

WHO/UNAIDS Technical Consultation
on
Voluntary HIV Counselling and Testing:
Models for Implementation and Strategies for
Scaling of VCT Services

Harare, Zimbabwe

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Executive Summary

This first international Voluntary Counselling and Testing (VCT) consultation was designed to share experiences of VCT delivery from all regions. The challenges and advantages of employing various approaches to VCT to serve different populations were explored. The benefits and problems of integrating VCT with other health interventions were also discussed.

It was acknowledged that there is great political and international will to develop and expand VCT services particularly in high prevalence developing countries. VCT has been shown to be a cost-effective intervention in promoting sexual behaviour change to reduce HIV transmission. It is also an important component of HIV care and prevention programmes for injecting drug users (IDUs). The UNGASS declaration also reflects a commitment to the rapid scaling up of VCT services in general¹, with a particular emphasis on accelerating access to PMTCT interventions² and ARV treatment, necessitating the rapid development of VCT to serve as an entry point for these interventions³.

Options for scaling up range from establishing and expanding services to increase the numbers of people who have access, and/or range of services provided, to broadening geographical coverage. Scaling up is dependent on HIV prevalence, health priorities, available resources, existing services and infrastructure, and the expected role and focus of VCT. Currently, in many high prevalence developing countries there is little or no access to VCT services and the concept of having access to VCT as being a human rights issue was considered.

Recent cost effectiveness data demonstrate that VCT is a cost-effective intervention in preventing HIV transmission and falls within World Bank criteria. Cost data was presented from other VCT sites and the difficulties of collecting and interpreting such data were discussed.

¹ **United Nations General Assembly, Declaration of Commitment on HIV/AIDS**, June 2001

P 19 "...recognizing that care, support and treatment can contribute to effective prevention through an increased acceptance of **voluntary and confidential counselling and testing**, and by keeping people living with HIV/AIDS and vulnerable groups in close contact with health-care systems and facilitating their access to information, counselling and preventive supplies."

² P 54 "...by 2005, reduce the proportion of infants infected with HIV by 20 percent, and by 50 percent by 2010, by ensuring that 80 percent of pregnant women accessing antenatal care have information, counselling and other HIV-prevention services available to them, increasing the availability of and providing access for HIV-infected women, including **voluntary counselling and testing**, access to treatment, especially anti-retroviral therapy and, where appropriate, breast-milk substitutes and the provision of a continuum of care"

³ P 52 "...by 2005, ensure: that a wide range of prevention programmes which take account of local circumstances, ethics and cultural values, is available in all countries, particularly the most affected countries, including information, education and communication, in languages most understood by communities and respectful of cultures, aimed at reducing risk-taking behaviour and encouraging responsible sexual behaviour, including abstinence and fidelity; expanded access to essential commodities, including male and female condoms and sterile injecting equipment; harm-reduction efforts related to drug use; **expanded access to voluntary and confidential counselling and testing**; safe blood supplies; and early and effective treatment of sexually transmittable infections"

Aims of the meeting

- To review models/approaches to VCT with reference to their implementation in middle income and developing countries
- To consider appropriate models/approaches to delivering VCT in the context of PMTCT, STI and TB programmes
- To consider issues in the provision of VCT for vulnerable groups
- To review strategies for introducing and expanding VCT services, including funding and sustainability and ensuring quality of counselling and testing

1. Key areas and recommendations

1.1 Quality of VCT service provision

All models of VCT presented described high quality pre and post-test counselling as essential components of their VCT services. All participants felt that in high prevalence countries there was no evidence that testing without the benefit of individual pre- and post-test counselling was beneficial or ethical. In low prevalence countries and countries with concentrated epidemics⁴ alternative testing strategies could be considered for particular situations such as PMTCT interventions, where very low numbers of seropositive pregnant women are seen⁵. However individual (or couple) counselling should always be available for people who request it even in low prevalence settings.

A weakness of some of the VCT models presented was the lack of ongoing counselling support available at the VCT site or the lack of facilities for referral of clients with more complex or long-term emotional needs.

Recommendations

It would be useful for UNAIDS/WHO to develop guidance on the *minimum standards* for pre and post-test counselling and give recommendations on the provision of ongoing counselling services and other support services that would ensure that the emotional needs were addressed for people following VCT. This may include training of a cadre of 'senior counsellors' who could offer support and supervision for other counsellors and accept referrals of more difficult cases. Training in 'advanced counselling skills' (to include areas such as counselling of discordant couples, counselling for adolescents, counselling for women with marital difficulties or abusive partners) could be considered.

1.2 Training, support and supervision of counsellors, including accreditation of different cadres of counsellors.

The background, training, roles and responsibilities of people carrying out pre- and post-test counselling varied widely between projects. It is recognised that in many VCT projects the majority of counsellors are nurses who have had additional HIV counselling training. Evaluation of counselling provided by nurse counsellors has usually revealed high levels of

