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HIV/AIDS RESEARCH BRIEF

PSP-One

Who Goes Where and Why? Examining HIV Counseling and Testing Services in the Public and Private Sectors in Zambia

BACKGROUND

Zambia, a small republic in sub-Saharan Africa, has significant HIV prevalence with an adult prevalence rate of 14.3 percent (Central Statistics Office, 2007). Zambians living in urban areas are at higher risk of HIV infection than those living in rural areas (20 percent vs. 10 percent, respectively), while more women are infected than men.

The Zambian HIV epidemic is generalized in nature and is largely driven by heterosexual sexual contact (World Health Organization, 2005). The United States President's Emergency Plan for AIDS Relief (PEPFAR) supports Zambia with more than $270 million in annual funding (FY08) and prioritizes interventions for both HIV prevention and treatment. In FY08, PEPFAR funds supported more than 640,000 HIV voluntary counseling and testing (VCT) encounters. As of September 2008, 167,500 Zambians received antiretroviral treatment with PEPFAR support (PEPFAR, 2008).

VCT services are a critical opportunity to provide risk-reduction counseling and information to all clients, and they act as an essential gateway for preventing HIV transmission. Additionally, VCT is a key entry point to HIV/AIDS services for people living with HIV (PLWHIV). The quality of VCT services is an important indication of the efficacy of HIV prevention in Zambia. The Ministry of Health (MoH) in Zambia recognizes the importance of providing high-quality VCT services in its National HIV and AIDS Strategic Framework 2006–2010.

Currently, VCT services are offered in four sectors in Zambia: public, private for-profit, nongovernmental organization (NGO), and mission (faith based). Although data concerning the quality of VCT are available from sector-specific evaluations, there have been no previous efforts to examine quality across all four sectors. Moreover, very little information exists about the private sector's role in delivering VCT services.

The private for-profit sector may be increasingly called upon to participate in Zambia's national AIDS response as demands for HIV prevention and treatment increase. There are 430 private health facilities in Zambia[1] with 380 of these sites concentrated in urban areas. It is important to understand both the role and the quality of VCT services in the private sector in order to further incorporate private providers into national HIV prevention efforts.

[1] The list of all private facilities and providers in Copperbelt and Luapula was received by PSP-*One* researchers from multiple sources including the Medical Council of Zambia in January 2009.

PSP-*One*
PRIVATE SECTOR PARTNERSHIPS FOR BETTER HEALTH

To address the information gap concerning both the private sector's role and the overall quality of VCT[2] services in Zambia, the Private Sector Partnerships-*One* (PSP-*One*) project implemented a study in April–May 2009 in two Zambian provinces—Copperbelt (urban) and Luapula (rural). The study examined how VCT services in the private sector compared in quality to the other three sectors. Additionally, PSP-*One* assessed the profiles of clients accessing VCT services in each sector and determined why clients chose to receive VCT services in one sector over another.

METHODOLOGY

To assess the quality of VCT services, we employed a mixed-methods approach. We conducted close-ended client intercept interviews with clients exiting VCT services[3]; open-ended, exploratory interviews with exiting clients; interviews with facility managers at all sampled sites; reviews of service statistics for VCT at all sites; and observations of the physical environment for CT.

We selected 90 VCT sites from all four sectors in Copperbelt and Luapula using systematic random sampling for inclusion in the study, and we interviewed 364 clients. For each facility, data collectors selected the maximum number of adult clients who had received HIV counseling, testing, and a test result during a six-hour window.

Table 1: Number of Facilities and Clients by CT Sector in Study Provinces

	Copperbelt			Luapula		
	Universe of sites	# of sites selected	# of clients	Universe of sites	# of sites selected	# of clients
NGO	24	9	79	13	5	20
Private	166	13	84	9	0	0
Gov't	121	17	71	119	11	66
Mission	14	3	8	10	2	18
Unknown	50	5	18	7	0	0
TOTAL	**373**	**47**	**260**	**157**	**18**	**104**

Table 2: Illustrative Quality Variables by Sector

	NGO %	Private %	Gov't %	Mission %	P value
Counselor answered questions with enough detail	90	87	78	75	0.09
Level of satisfaction with privacy of CT session					
Very satisfied	69	70	51	78	0.12
Satisfied	28	26	36	22	
Undecided	1	1	3	0	
Not satisfied	1	2	10	0	
Very unsatisfied	0	0	1	0	
Clarity of HIV test result					
Very clearly	74	85	69	67	0.00
Clearly	26	14	28	33	
Undecided	0	0	3	0	
Unclearly	0	1	0	0	
Very unclearly	0	0	0	0	

Facility-level data were collected for all sampled sites. Table 1 shows sampled facilities by sector as well as the number of clients interviewed in the two study provinces. All private sites were selected with certainty for inclusion in Luapula although none of the sites was equipped to provide HIV testing at the time of data collection.

