

Mercy Mura

OF Late nimeanza kufikiria sana juu ya siku za usoni. In fact, tangu nilipo angusha album yangu ya kwanza nina plans kubwa na singependa ziharibiwe.

SCALING-UP

VOLUNTARY COUNSELING AND TESTING IN AFRICA

That's why nimpitia kituo cha VCT njue hali yangu ya HIV. Waliniexplainia vile naweza kaa bila kupata HIV. Na kama nilikuwa na HIV at least vile bado naweza

SNAPSHOTS FROM THE FIELD

ishi maisha poa. Na sasa kwa sababu ninajua hali yangu, naweza kusimamia

maisha yangu. Usiwache hali yako ya

HIV isimamie maisha yako, chukua

usimamizi. Pitia kituo cha VCT

ujue, niaje.



SNAPSHOTS FROM THE FIELD

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AND TESTING IN AFRICA



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Cover photo: Kenyan VCT poster featuring singer Mercy Myra discussing in Swahili why she chose to seek voluntary counseling and testing. Courtesy of Mercy Myra.

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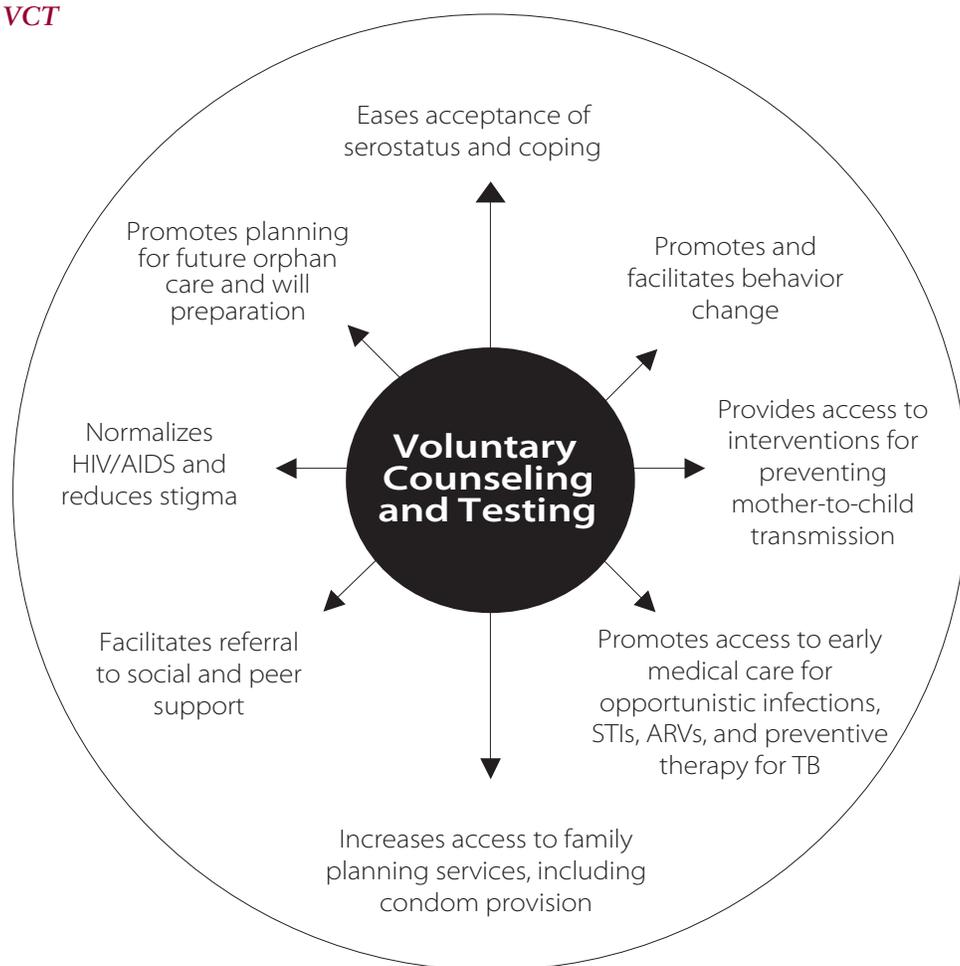
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When HIV tests became available in the developing world in the mid-1980s, those who tested positive were generally regarded with fear and suspicion. Stigma and the absence of treatment options initially hampered voluntary counseling and testing (VCT) programs.