⁴ **UNAIDS/WHO HIV epidemic definitions:**

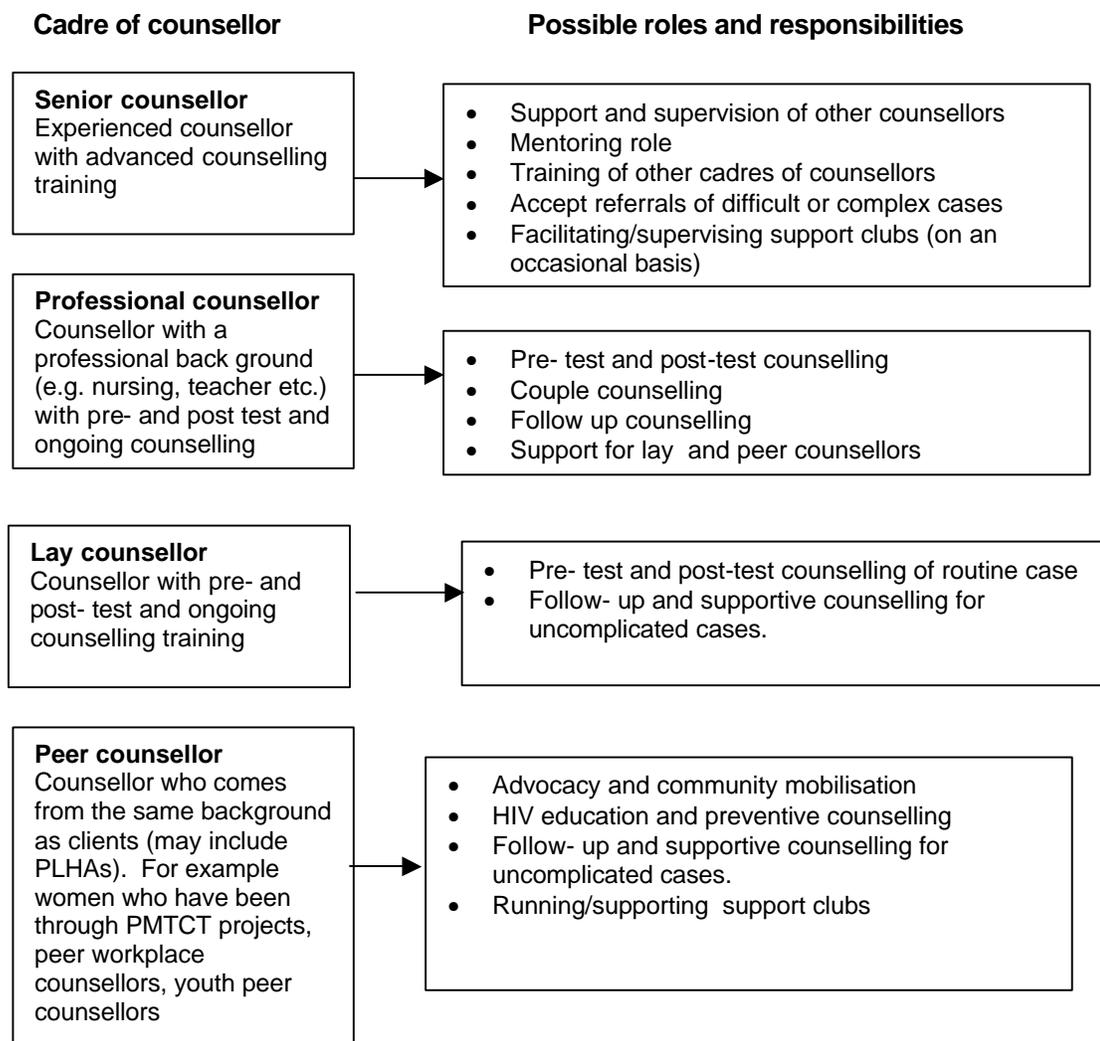
1. **Low-level** - below 1% in the general population, under 5% in high-risk groups
2. **Concentrated** - below 1% in the general population, over 5% in high risk groups
3. **Generalised** - over 1% in the general population.

⁵ A series of different testing strategies that could be considered for HIV testing under various conditions is discussed at length in the document **VCT for PMTCT interventions** that was distributed at the meeting.

client satisfaction and high quality of counselling and counselling content. However, for many projects, especially those where scaling up is envisaged, other cadres of counsellors will be needed. In many high prevalence developing countries there is already a shortage of nursing staff. In free-standing VCT sites, employing counsellors will draw them away from other health care services and in integrated sites, nursing staff are often already overstretched and unable to take on additional extensive counselling duties. This has led to some sites training other cadres of counsellors including 'lay counsellors', 'peer counsellors', 'PLHA counsellors' and 'volunteer counsellors'. Many of these categories of counsellors are overlapping and definitions are not uniform. For example one project described volunteer counsellors as 'professionals working in other fields (including counselling) who offer their services free to work part time in HIV counselling. Another VCT service described volunteer counsellors who were unemployed community members who offered 'counselling' as part of home based care. This can make comparisons of VCT services difficult, yet the use of other cadres of counsellors will be essential for scaling up projects and ensuring long-term care.

Recommendations

- The recognition of different cadres of counsellors with different roles
- The development of training, support, supervision and accreditation for each category of counsellor, for example:



1.3 Development and standardisation of HIV testing policy

The advances in HIV testing technology has lead to an increasing number of simpler, rapid HIV tests being available. These can be particularly appropriate for use in VCT services as they can allow clients to receive their HIV test results without delay, as occurs when ELISA kits are used. Furthermore, many of the rapid test kits can be used by non-laboratory trained personnel without the need for laboratory equipment or a constant electricity and water supply. They are also suitable for testing small numbers of samples and some can be stored at room temperature. This makes them suitable for use in many VCT sites and can facilitate VCT delivery in remote or rural locations.

Recommendations

Current HIV testing algorithms were developed when some HIV tests had less optimal operating characteristics (sensitivity, specificity, PPV, NPV). Updating of the WHO testing algorithms was recommended with particular reference to HIV testing in VCT and PMTCT settings and settings where HIV prevalence rates are 5-10%⁶.

There are large numbers of different rapid tests currently available. To help countries and VCT sites make appropriate kit selections WHO must continue to provide up to date guidance of the suitability of rapid tests for VCT and PMTCT settings.