FINDINGS

How does VCT quality in the private sector compare to the other sectors?

We asked clients questions about VCT service quality based on the quality variables specified by the World Health Organization (WHO), UNAIDS, and the Zambian MoH (2006). Table 2 presents quality scores for three illustrative variables of VCT quality: *counselor answered client questions with enough detail;*

[2] This study focused on voluntary HIV counseling and testing (HCT) as opposed to provider-initiated HCT. The study only examined HCT sites that were static or fixed, although mobile HCT sites do exist in Zambia.

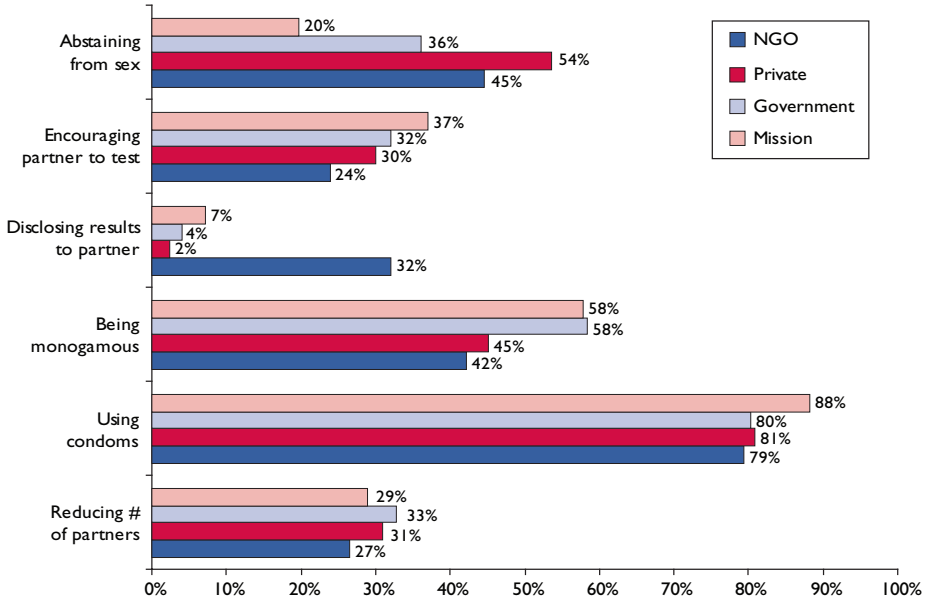
[3] Clients were required to have received both HIV pretest counseling and an HIV rapid test.

level of client satisfaction with privacy of session; and clarity of HIV test result explanation. Our data collection instruments covered all of the main quality variables specified by the Zambian National Guidelines.

In many of the quality variables we examined, no clear patterns existed among the sectors; that is, no one sector emerged with a consistent, statistically significant higher quality score across all or most of the variables. The private sector, however, did perform on par with the other sectors in VCT quality. This performance is noteworthy given the lack of inclusion of the private sector in most HIV prevention training opportunities in Zambia. In certain variables of quality, the private sector outperformed the other three sectors. These variables included counselor's clarity of explanation about HIV test result and counseling on abstaining from sex.

Although we did not find consistent patterns in quality across the sectors, we did discover low performance in some key VCT areas across all of the sectors. As Figure 1 shows, less than 1 in 3 of clients across all sectors received counseling on reducing the number of their sexual partners and only 4 percent of clients in the public, private, and mission sectors received counseling about disclosing test results to their partners. Results showed that all sectors stress a heavy emphasis on counseling about using condoms, but offer much less emphasis on reducing multiple concurrent partners.

Figure 1: Methods Discussed with Counselor for Reducing Exposure to HIV



Open-ended interviews with clients revealed that in all sectors, counselors focus on minimizing blood exchange and living a positive life as a PLWHIV in the pretest counseling session. However, blood exchange is not the primary driver of the Zambian HIV epidemic and, given that a client's status is not yet known, pretest counseling should stress risk reduction as well as prevention of future transmission (WHO 2004).

What are the characteristics of clients accessing VCT services?