Today, the availability of care and support—and in some places, treatment—for people who test positive has placed VCT at the center of many African countries’ national AIDS policies. VCT has evolved into a tool for curtailing the spread of HIV, a critical entry point to care and support for people living with HIV/AIDS (PLHA) and a valuable healthcare referral conduit for all clients. In many settings, the benefits of knowing one’s HIV serostatus are driving demand for VCT. The figure below shows these benefits.

Benefits of VCT



Gloria Sangiwa, Associate Director for VCT/Mother-to-Child Transmission at Family Health International (FHI), explains that VCT accomplishes more than testing blood and providing counseling to HIV-positive clients. “It’s a vital point of entry to other services, including preventing mother-to-child transmission, clinical management of HIV/AIDS symptoms, tuberculosis control, and psychosocial and legal support.”

“TIPPING” PUBLIC PERCEPTION

Several barriers prevent people, particularly those in the critical 15-to-24 age group, from accessing VCT services. Barriers include worries about confidentiality; perceived pressure to notify partners or family members; inaccurate risk perception; fear of stigma; lack of information about the realities of living with HIV; and inadequate post-test support, care and treatment. VCT is also unavailable in many areas, and services need to be expanded to reach more people from all risk groups.

“The current thinking is that VCT needs to be scaled-up across the board,” says Sangiwa. “VCT is a cost-effective preventive measure and a gateway to other HIV prevention, care and support services. Scale-up will help reduce HIV transmission by creating a larger community of people who know their status, leading to constituencies of HIV-positive people who will advocate for prevention, human rights, and treatment and support.”

Sangiwa points out that if enough people know their HIV status, it will create a “tipping point” in public perception of the disease that will reduce stigma, personalize risk and change social norms.

THE CHALLENGES OF SCALE-UP

In many countries, VCT has grown in response to public demand, but it sometimes lacks referrals to care and support services. Care and support services are critical to scaling-up because the community must understand that there is some hope beyond a positive test result before large numbers of people will choose to be tested.

In some settings, VCT services are unevenly distributed, causing under-utilization of certain sites and overcrowding at others. When counselors at overcrowded sites face ever-growing numbers of clients—and inevitably, more positive test results—they frequently “burn out” from stress. Thus, many countries have incorporated counselor support activities into their national VCT plans.

Another challenge to scale-up is the gender inequality that continues to plague African society. Women who fear that being tested may elicit a violent response from their partner remain reluctant to learn their status or to encourage their loved ones to do so.

No formula exists for a successful scale-up program, as each community’s culture and acceptance rates differ. However, several African countries have creatively surmounted common barriers to VCT expansion. The following case studies share highlights and lessons from VCT programs in Kenya, Ethiopia, Rwanda and a confederation of West African nations that are supported by the IMPACT Project. IMPACT is funded by the U.S. Agency for International Development and managed by Family Health International.

CASE: KENYA

Rapid Scale-up Through Service Integration

Of Kenya’s 31 million people, an estimated 6.7 percent are HIV positive, a number that Kenya hopes to decrease through a rapid scale-up effort that aims to put 350 VCT sites into operation by 2005. In less than two years, more than 240 VCT sites have been established in rural and urban communities across the country. The IMPACT Project, with funding from the USAID’s

Kenya mission (USAID/Kenya), has set up 79 sites in three regions where HIV prevalence and the risk of new infections are highest. Most VCT sites are integrated into existing healthcare facilities.