1.4 VCT services for vulnerable groups, including closed communities, men having sex with men, sex workers, etc.

In countries with low prevalence or concentrated epidemics the first priority is to provide HIV prevention and care services, including VCT, for high-risk groups. The risk groups targeted will depend on local factors and be based on formative research. VCT services should not be confined to pre- and post-test counselling but also include ongoing and supportive counselling and counselling to address underlying vulnerabilities and risk behaviours. Counselling of family members and sexual partners will also often be important. When targeting particular groups it is important not to increase marginalisation and stigma. Furthermore HIV awareness and prevention for the general population must not be ignored.

Ideally VCT for all populations should be available and scaling up of services is a priority. However it is recognised that when adopting approaches for scaling up it will be necessary to make priorities and this may include initially targeting interventions for the most vulnerable groups.

1.5 VCT and counselling services for children and adolescents, especially counselling and adolescent friendly services

In many countries with emerging epidemics, it is recognized that young people play a pivotal role in slowing the current pace of HIV transmission. Consequently there is great urgency to provide HIV care and support services for young people, including VCT. Currently although VCT programmes are being developed and expanded there has been little emphasis on providing VCT services to meet the needs of young people.

⁶ Current WHO HIV testing algorithms (See *Weekly Epidemiological Record* 1997 **12** 81-87) require that in situations where the HIV prevalence is less than 10% all HIV seropositive test results are confirmed with a third different HIV test before a test result is given.

Recommendations

Development of VCT services which meet the needs of young people in terms of youth friendly counselling as well as physical locations which will appeal to that age group.

Ongoing emotional care must also be considered when developing VCT services for young people. This can be provided by post-test clubs though it may also be necessary to provide more individually tailored emotional care or referral to other counselling agencies. Young people may not only have HIV related counselling needs but also require help with other problems of adolescence including relationship difficulties and financial issues affecting educational opportunities, especially for young women.

Other support services that must be available for young people following VCT include HIV prevention services (including the free provision of male and female condoms), youth friendly health services for the diagnosis and treatment of STIs, and reproductive health services (including the provision of family planning). Linkages with youth friendly health services, where they exist, are essential. If these are not available development of such services should be considered.

The uptake of ongoing care and support services by young people following VCT is not known. Although follow-up of young people following VCT is difficult, particularly in sites where anonymous VCT is offered, operational research to determine the long-term outcomes of young people following VCT should be considered, to ensure that young people (particularly those who test seropositive) are not left unsupported and disadvantaged following testing.

Outcomes for young people following VCT are also very poorly understood. There is an urgent need to develop effective behavioural interventions to help young people sustain safer sexual practices following testing and emotional support options adapted for the needs of young people who test seropositive. These interventions will also need careful evaluation.

Evidence from other health interventions has demonstrated the importance of training health providers to communicate more effectively with young people. UNICEF and UNFPA have experience in this field and could expand this programme with a greater emphasis on the provision of counselling and support services for young people.

1.6 Strengthening of the health sector and re-organisation of existing health services to facilitate better implementation of VCT services

Health sector strengthening

Health service delivery is weak in many developing countries. While this contributes to general health indicators such as mortality and morbidity, it also affects the potential impact of services designed to support HIV prevention and care and treatment for PLHAs and their families. It is also clear that VCT is most effective as part of an integrated delivery system where related psychosocial, spiritual and medical services are part of the array of services immediately available to people presenting for VCT.

Recommendations

- Parallel strengthening of the health sector will be necessary in many settings to facilitate better implementation of VCT.
- Re-examining the organisation of health services is necessary to develop more effective integrated services given limited resources (staff, space, funding etc).

1.7 Community mobilisation and communication strategies to increase uptake of VCT and contribute to stigma reduction

Community mobilisation serves to increase awareness as well as acceptability of new issues. The success of VCT will rely on the support of community members especially with regard to young people where issues of consent and confidentiality have legal implications for health care providers.

Recommendations

Formative research and community participatory planning should guide VCT development and help to provide relevant communication strategies to emphasise the benefits of VCT and challenge myths and barriers to testing.

1.8 Goals and targets to guide scaling up and facilitate monitoring and evaluation

As discussed in section on goals and targets (page 16) it is important to set realistic goals. However, these can be difficult to define for VCT interventions. Setting goals of, for example, attendance at a VCT site or number of clients tested might not be realistic and failing to reach ideal goals and targets should not always be seen as a negative outcome. Failing to reach overly ambitious goals can be demoralising for counselling staff and create an atmosphere where chasing targets is more important than providing a high quality service. For example in the UN PMTCT programmes the *ideal* target would be 100% of women being counselled and 100% of seropositive women being able to access a full regimen of ARV therapy for PMTCT. In reality uptake was found to be much lower as women declined the intervention at each stage. This should not be seen in a negative light as this PMTCT service is new and if uptake had been 100% it may have reflected the inability of women to decline services. However, failing to meet reasonable targets can allow the service providers to examine their services and develop and improve them to increase acceptability.

2. Models of VCT⁷

VCT is a key component of both HIV prevention and care programmes. VCT has been shown to be a cost-effective HIV prevention intervention. It also has a major role as an entry point to a wide range of care and support services. The development of increasing numbers of effective and accessible medical and supportive interventions for people living with HIV/AIDS (PLHA) means that VCT services are being more widely promoted and developed and many developing countries are gradually instituting VCT as part of their primary health care package. These interventions include cotrimoxazole prophylaxis, tuberculosis preventive therapies (TBPT), antiretroviral (ARV) therapy for the treatment of HIV disease, and ARV and other interventions for the prevention of mother-to-child transmission (PMTCT).

Different models/approaches are being developed to deliver VCT services. Each of these has key features, and distinct advantages and disadvantages. Various models were presented during the meeting and the advantages and cautions with each approach discussed.

