Experience and Reproductive Health*. Washington DC: PRB, 2001.

Reynolds HW, Liku J, Maggwa BN, et al. *Assessment of Voluntary Counseling and Testing Centers in Kenya: Potential Demand, Acceptability, Readiness and Feasibility of Integrating Family Planning Services into VCT*. Nairobi, Kenya and Research Triangle Park, NC: Family Health International (FHI), 2003.

Reynolds HW, Liku J, Kimani J, et al. *Integrating Family Planning Services into Voluntary Counseling and Testing Centers in Kenya: Operations Research Results*. Research Triangle Park, NC: FHI, 2006.

Singh S, Bankole A, Woog V. Evaluating the need for sex education in developing countries: sexual behaviour, knowledge of preventing sexually transmitted infections/HIV and unplanned pregnancy. *Sex Educ* 2005;5:307-331.

Slaymaker E. A critique of international indicators of sexual risk behaviour. *Sex Transm Infect* 2004;80 Suppl 2:ii13-21.

Slonim-Nevo V, Mukuka L. AIDS-related knowledge, attitudes and behavior among adolescents in Zambia. *AIDS Behav* 2005;9:223-31.

Sonfield A. Working to eliminate the world's unmet need for contraception. *Guttmacher Policy Review* 2006;9:10-13.

UNAIDS/MEASURE Evaluation Indicator Field Test Group. *Measuring Risky Sex and Condom Use*. Chapel Hill, NC: MEASURE Evaluation, 2001.

United Nations Population Fund (UNFPA). *Donor Support for Contraceptives and Condoms for STI/HIV Prevention*. New York: UNFPA, 2005.

United Nations Population Fund (UNFPA) and Population Reference Bureau (PRB). *Country Profiles for Population and Reproductive Health, Policy Developments and Indicators 2005*. New York and Washington, DC: UNFPA and Population Reference Bureau, 2005.

The Voluntary HIV-1 Counseling and Testing Efficacy Study Group. Efficacy of voluntary HIV-1 counselling and testing in individuals and couples in Kenya, Tanzania, and Trinidad: a randomised trial. *Lancet* 2000;356(9224):103-12.

World Health Organization. *Medical Eligibility Criteria for Contraceptive Use*. 3rd ed. Geneva: WHO, 2004a.

World Health Organization. *National AIDS Programmes: A Guide to Indicators for Monitoring and Evaluating National HIV/AIDS Prevention Programmes for Young People*. Geneva: WHO, 2004b.

World Health Organization. *Selected Practice Recommendations for Contraceptive Use*. 2nd ed. Geneva: WHO, 2004c.



P.O. Box 13950
Research Triangle Park, NC 27709 USA

Telephone: 1.919.544.7040
Fax: 1.919.544.7261
Web site: www.fhi.org