The population is ready for such an ambitious implementation, reports Jane Harriet Namwebya, FHI's Technical Officer for VCT in Nairobi. "We have reached the point where people understand the term VCT and the importance of knowing your status. The stigma of a positive diagnosis has certainly gone down."

The early success of expansion is reflected in the number of Kenyans who have sought services. More than 200,000 clients have been tested since 2001 at IMPACT-supported sites alone, and over half of that number stated "planning for the future" as their main reason for being tested.

A SERVICE, NOT A PROJECT

Sustainability is a top priority for Kenya's VCT programs, says Namwebya. "We need to treat [VCT] as a nationwide service, not a project, which is a different mindset for many nongovernmental organizations (NGOs)," she explains. "Ownership of VCT is essential. It can't be seen as a project with an endpoint."

Giving the government of Kenya ownership of the VCT program is a priority for the IMPACT Project. The Kenyan government "owns" VCT in that most of the IMPACT-supported sites are in government health facilities that were selected in collaboration with government health officials, and the counselors providing the services are government employees. Additionally, where FHI/IMPACT once provided the HIV test kits, all VCT sites—including those established under IMPACT—now receive kits from the government.

"We are now working to integrate VCT service delivery within the government system," Namwebya adds. "For example, delivery of the HIV test kits is done by the Ministry [of Health] rather than by us. Supervision for all VCT sites takes place at the national level, conducted by officers from NASCOP [National AIDS and STD Control Program]." IMPACT also works with the Centers for Disease Control and Prevention (CDC) and NASCOP to train provincial-level laboratory technologists to provide quality assurance for the HIV tests. "Again, these are government salaried officers, and we think that operational funds for their activities will come from the government treasury," Namwebya explains. IMPACT also helped establish a NASCOP task force that meets monthly with NGOs to discuss integration and capacity issues.

Despite these successes, Namwebya points out that transferring ownership is a difficult process. "The issue of ownership takes time, especially if the government feels that by depending on you, they can access more funding support."



A billboard promoting FHI-supported VCT services in Kenya asks, "What would I do if my partner has the HIV virus?"

Video still: Robert Ritzenthaler/FHI

SETTING STRONG, RELIABLE STANDARDS

Standardization is essential to VCT scale-up, and it proves a challenge to a scientific enterprise like medical testing. “In our very rapid scale-up, we were working with a diverse collection of partners and agencies who were already involved in HIV/AIDS, but who were operating like small information services, all working in different ways,” Namwebya recalls. “Some were working slower on implementation than others; some were more quality-oriented. There were a lot of issues to work out.”

FHI worked with the Kenyan government and all partners to develop and disseminate national VCT guidelines. National Guidelines for Voluntary Counseling and Testing, published in 2001, is designed to ensure consistent, high-quality services at all sites.

VCT quality assurance focuses on two fronts: counselor training and lab testing. IMPACT and other partners designed a standardized training curriculum for VCT counselors, who come from both NGO and government backgrounds. “We made sure all the stakeholders were involved in developing the training system we have, and we really stressed supervision,” says Namwebya. IMPACT also contracted with the Kenya Medical Research Institute to create a quality assurance system for lab tests and to train counselors to conduct them. To date, 127 counselors certified using the new VCT curriculum are working at the IMPACT sites. Counselors are qualified to administer and read rapid HIV tests that allow clients to receive their results the same day they are tested.



Mock VCT counseling session at Kenyatta National Hospital, Nairobi, Kenya

Video still: Robert Ritzenthaler/FHI

IMPACT also cooperates with Population Services International to promote VCT services through a mass communications campaign using radio, TV and billboards. A separate program conducted through MAP International sensitizes religious leaders about the importance of counseling and testing.