⁷ For full discussion of approaches to VCT see paper on models of VCT

The current approaches to VCT service delivery include:*

1. Free-standing services (**AIC**, Uganda, **Kara**, Zambia)
2. Integration into primary health care services (ANC/MCH, TB, primary health care settings, **ProTest** sites (**Cape town**, South Africa), **PMTCT** projects and programmes (**Botswana** and **Zambia**)
3. Integrated into hospital settings (**Bamrasnaradura** Hospital)
4. Social marketing (**New Start**, Zimbabwe)
5. Private sector (private hospitals, private practice and workplace clinics)
6. Home testing
7. Mobile/community outreach VCT

* bold indicates sites presented at the meeting

2.1 Free-standing VCT Sites

AIDS Information Centre, (AIC) Uganda

Josephine Kalule, Project manager AIC, Kampala, Uganda

AIC has grown from 1 site in 1990 to 51 in 2001, and a cumulative total of over 500,000 people have been tested. All sites have strong community support and involvement.

Features of AIC VCT services include

- Cost sharing (since 1994) - but have at least 1 day per week when VCT is free
- Rapid testing with same day results (since 1997)
- Syndromic management of STIs,
- TB information and preventive therapy
- Family planning
- Linkages with support services such as those provided by TASO and other AIDS service organisations.

Common reasons for seeking VCT at AIC are marriage (25%) and those worried about their status (22%). Male and female attendance is similar.

25% of clients test as couples

46% of clients are aged between 20-29.

Females (15-19 and 20-24) have shown the most significant declines in HIV prevalence among the youth. Males (25-34) have shown the most declines among adults.

Challenges faced by the program include inadequate follow-up and support services, youth friendliness of programmes, expansion to ensure affordable and sustainable services for the majority of Ugandans, and limited infrastructure, capacity and staff.

2.2 Social marketing of VCT

New Start Zimbabwe

Patrick Osewe, USAID, Harare, Zimbabwe

The New Start programme was launched in 1998 by the NACP, PSI and USAID Zimbabwe, and now consists of 10 centres offering high quality counselling and testing services, with same day results available at most sites.

New Start has 5 different delivery models, each with varying strengths and weaknesses:

- Public sector clinics
- Public/NGO partnership
- Private sector providers
- NGO providers
- Free-standing

The free-standing site, which is directly managed by PSI and located within a high density commercial area in a major city (Harare) receives the largest volume of clients (55-60% of total New Start clients). The most common reason for testing is curiosity (66%), followed by marriage (14%). Males constitute 56% and females 44% of New Start clients. However, 28% of female clients test positive, compared to 16% of males.

Features of New Start VCT services include

- Training program for both counsellors and support staff such as receptionists
- Innovative communication and community mobilisation campaigns, based on social marketing and franchising principles
- Rapid testing with same day results
- Provision of male and female condoms
- Cost sharing (but with 'promotion' periods when testing is free)
- Quality assurance measures (of both counselling and testing)

Challenges include:

Development of follow-up services (currently not developed)

Staff burnout (a programme of support is being developed)

Community mobilisation

Partner involvement and notification, and a general lack of national or regional standards to guide different aspects of programme implementation. New Start is currently scaling up its services through mobile outreach, implementing youth friendly initiatives and establishing effective linkages with identified support organisations.

2.3 Integrated VCT Sites

Integrated into primary health care settings

ProTest, South Africa

Pren Naidoo Project co-ordinator of the Central District ProTest sites

This TB/HIV Pilot Project was started in 1999 to address the burden of TB and HIV/AIDS/STI at district level, in response to recommendations for improved collaboration between national TB and HIV/AIDS/STI programmes. VCT is the key component in the link between TB/HIV activities. A baseline study was conducted and 8 health facilities, 4 under Cape Town local authority and 4 under Western Cape provincial administration. The approach to implementation was phased over time, allowing for staff acceptance, tailoring of the programme to client needs and local resource conditions, and capacity building to ensure sustainability.

The programme activities are designed to meet 3 primary objectives:

- To improve comprehensive HIV/AIDS/STD/TB care and referral and to ensure continuity of care
- To increase access to VCT, decrease the barriers to VCT, and improve the quality of VCT
- To facilitate collaboration between TB and HIV/AIDS/STI programmes at district and community level and between private and public stakeholders

There is a high (95%) acceptability of HIV testing following pre-test counselling among all clients.

68% of clients self-refer, out of whom 56% refer themselves due to their own perceived risk behaviour. 32% of clients test due to medical conditions and are referred for VCT by health staff (43% with STIs, and 15% with TB)

HIV positivity is significantly higher among females than males, until after 45 years of age. The difference is highest among the 20-24 age group, with males' positivity at 8% and females' at 30%.

Lessons learned

- Setting up a successful project depended on the co-operation between stakeholders and community involvement
- Building sustainability, including that of human resource must be addressed
- Critical success factors for the project have been management support and ownership, appropriate human resource practices, a facilitated approach to implementation and building responsive, rather than bureaucratic systems.

Service challenges

Improving access for women and youth

Promoting client centred care

Optimising the use of the network of health service providers

Utilising the "pilot" for extension of activities.

Integrated into hospital services

Bamrasnaradura Hospital, Thailand

Kathleen Casey , VCT and Psychosocial Adviser, HIV/AIDS Prevention, Department of HIV/AIDS, WHO, Geneva, formerly consultant for MoH, Thailand

- The HIV clinic at Bamrasnaradura Hospital sees on average 600 patients a day.
- Psychosocial support services available at the hospital include a wide range of psychological care: individual, group, discharge, ANC, nutritional, telephone and spiritual counselling.
- Other support services include social welfare and peer support.