Our data contribute to an understanding of the profiles of clients who choose to visit different types of facilities for VCT services. Figure 2 shows that there is a significant difference across sectors in the age distribution of clients accessing services. The youngest clients (aged 15–24) were most likely to visit the NGO sites, while the oldest clients (aged 35 and older) were most likely to visit the private sites.

Figure 2: Age Distribution of Clients by Sector

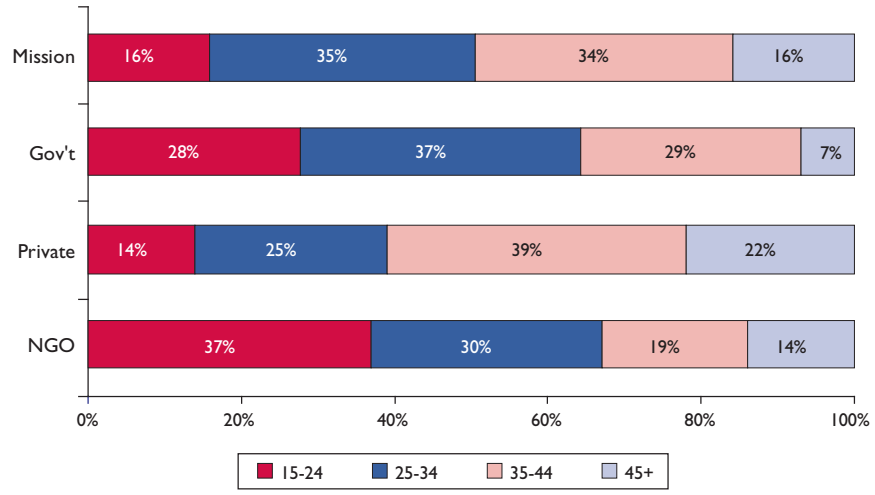


Table 3: Client Education Levels by Segment

	NGO n=99	Private n=84	Gov't n=137	Mission n=26	P value
Education					0.00
None and Primary	7%	2%	7%	0%	
Secondary	29%	30%	49%	61%	
Higher than secondary	51%	45%	38%	39%	
Non response	13%	22%	7%	0%	

Table 4: Gender and Utilization of VCT Services by Sector

	NGO n=99	Private n=84	Gov't n=137	Mission n=26	P value
Male	49.6	42.9	33.3	47.7	0.12
Female	50.4	57.1	66.7	52.3	

Table 3 specifies that the NGO sector attracts the most educated clients, although the average client accessing VCT services across all sectors is educated. Only 4 percent of the clients in our study had no education or only primary levels of education. Population-level data indicate, however, that 65 percent of women and 51 percent of men (Central Statistics Office, 2007) have no or primary levels of education. Overall, VCT services are attracting the most educated segments of the population across all facility types and are not reaching the least educated segments of the population.

Table 4 indicates no statistically significant differences in the utilization of VCT services by sector according to gender. However, public sector sites attracted the highest percentage of females. In our sample, more females utilized VCT services than males.

Out-of-pocket payments (OOP) for VCT services occurs most frequently in the NGO sector (Table 5), although the median cost of the service is significantly higher in the private sector. It is important to note that the vast majority of clients across all sectors do not pay OOP for VCT services. This finding indicates an absence of financial barriers to seeking an HIV test in Zambia.

Why do clients choose one sector over another for VCT services?

During open-ended, unprompted interviews, we asked clients their motivations for accessing VCT services at a particular site and sector. Across all four sectors, geographic proximity (or "closeness to home") emerged as the most important reason why a client chose a particular site. Close-ended data collected from clients support this conclusion since most clients walked to their VCT site. On average, 63 percent of clients walked to their VCT site. Since most clients spent less than 30 minutes commuting to their site, we can conclude that clients did choose to access VCT services at sites close to their homes.

These results are noteworthy because in some HIV high-prevalence environments, clients report choosing VCT and treatment sites far from home to avoid detection and stigma by community members (Bwambale et al. 2008). Therefore, accessing VCT services close to home suggests that Zambians in Copperbelt and Luapula may not fear stigmatization related to their HIV status.

Are there urban and rural differences in VCT quality?