Tracking the success of the VCT initiative is a large part of quality assurance. Namwebya explains, “Some measures are obvious, like the number of clients seen, but other data can be just as crucial, such as why they came.” VCT sites set up by FHI use a data form to ask clients such questions, and IMPACT is now standardizing client satisfaction questionnaires at non-FHI sites.

TRUE INTEGRATION

FHI’s goal in Kenya has been to integrate VCT into existing health facilities. To achieve this, FHI primarily blended VCT into settings where IMPACT’s prevention and care programs were already in place. This approach enables FHI and the Kenyan government to provide comprehensive care where infrastructure and personnel already exist, resulting in a less costly program that can expand rapidly using government infrastructure.

However, adding VCT services does not automatically stimulate linkages to other healthcare services like tuberculosis (TB) treatment, family planning, or sexually transmitted infection management. Truly integrated VCT services require an active, sound referral system. Ideally, clients testing positive should be able to get information and recommendations about ongoing counseling, home care, TB services, and other services. People testing negative should also be offered access to other healthcare services at the site or nearby.

VCT is an excellent service point for making family planning referrals, Namwebya believes. “But our referral rates for family planning are very low, and we need to make a great improvement in this area.” FHI is working with the Kenyan Ministry of Health and other partners to test a national strategy for integrating family planning and VCT services. A feasibility assessment for integrating FP services into VCT in Kenya is highlighted in the box on page 6.

IMPACT also encourages other health providers to point clients toward VCT. Professionals working in other areas of health “don’t always have an understanding of VCT or how they can link with VCT,” Namwebya asserts. “Not only should referrals and linkages be emphasized during training of VCT counselors, but other healthcare providers need to be sensitized to the benefits of clients knowing their [HIV] status.”

Sensitization of outside providers is being accomplished through trainings conducted in partnership with the Johns Hopkins Program for International Education in Reproductive Health. District-level personnel were trained as trainers who teach health facility-level providers about VCT and the importance of referrals. Providers then return to their health facilities and give an orientation on VCT to their colleagues. Namwebya explains, “In the end, many more people beyond the VCT counselors now know about VCT services.”

ONGOING CHALLENGES: DISTRIBUTION WITHOUT DUPLICATION

The FHI team continues to smooth out the barriers to fully integrated VCT services. Two recurring—and related—issues are uneven resource distribution and duplication of efforts by the government.

While the country has over 130 VCT sites, location is a key issue. Clients crowd the urban clinics, while some rural sites serve only one or two clients a day. Resource distribution is being addressed at the national level, says Namwebya. “We are working to make sure all government hospitals have VCT, and we have asked our partners and donors to focus on underserved districts.”

To minimize duplication of efforts, FHI promotes collaboration and information sharing on many fronts. “Duplication by other partners sometimes cannot be avoided, especially if all are working in the same area,” Namwebya laments. Whenever possible, donors and partners try to communicate and work together to avoid duplication in any given area. “For example, the government has changed their rollout plan in Mombasa because IMPACT was already working there.” Monthly meetings between NASCOP and nongovernmental organizations have proved a useful opportunity for partners to update one another on where each plans to expand.

Staffing issues also continue to trouble the program, chiefly because of a government-imposed ban on recruitment in the health sector. Full VCT integration and coverage for all populations in

Kenya “can’t be done effectively without more staff,” says Namwebya. “We should put pressure on the International Monetary Fund and governments to lift the ban, and in the meantime, we should explore the use of lay counselors, as is being done in Botswana and South Africa.”

KEY FINDINGS FROM FHI/KENYA’S FAMILY PLANNING AND VCT INTEGRATION ASSESSMENT

Potential demand for family planning services

- 40 percent of sexually active VCT clients reported that they either did not use contraceptive methods or used traditional methods.
- 84 percent of providers explained to clients that condoms prevent HIV transmission, but only 58 percent mentioned that condoms prevent pregnancy.
- Very low referral rate for family planning (10 percent) or other reproductive health services (25 percent)

Readiness

- Clients expressed concern about confidentiality and follow up.
- Little to no family planning equipment and few contraceptive methods (with the exception of condoms) are available in VCT centers.
- 60 percent of VCT providers are clinicians; 37 percent have family planning training.