A review of service issues was conducted in 1995, during which several key issues were identified and a problem solving focus adopted. A major counsellor and staff training initiative emerged as a result, with all levels of staff receiving training in basic communication skills and strategies for managing difficult patient and client situations. The initiative was implemented through a tiered, modular approach designed to train staff at different levels.

Integrated with MCH services

Zambia PMTCT Programme

Doreen Mulenga UNICEF, New York, formerly with UNICEF Zambia

In August 1998 the Zambia Minister of Health appointed an MTCT working group to implement a comprehensive PMTCT program, in partnership with UNICEF, and other organisations. Three pilot districts were selected with each site linked to a hospital and Primary Health Care facility.

The programme strategic approach consisted of VCT, a minimum package of care including AZT/NVP, strengthening community networks, advocacy and communication, and monitoring and evaluation.

Community mobilisation and male involvement strategies have been key factors in the success of the Zambia model. There has been high partner involvement where community/male mobilisation was high.

Communication approaches have successfully targeted messages to specific segments of the community.

Major constraints to the programme include:

- Articulating effective messages to women in cultures where a high premium is placed on having children
- Promoting VCT in a resource-constrained setting where a basic package of health is costed at US \$13, VCT alone costs US \$14, and current health spending is US \$5.

3. Conclusions and discussion of models/approaches to VCT delivery

3.1 There is no ideal model of VCT

The different models presented represented wide experience in the development of VCT services. The target populations and service users may vary considerably among VCT sites. The models described offer very different approaches to VCT delivery and providing a range of services following testing. The differences highlight the need to recognise that VCT is not a uniform intervention. VCT should be flexible and able to adapt to the needs of the population it serves. It is unlikely that one model will be suitable for all populations, nor will one model be feasible for all settings (low vs. high resources). Approaches enabling pregnant women to access VCT and PMTCT interventions will differ significantly from approaches aimed primarily at providing diagnostic and ongoing supportive counselling for people attending medical services. All the approaches described have been demonstrated to be feasible and acceptable, but many challenges exist if rapid scaling up of services is to occur.

3.2 Different approaches may be required for different populations

In low prevalence countries services for higher risk groups are an important priority. Approaches to VCT should consider targeting groups, such as young people, IDU, men having sex with men, sex workers, people in prisons and detention centres and clients at blood transfusion centres. The target populations and service users may vary considerably among VCT sites and thus the approaches and models for VCT implementation will vary reflecting the needs of the communities they serve.

In high prevalence settings the aim will be to provide VCT services that are accessible to the general public, although they may also include a focus on a specific client group.

Most VCT services recognise that targeting young people is of great importance in sub-Saharan Africa where the potential for VCT as an important intervention in HIV prevention is greatest in this group. Most VCT models described do not have services specifically designed for young people or counsellors trained to cope with the special needs of young people. An increased focus on the provision of VCT services for young people and ongoing training for counsellors in youth counselling is recommended.

3.3 Documentation of successful VCT approaches is urgently required

Documentation of experiences and lessons learned would be useful for assisting countries that are considering the introduction and expansion of VCT services, increasing coverage and range of services offered. Documentation of effectiveness will also facilitate the procurement of funds for the expansion of these services. This is particularly important in high prevalence countries where access to the general public is recommended.

4. Specific common issues

4.1 Counsellors

In many countries counselling has not been recognised as being a specialised area of expertise. Training needs for supervisors, minimum counselling standards and counsellor roles and job descriptions are largely undefined, and the curriculum for counsellors is not uniform.

Counselling supervision consist of three major aspects:

- Clinical casework monitoring
- Supervision of administration of VCT facilities including monitoring and evaluation, quality assurance
- Caring for counsellors' psychosocial needs, including their own worries about HIV infection for themselves and their families.

Supervisors should have training and experience, and employ a broad range of strategies and models of supervision.

Counselling skills training should be standardised in countries and NAC/NACP should take a lead role in setting and implementing curriculum standards with national counselling institutions. Existing national and regional counselling associations can be strengthened to respond better to counsellors' needs for professional development and enforcement of ethical conduct.

Training

Several areas were identified where VCT counsellors need further training:

- Counsellors need ongoing training in skills to better assist clients with issues of disclosure, risk reduction and avoiding violence. Counselling discordant couples poses particular difficulties for many counsellors.
- Coping with the burden of managing complex behavioural issues such as prolonged depression, marital conflict and drug and alcohol problems.
- Counselling for young people and communication skills for counselling young people, children and families.

Increasing capacity for counselling

- Expanding the pool of potential counsellors beyond those who already have a formal counselling and/or health background, by identifying and training other selected members of the community.
- Include HIV counselling training into the ordinary curriculum of health workers and social workers to develop a much bigger pool of trained counsellors.

Burn-out and stress management

- Burnout has been identified as an important factor in high counsellor turnover and loss. There is a need to provide programs that support and nurture counsellors. For example,

TASO and New Start are developing a special intervention to assist counsellors in acquiring the skills needed to help themselves prevent burnout.

4.2 Counselling

Legal issues

- Legal and other implications of training practitioners without a formal counselling/medical background, or “lay” counsellors to provide VCT services.

Quality of counselling

- Managing counsellor-client ratio so as not to compromise quality (many VCT services report that counsellors cannot generally see more than 7-10 clients per day, if they are to provide high quality counselling).
- Active promotion of couple counselling is necessary for promoting disclosure and behaviour change.
- Extending/expanding counselling to support and inform those that are affected including carers, families and partners.
- Counselling to facilitate disclosure to partners and other family members.

Confidentiality/issuing of results

- Lack of sharing of results (with other health service providers may prevent access to prevention and care interventions. Some programmes such as PMTCT share results with medical personnel to help provide care as needed. However, where stigma is high, lack of confidentiality (i.e. referral to other health services) may be a deterrent to those who desire anonymity.