The findings presented above are for results where there are no significant differences in VCT quality

Table 5: OOP Rates and Median Amounts by Sector

	NGO n=99	Private n=84	Gov't n=137	Mission n=26
Paid for service received today				
Yes	20%	11%	4%	0%
No	80%	89%	96%	100%
Median cost (in dollars)	$0.21	$7.50	$0.38	N/A

Table 6: Urban and Rural Public Sector Quality Variables

	Copperbelt (urban)	Luapula (rural)	P value
Very Clear explanation of test results	83%	59%	0.0386
Discussed reducing # of partners	30%	35%	0.5715
Discussed disclosing results to partner	6%	3%	0.4871

between the urban (Copperbelt) and rural (Luapula) provinces.

As Table 6 indicates, only one quality variable differed significantly in the urban and rural public sites[4]. Clients from urban public sites were more likely to feel that they received a very clear explanation of their HIV test results. In terms of the key quality dimensions of counseling clients about sexual partner reduction and disclosure of HIV test results to partners, we found no significant differences between the urban and rural public sector sites. This finding suggests that rural sites may not lag behind urban sites in VCT quality.

CONCLUSIONS

These findings confirm that the private for-profit sector performs on par with other sectors in the quality of its VCT services and, in certain quality variables, outperforms the other sectors. These results contribute to the evidence base by establishing that the private sector performs VCT services that are within the overall quality parameters of VCT services provided in Zambia.

The private sector's performance is especially noteworthy given the lack of HIV prevention training opportunities offered to private providers and the lack of inclusion of the Zambian Private Practitioners Association in establishing or guiding the Zambia National Guidelines for HIV Counseling and Testing.

Originally, this study set out to examine differences in VCT quality among the public, private, NGO, and mission sectors. Although we found no consistent patterns of quality among the four sectors, serious areas of underperformance were revealed across all VCT service providers. Most clients did not receive counseling on partner reduction or disclosure of HIV test results to partners. In a generalized HIV epidemic where multiple concurrent sexual partnerships are a significant driver of new infections, discussion of risk-reduction methods should be a main focus of pretest and posttest counseling.

Finally, these results enrich our understanding of both the profiles and motivations of clients in choosing to access VCT services in one sector over another. Overall, VCT clients in Copperbelt and Luapula are significantly more educated than the overall population and largely do not pay OOP for VCT services. Clients in our study do not fear community stigma when accessing VCT services and largely choose where to access VCT based on geographic proximity. While these results are illuminating, they are only generalizable to the provincial level.

Most clients across all sectors reported being "very satisfied" with the quality of VCT services they received. However, in many instances, clients were very satisfied with low-quality services according to national and international standards. Open-ended interviews with clients show that the attributes that clients often associate with satisfaction (including the friendliness and "niceness" of counselors) may not correspond with technically competent counseling that emphasizes risk reduction and difficult behavioral change. A renewed focus on adapting counseling topics to the realities of Zambia's HIV epidemic will improve the efficacy of VCT across all sectors. In addition, including private providers in this effort will ensure high-quality VCT services for clients choosing the private for-profit sector.

[4] Since no private sites in Luapula were eligible for inclusion in the study, we could not compare urban and rural private sector dimensions of quality.

REFERENCES

Bwambale, F., S. Ssali, S. Byaruhanga, J. Kalyango, and C. Karamagi. 2008. Voluntary HIV counseling and testing among men in rural western Uganda: Implications for HIV prevention. *BMI Public Health,* 8:263.

World Health Organization. 2004. *National AIDS programme: A guide to monitoring and evaluating HIV/AIDS care and support.* Geneva.

World Health Organization. 2005. *Summary country profile on HIV/AIDS treatment scale-up – Zambia.* Geneva.

The President's Emergency Plan for AIDS Relief. 2008. *FY08 Country Profile: Zambia.* http://www.pepfar.gov/press/countries/profiles/116348.htm

Zambia Central Statistical Office, Ministry of Health, Tropical Diseases Research Centre, University of Zambia and Macro International. 2007. *Zambia Demographic and Health Survey.*

Zambia Ministry of Health and Japan International Cooperation Agency. March 2006. *Zambia National Guidelines for HIV Counseling and Testing.*

About PSP-*One*

The PSP-*One* project is USAID's flagship project, funded under Contract No. GPO-I-00-04-00007-00, to increase the private sector's provision of high-quality reproductive health and family planning (RH/FP) and other health products and services in developing countries. PSP-*One* is led by Abt Associates Inc. and implemented in collaboration with eight partners:

Banyan Global	IntraHealth International
Dillon, Allman and Partners, LLC	O'Hanlon Health Consulting
Family Health International	Population Services International
Forum One Communications	Tulane University School of Public Health and Tropical Medicine

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