Acceptance

- Integration is acceptable to the majority of providers and clients.

Feasibility

- Average VCT contact is 26 to 61 minutes (mean = 44 minutes)
- Time spent with VCT clients comprises 22 to 51 percent of the day’s activities.
- Family planning services could be accommodated if counselors came to work on time, did not leave early and used time currently spent on non-work-related activities to serve clients.

Although VCT is intended to be an entry point to various forms of care and support, it was not originally designed to provide family planning services in Kenya. The level of family planning integration at each VCT facility varied for reasons that include: the counselors’ training background, financial and logistical factors, referral mechanisms, and contraceptive supply channels.

Due to these differences in capacity, the decision to integrate family planning into VCT and the extent of the integration should be made at the facility level. At minimum, providers should assess clients’ risk for HIV, sexually transmitted infections (STIs) and pregnancy and refer clients who want to avoid pregnancy and are not using an effective contraceptive method. While it is unrealistic to expect VCT centers to offer all contraceptive methods, the recommended basic level of service should include information, education, and counseling (IEC) on methods and method choice, provision of condoms and pills, and referrals for other methods.

CASE: ETHIOPIA

Accelerated, Simultaneous Scale-up

In 2002, IMPACT provided technical assistance to the Government of Ethiopia to set up and simultaneously open 20 VCT sites. The Ethiopia VCT program had begun just six months earlier, growing out of FHI's discussions with regional health bureaus about the best ways to offer care and support for the nation's estimated 2.1 million people living with HIV/AIDS. According to Dr. Girum Gebreselassie, Care and Support Officer for FHI/Ethiopia, "We played a catalyst role with the government, showing them it was possible to integrate VCT into existing health services and then giving them ownership. At that time, there was no such thing as an 'HIV clinic,' and some health departments worried about stuffing existing healthcare sites with too many services. But we pointed out that there was nothing being done for HIV. It was high time we took part in prevention at a national level, and informing people of their status is central to that. Why were we denying the public the right to be tested?"

In a series of consensus-building meetings, players from the regional, zonal and health center tiers identified resource and quality gaps at the proposed sites and brainstormed ways to accomplish rapid scale-up. The meetings were followed by several workshops that gave birth to a single plan of action for the simultaneous launch of 20 VCT sites in the Addis Ababa Administrative Region. One was located in a major hospital, and the rest were integrated into existing health centers. "In the end, the government created a formalized VCT relationship with its regional health bureaus and committed to full staff deployment," explains Gebreselassie.

Staff training stressed the importance of referrals within and outside of the health center. An active referral program points clients to other services at the health center and beyond, including post-test "clubs" for clients diagnosed with HIV. VCT has been integrated into a standard package of services at each health center, and each site provides pre-test, post-test and ongoing counseling in a designated VCT space at a cost of US \$1.25. The fee is waived for clients who cannot afford to pay.

In the first three months of operation, more than 2,000 clients received testing. Almost a quarter (23 percent) tested positive, with the highest rates among those ages 20 to 34. Of all clients testing positive, a significant majority (69 percent) were female.

ZONES OF QUALITY

FHI was determined to proceed with a simultaneous, rather than a phased-in launch, "because we already had some sites ready, and we had the experience to get them up and running quickly without compromising quality," Gebreselassie explains. Ensuring quality during this accelerated, synchronized approach was a critical factor in the scale-up planning. "We decided we were not going to try to manage, coordinate and monitor the sites from the top, but from each zone."

A series of coordinated workshops for counselors, peer supervisors and lab technicians trained newly recruited and reassigned staff. Each VCT site employs a minimum of one counselor and one specially trained peer supervisor. Two VCT supervisors from each zonal health department and two regional VCT coordinators from the national health bureau monitor the sites.