Most VCT services report that provision of written results to clients currently appears to be potentially more harmful than beneficial.

Disclosure

- Sharing HIV status with sexual partner/s is important for HIV prevention, particularly in the longer-term. However, in many studies disclosure rates are low and women fear abandonment or abuse if they are found to be seropositive. More research is needed on effective violence prevention strategies for partner disclosure as well as strategies for increased skills for better communication and mutual support.

Rapid Tests

- New simple rapid HIV tests mean that personnel who are not laboratory technicians will be able to effectively conduct HIV testing in many sites.
- With rapid testing clients are likely to be seen only once by a counsellor, limiting the opportunity for extended interaction and subsequently increasing the need for referral services.

Quality Assurance

- Mechanisms for analysing and providing accurate feed back to VCT sites and counsellors from a wide variety of monitoring and evaluation techniques should be considered (for example client exit interviews, counsellor interviews, observations of counselling sessions, mystery clients etc).
- An external quality assurance system should be developed to ensure that quality of HIV testing is maintained.

4.3 Uptake of VCT

Uptake of VCT varies considerably between sites, countries and populations. Increasing uptake requires addressing attitudes towards HIV and VCT in the community and promoting its benefits. Promoting acceptance of and discouraging discrimination against PLHA, and normalisation of the epidemic in general are essential if VCT is to be an acceptable service. Strategies should target and engage the community in the design and development of VCT services, improve the quality, variety and accessibility of VCT services (including developing access in rural settings), and sensitise staff to project more positive attitudes in promoting VCT and supporting PLHA. The development of support services for those who test positive is also important and the possibility of referrals to other organisations for follow-up, treatment, care and support services (including TB, STI treatment and provision of other drugs) increases uptake of VCT.

Communication

Innovative communications strategies have also been shown to greatly increase demand at New Start in Zimbabwe and Macro in Malawi.

Communication strategies could include:

- Developing positive prevention messages emphasising that the majority of people, including those in sub-Saharan Africa, are not infected.
- Targeting women, but without increasing stigma and blame, given the great variance in prevalence between men and women.
- Providing communication strategies, which target youth, marginalized groups and vulnerable populations, where appropriate.
- Emphasising the beneficial interventions and support services including financial assistance available for those who test seropositive.

Goals and targets

There are no clear guidelines for defining goals and targets for scaling up VCT services. In some areas these goals are more apparent. For PMTCT programmes the goal is to provide 100 percent counselling to pregnant women. For other VCT services, it is more difficult to define success or shortfalls in VCT delivery. The South African Ministry of Health has developed goals for VCT coverage (number of health care institutions to offer VCT) as well as targets for the number of people who have been through VCT. USAID and FHI have established working groups that are currently developing goals and indicators for VCT and care.

5. VCT in the Context of PMTCT⁸

Regional experience

- **UNICEF pilot sites.** Currently there are 19 countries, with 79 implementing sites and 2 national programmes in the UN sponsored PMTCT programmes. Most are in sub-Saharan Africa. It is envisaged that this PMTCT programme will expand greatly over the next 5 years.
- **Brazilian National PMTCT programme.** (Maria Christina Pimenta). Brazil has maintained high adherence and ensured a minimum standard of care through substantial government commitment and funding and training of doctors, nurses and social workers, counselling and testing, including rapid tests for women who do not attend ANC, followed by treatment for both mother and child. Widespread access to ARVs has been a strength of the programme in Brazil.
- **Russia** (Julie Banks). Russia practices a policy of mandatory testing for all vulnerable groups (e.g. army, pregnant women, IDU). While the epidemic is largely concentrated among young injecting drug users, MTCT has emerged in the second wave of the epidemic. Medical professionals do not have the skills to counsel patients, and all HIV infected women are often advised to have abortions. Those who choose to carry their pregnancies to term are referred to the only institution that provides AZT, which is located in St. Petersburg, making it hard for the majority of HIV infected women to access. Infected children who are abandoned are kept together at special state orphanages until their death.
- **India** (Sundar Daniel and Dr Reddy). India has 3 research sites with well-structured VCT programs that provide AZT and NVP.
- **Cambodia** (Ly Penh Sun) With regard to the Prevention of Mother to Child transmission in Cambodia, there is one pilot site (National Center for Mother and child health) in Phnom Penh city, and they are still in the phase of training of counsellors. They will use the lab. at the Center as an integrated VTC service.

Common findings

Poor uptake of VCT in ANC settings and poor completion of ARV regimens. Many PMTCT programmes have experienced initial low rates of acceptance. Ways that could increase participation include;

- Improving ongoing care for women following VCT.
- VCT models that require clients to “opt out” if they do not want testing appear to increase uptake more than those, which require clients to “opt in” or choose to undergo testing.
- Attitudes of health care staff and counsellors are very important in the success of PMTCT interventions. Higher rates of uptake are seen where the midwives/counsellors are supportive and understand the benefits of PMTCT.

Husband/partner involvement. There is need for greater involvement of men in ANC in spite of cultural practices that may limit male involvement. The focus of VCT, particularly in

⁸ See paper on VCT for PMTCT interventions, which includes discussions of the models of VCT used in ANC settings, issues on scaling up, barriers to VCT and involvement of partners.

association with PMTCT interventions, should be expanded beyond the individual to include couples.

Funding. In order to provide acceptable interventions adequate funding must be provided. There is need for increased investment in the health sector to deliver these interventions. National health financing which currently averages US \$11 per capita in sub-Saharan Africa must be increased if VCT and PMTCT interventions are to be more widely and uniformly available.

6. VCT for young people

The definition of 'young people' in studies describing VCT services for young people ranges from ages 10-24 to 18-30 years. UNICEF definitions, for simplicity, will be used in this document⁹. Although there are very few VCT services that have been developed specifically for young people, a significant proportion of clients of general VCT sites are young people. The proportion of young people tested for HIV varies by age, country and gender. More young females have been tested than young males. This is attributable to the higher use of health care services (particularly reproductive health services and ANCs) by young women. Young people form the majority of clients tested as pre-marital couples. Young people are also more likely to be tested out of curiosity or due to peer pressure, than attend because of symptoms or to access health care services.

Relatively few **adolescents** access VCT services due to policies (such as the age of legal consent and disclosure issues), lack of awareness of services, and lack of youth friendly services. Health workers have been slow to address the specific needs of both infected and uninfected youth and training of health care workers in communicating with adolescents has been poor in most countries.

In some countries interventions for adolescents have been developed, such as youth friendly health corners in health centres, outreach programs to schools and colleges and integration of special paediatric counselling components into counsellor training curricula. However, these activities need to be expanded greatly if they are to produce a significant impact.

⁹ UNICEF definitions

Adolescent	10-19 years
Youth	10-24 years
Young person	15-24 years

Kara Counselling and Training Trust (KCTT) counselling services for young people

Stanley Chama, Manager Hope House, Kara Counselling, Lusaka, Zambia

KCTT has offered HIV counselling services since 1989 and VCT since 1992.

KCTT started with a free-standing VCT site in downtown Lusaka. This site provided the first anonymous walk-in VCT service in Zambia. This model was then replicated in a light industrial area in Lusaka.

The service at 'Hope House' was developed in consultation with the 'Positive and Living Squad' (PALS). The PALS are a group of people who were open about their HIV status. They aimed to provide HIV support for people following VCT, deliver HIV education in the community, workplaces and schools and have an advocacy role in promoting the rights of people with HIV and challenging stigma and denial. Hope House provided a wide range of support services for people living with HIV/AIDS (PLHA).

Following these first two centres, four others were opened in Lusaka – all sharing common principles but with different services and serving different populations. Some are located within health centres and have close links with medical interventions, such as TB screening and treatment and provision of TB preventive therapy and STI screening and treatment. One centre has developed family counselling, responding to the needs of families caring for symptomatic family members. A further centre has been established in Choma, in the Southern Province of Zambia – providing VCT and support services to the local rural community.

Key elements of the youth service

- Youth are actively involved in designing programs and also engaged as peer counsellors.
- Outreach activities to schools and youth groups promote VCT and counselling services and discuss the benefits of VCT for young people.
- Monitoring and evaluation of the service has been key in the development of the services.
- Difficulties in ensuring adequate and long-term funding have been major constraints to scaling up.

Special issues in providing VCT and counselling services for young people.

- **Rape and sexual abuse.** Young people are often particularly vulnerable to rape, especially from people close to their families. However young people are often reluctant to report rape or sexual abuse or to seek counselling and VCT following sexual assault. Very few services have been developed to help young people who have been raped or abused. In Uganda the NGO 'Hope after Rape' provides support to young people. Development of this type of service is a high priority.
- **Counselling for children and young people affected by HIV.** Most HIV counselling focuses on disclosure to partners, rather than disclosure by parents to their children. Children are often traumatised when they learn about their parents' or their own HIV positive status. Providers need training to develop skills in working with young people and children in particular. The 'Memory Book' project in Uganda, which worked with families to chronicle events for children, empowered women to disclose their HIV status to their families.
- **Legal issues.** Some adolescents are unable to access VCT because they fall below the legal age of consent for medical services, requiring parental/guardian involvement. This

can create an obstacle to health-seeking behaviour for young people who are sexually active and must be considered in the context of expanding VCT service delivery. Age of consent for medical interventions (including VCT) varies between countries. In Uganda, the legal age for sexual consent is lower than that for obtaining medical services. In Brazil adolescents over the age of 12 have the same rights to health services as adults and do not require parental consent for VCT.

- **IDU and sex work.** In India, Eastern Europe and some parts of Latin America, HIV is closely associated with IDU and sex work. Young people/adolescents are often more likely to be IDUs or exploited in the sex industry. Special communication strategies need to be developed to reach these vulnerable and often marginalised young people.

- **Who should carry out counselling for young people?**

It is important to discuss with young people their views about whom they would find most appropriate as counsellors. This may vary between settings. In a qualitative study from rural South Africa young people indicated they wanted 'young parents' who were not as old as their own parents, but not too young as to be 'childish' as counsellors. Peer counsellors were not favoured as they felt that they would not be able to trust their advice. Unlike their parents, these young people did not trust traditional healers. In a study from Uganda it was found that counselling could be effectively delivered within a cultural context, by 'traditional' counsellors such as aunts and grandparents, especially during occasions such as initiation. In Eastern Europe outreach peer counsellors (young former IDUs) were found to be effective in providing outreach education services for young drug users, but specially trained counsellors were more acceptable in providing counselling around testing.

7. VCT for vulnerable populations

VCT for people with drug and alcohol problems

Harm reduction services for IDUs are being established in Eastern Europe and Asia, but there are few examples of effective and acceptable VCT services being integrated into these settings. Disclosure of HIV status and IDU practice is mandated in many drug rehabilitation/treatment services, discouraging people from accessing care.

Alcohol misuse is common and often under-reported. Alcohol is an important risk factor for HIV infection yet is seldom emphasised in HIV counselling and alcohol use/abuse is not usually included in risk assessments for HIV. Studies have shown that risky sex is much more likely to occur in association with alcohol consumption.

Strategies for improving access and acceptability of VCT to young people with drug and alcohol problems should focus on increasing awareness of VCT counsellors on the importance of drug and alcohol issues, and drug and alcohol counsellors on HIV/VCT issues. Advocacy for increased harm reduction services and integration of drug services and VCT is important. The importance of alcohol/drug use in HIV risk behaviour in Africa and Asia should also be emphasised.