Peer supervisors are key to the program's success. These individuals observe and monitor quality at a single site and are prepared to step in when volume is high or counselors need a break.

“They are essential to avoiding counselor burnout,” says Gebreselassie. Burnout is also mitigated by a system of peer support groups that enable counselors to share frustrations and coping skills, as well as receive up-to-date training.

ONGOING CHALLENGES: MEETING DEMAND AND MONITORING RESULTS

The program is struggling with how actively to promote VCT amid already robust public demand. “It’s a balancing act. We must control capacity while making sure more people get tested,” Gebreselassie explains. The program plans to utilize community and religious leaders and a mass media campaign to reach potential clients.

A monitoring and evaluation system will also help identify needed changes. Refinements might include strengthening the counselor support groups and post-test clubs, establishing supervisory and quality assurance systems to standardize VCT countrywide, and building health bureau and VCT staff’s capacity to integrate VCT into other health centers and to document and share lessons learned.

Gebreselassie offers some advice for other programs considering simultaneous integration: “Essentially what made our program work was getting initial buy-in from local government, especially the regional health bureaus. Also important was marking a clear delineation of roles and responsibilities among the different actors, with government taking the lead, and making sure the logistics and systems, like the national guidelines and test kit distribution arrangements, were built first.”

CASE: RWANDA

Meeting Overwhelming Demand for Testing, Care and Support

Rwanda has national HIV infection rate of 8.9 percent, and its population and leaders have embraced VCT as a promising tool for combating the epidemic. “The demand for VCT is very high in Rwanda,” says Theonille Mukabarasi, VCT Team Leader for FHI/Rwanda. “Rwandans look to the experience of their neighbors in Uganda to see how an organized campaign of behavior change communications, VCT and HIV care and support can turn around a hopeless situation,” she says.

IMPACT’s approach has been to rapidly integrate VCT into health centers and district hospitals where related services—prevention of mother-to-child transmission (PMTCT), TB prophylaxis and support for people living with HIV/AIDS—are available. With funding from USAID and CDC, FHI established 22 VCT sites between 2000 and 2003. In 2002 alone, nearly 80,000 clients sought testing.

The progress is striking considering that prior to 2000 the country had only one freestanding VCT site in Kigali. Other sites that provided testing had very limited, if any, counseling services. Blood was sent to a single central laboratory where results could take up to three months, and almost one-third of clients never received their results.

Today, clients receive individual, anonymous, same-day testing at 22 integrated sites in Kigali and seven of the country’s 12 provinces. All clients receive individual pre- and post-test counsel-

ing, plus information, education and communication sessions. Ninety-eight percent receive their results, typically on the same day. Those who test positive are referred for services such as PMTCT, prevention of TB and opportunistic infections and, at four sites, antiretroviral therapy (ART) as needed.

KEEPING UP WITH DEMAND

Convincing clients to get tested is not a problem in Rwanda, according to Mukabarasi. “Even before FHI became involved in 2000, clients would camp out, sometimes for two or three nights, waiting for appointments at the single VCT center in Kigali.”

The challenge was to scale-up rapidly enough to meet the robust demand for services. The existing center in Kigali, the Centre d’ Information Rwandais sur le SIDA (CRIS), became the launch pad for the strategic, phased-in, 18-month scale-up. All VCT sites in Rwanda have adopted CRIS’s computerized client record-keeping system, which provides data to the FHI/Rwanda office on a monthly basis.

“The Ministry of Health has been immensely supportive by stressing VCT as a primary HIV prevention strategy,” Mukabarasi reports. The Ministry’s involvement allowed FHI to standardize testing and care nationally. With backing from the Ministry’s AIDS Control Program, IMPACT has developed national VCT guidelines, HIV testing algorithms, a training curriculum for counselors and technical standards for laboratories.

GATEWAY TO PREVENTION AND CARE

High numbers of positive HIV tests come with the high demand for VCT. In urban areas, 12.7 percent of clients test positive, and 7.5 percent test positive in rural centers. “Having the services to support positive clients is central to our VCT efforts in Rwanda,” says Mukabarasi. FHI/Rwanda is spearheading models for comprehensive care and support for PLHA. One site, Biryogo Health Center, offers VCT, PMTCT services, opportunistic infection prevention and antiretroviral therapy.

Using the Center’s strong links to a community-based PLHA organization, a local NGO supported by FHI is piloting home-based care and a micro-credit program that pairs HIV-positive business owners with HIV-negative families and community members to ensure sustainability of the enterprise even when the PLHA is too sick to work.

COMBATING COUNSELOR BURNOUT

Counselor burnout is a side effect of high demand that can harm a VCT program if it is not addressed. According to Mukabarasi, “What we are facing now is that counselors are too busy. We are meeting with the Ministry of Health and talking to providers themselves to determine the scope of the problem—the number of types of clients they are seeing, their typical fears and concerns, and how to address growing requests for ART. We know we need more training to avoid losing counselors to burnout.”

IMPACT is pursuing two approaches to counter burnout in Rwanda. At the level of the VCT sites, counselors hold daily meetings to share the challenges of the workday, emphasizing difficult emotional issues. Each counselor also identifies a peer as a personal counselor that he or she can talk to about stress and depression when the need arises. “Some VCT sites even organize outside

trips to a quiet environment where counselors can have sessions to share their heartfelt thoughts,” Mukabarasi says.

IMPACT trainer-supervisors conduct formal quarterly sessions that help counselors become more aware of the way they affect, or are affected by, their clients. These sessions are used to release emotions and to recharge energy and ideals. Once a year, IMPACT also organizes three-day counselor meetings away from the VCT sites.

ELEMENTS OF SUCCESS

Simple but significant elements that have contributed to the success of Rwanda’s VCT scale-up include:

- Strong political and religious engagement at the national, provincial and local level
- Standardized procedures, training, materials and forms
- Theoretical and practical training on both counseling and testing
- Promotion of the new VCT services among community health workers
- Follow-up care and support around VCT
- Grassroots HIV prevention interventions, especially for youth

FHI’s VCT experience will help the Rwandan government expand VCT services to more than 100 sites across the country. FHI also plans to develop mass media and interpersonal communication campaigns to encourage couples to seek VCT.

ONGOING CHALLENGES

Public sector VCT sites continue to struggle with staffing inefficiencies. IMPACT is addressing this by training more counselors at each site and instituting a rotation system to ensure full coverage and ample opportunities for all counselors to use their skills.

Mukabarasi also notes that the program needs to increase referrals for and linkages to support and care services. “There are not enough points of referral for medical and non-medical care for HIV-positive clients, so we are actively advocating for donors to provide more support for care programs.”

TOWARD A COMPREHENSIVE MODEL

In 2003, VCT centers in Rwanda offered linkages to:

- Tuberculosis and opportunistic infection prevention (two sites)
- Prevention of mother-to-child transmission (eight sites)
- Antiretroviral therapy (four sites)
- Micro-finance program for PLHA (one site)
- Home-based care (nine sites)
- Ongoing counseling, support and referrals for HIV-positive clients (one site)

CASE: WEST AFRICA

Cross-Border Coordination Through Top-Down Training

HIV rates in West Africa are comparatively low, creating unique challenges for establishing and encouraging use of VCT services. In such “low-prevalence” areas, stigma is higher and people are more reluctant to be tested.

Before FHI began its VCT program in West Africa, a host of small countries were pursuing their own programs, training and tools with no standardization or coordination. “Each NGO was implementing services as needed in an ad hoc way,” says Charles E. Zouzoua, Technical Officer at FHI’s Action in West Africa Region Program (AWARE). “Our goal was to pull the various regional efforts together by establishing and implementing a centralized training approach that cascades standardized knowledge and practices down through all levels of VCT management and staff.”

EACH ONE TEACH ONE

With funding from USAID, FHI/IMPACT is working in Burkina Faso, Cameroon, Cote d’Ivoire, Mauritania and Togo on a unique “train the trainer” initiative. Its purpose is to create a pool of highly skilled counselor-trainers to serve the entire multinational region.

The initiative grew out of a 2001 meeting FHI convened for national AIDS program and NGO representatives from the five countries to standardize policy, norms and procedures for VCT across borders. Since the meeting, “each country has adopted a manual of policy, norms and procedures with slight changes of their own that best suit their regional differences,” Zouzoua reports. “We also worked together to develop training tools and a referral protocol that facilitates clients’ movement into care and support services.”

Initially, FHI and a group of eight NGOs designated a single, freestanding VCT site in Burkina Faso as the headquarters for oversight, training and technical assistance for the AWARE region. This headquarters was used to train an initial 50 counselors using a standardized curriculum. These 50 counselors then returned to their own countries to train others. “They have now trained a pool of 600 counselors, all with the ability to train others—not just for FHI, but for everyone providing VCT in the region to draw from,” says Zouzoua.

Today, AWARE directly supports seven VCT sites and indirectly supports four more through the Regional VCT Resource Center in Burkina Faso. The average age of the male and female clients at the AWARE-supported sites is 24, and most report seeking VCT services because of “high-risk sexual contacts.”

“As demand increases, NGOs will want to implement more VCT sites, and our pool of counselors won’t be sufficient,” he says. “That’s why our ‘train the trainer’ approach is perfectly designed for scaling-up, and we’ll keep adding continuing education to the curriculum.” FHI also arranges to supplement permanent staff with trained part-time counselors.

ONGOING CHALLENGES: INCREASING AWARENESS, AVOIDING STIGMA

In low-prevalence settings, “You have to target specific groups—high-risk or vulnerable populations—for the intervention to be cost effective, and this runs the risk of stigmatizing the service,”

says Zouzoua. In West Africa, HIV tends to be concentrated among a few populations—uniformed services, transportation workers, commercial sex workers and youth—so the challenge remains to increase risk awareness and testing among the general population.

FHI is working to reduce stigma and expand testing among the general population by publicizing the benefits of knowing one's status. "Since the vast majority of clients will test negative, VCT must be advanced and promoted as a protective measure—knowing your status can help you stay healthy," Zouzoua explains.

High-risk clients must also be encouraged to test. "A big part of that is making sure we have care and support services in place for those who do test positive," says Zouzoua. To this end, FHI is working with local partners to set up and promote such services.

The program is currently working to improve referral rates to care and support services for HIV-positive clients. One particularly successful scheme combines TB and VCT referrals by linking to government-employed community health providers. As part of the standard TB protocol, providers ask TB patients about their HIV status and refer many for counseling and testing at the nearest VCT center.

Another challenge is social resistance to providing VCT to youth. "We are addressing this through one-on-one conversations with young people, local government officials and religious leaders. We feel strongly that young people must have free access to a service that saves lives," Zouzoua explains.

CONCLUSION

Differences between cultures, countries and HIV prevalence rates mean that no single formula exists for successfully scaling-up VCT. However, challenges similar to those faced by the FHI-supported VCT scale-up projects in these case studies are likely to emerge for other VCT projects preparing to expand. Lessons applicable throughout the developing world include the importance of developing strategies for preventing counselor burnout and fostering sustainability through involving the government in VCT.

As stigma decreases and more people recognize the benefit of knowing their HIV status, scale-up of VCT services is necessary to meet burgeoning public demand in many areas. Increasing the availability of voluntary counseling and testing services is a vital step toward curbing the spread of the disease and providing care to all people living with HIV/AIDS.