VCT for sex workers (SWs)

A sex worker is defined as an individual who exchanges sex for money/materials but also includes indirect forms of exchange that are not traditionally perceived as sex work.

In many countries sex workers lack access to VCT, are subject to stigma, discrimination, police violence and exploitation. Many SWs are young and some have additional problems of drug and alcohol use/abuse.

VCT strategies should include sensitising VCT personnel on sex work, making youth friendly services available and integrating VCT with STI and RH services. Peer educators should be identified amongst SWs and trained on promoting VCT and condom use. SWs and their clients, bar owners and the police should also be sensitised on VCT and condom use. NGOs, health providers and peers should also provide on-going support for the SWs.

Strategies to reach SWs in non-brothel settings including training counsellor to address issues around sex work sensitively and include sex work in risk assessments where appropriate.

VCT and Closed Communities

Closed communities include prisons, commercial farms, mines, refugee camps/ communities and the military.

Key issues in **prisons** are the rights of the individual and acknowledgement of same sex relationships. VCT strategies should address advocacy for provision of VCT services in prison and confidentiality for the prisoner, encouraging prisoners to accept VCT services (where confidentiality and free choice can be ensured and access to HIV care and prevention options are available) during their time in prison.

Confidentiality, role of the employer, and influences of a small community impact on VCT services in **commercial farms** and **mines**. Strategies could include advocacy to influence farm employers regarding the benefits of providing VCT and ongoing medical and preventative services, training peer educators within the community and the development of support systems within the community.

Refugees and people in **detention camps** have to contend with issues of resettlement, and repatriation, and in some cases family separation as well as physical abuse and coerced sex. Strategies for VCT in such settings should include developing working relationship/policies between HIV services organisations and UNHCR, crisis/conflict working organisations, advocacy for better practices in receiving countries, documenting experiences from refugees to lobby for change and focusing on crisis zones.

There are two categories of **military personnel**, personnel in a standing army and conscripts. There has been a recent focus on peacekeeping forces, where peacekeepers from high prevalence countries pose HIV risk in countries where stationed and peacekeepers from low-prevalence countries who are stationed in high HIV prevalence areas are placed at higher risk of acquiring HIV. It has been proposed that mandatory HIV testing could be helpful in preventing HIV infection among peacekeepers and receiving populations. However promoting VCT and providing HIV preventive services is more likely to be effective and will also prevent discrimination. Strategies could include increasing awareness among military of benefits of VCT, establishing a voucher¹⁰ system for VCT provision to ensure confidentiality and providing a mobile VCT service for army bases.

¹⁰ Voucher system is where employees are given vouchers to attend anonymous VCT center away from the workplace/military establishment.

8. Scaling up VCT services¹¹

Three examples of VCT programmes that have achieved, or aim to achieve national coverage were presented.

Thailand National HIV Counselling Programme

Prawate Tantiwatunushul, Department of Mental Health, MoH, Thailand

Key features of the Thailand VCT programme include the following:

- A government project
- Initial high turnover of counselling staff
- All hospitals have VCT services
- Community awareness and mobilization to increase uptake, especially in PMTCT programs.
- NGOs have been very supportive and provide ongoing support services.

Highlights of discussion:

- The military administers its own mandatory testing system, but is now seeking to shift emphasis to include counselling.
- Linking units that will constitute part of the service system (e.g. counselling and other support services) is a key issue. The communities have been very innovative, especially the nurses in relation to linkages between TB and HIV, and smaller hospitals have done this more easily than larger hospitals.
- Thailand has used monitoring and evaluation tools that were adopted from those developed by UNAIDS/WHO for assessing VCT services.
- The quality of counselling and the profile of the client (IDU, SW, etc.) have more of an impact on uptake of VCT than the use of rapid tests over standard tests. Rapid tests do not necessarily mean same day results for clients, especially where laboratory technicians have to deal with large volumes of specimens. The bigger issue with rapid tests is on the technical simplicity of administering the tests, not whether the clients return or not. However, the cost to the client (time and transportation) should also be considered in designing VCT services.

¹¹ For full discussion of scaling up VCT services see paper WHO/UNAIDS (2001) **Scaling up VCT services**

Zambia Voluntary Counselling and Testing Service (ZVCTS)

Francis Kasolo, Head of the Department of Virology, Lusaka, Zambia

In Zambia VCT services have been provided by NGOs since the late 1980's. However, with 19.7% of ANC attendants testing positive and estimates of 500 new HIV infections and 200-300 HIV related deaths per day, there was recognition of the need for government involvement in VCT. A one-year pilot project on the establishment of a National VCT service was initiated in 1999 to determine acceptability of VCT among the Zambians and examine feasibility of setting up same day service. Twenty-two sites were identified across the country using criteria that included availability of trained counsellors and laboratory technicians, and support of the district management team.

Among the major lessons learned from the pilot were the need for sustained community mobilisation, staff motivation, linkages between local NGOs and ZVCTS, and a clear organisational structure for the ZVCTS. Same day service was also found to be more acceptable. A consolidation phase was subsequently designed in which a national organisational framework was established for the ZVCTS and a technical working group representing various stakeholders formed on VCT and care. Its tasks were to integrate and establish joint work plans on VCT with local NGO's, ZCC, DHMT and other stakeholders, and to provide logistic support to other established VCT services. VCT services were better co-ordinated and joint training programs established for counsellors and laboratory technicians with ZCC and other stakeholder. Joint community mobilisation strategies were also initiated with local NGOs and DHMTs. VCT coverage was increased from 22 centres to 37, with approximately 100,000 clients attending ZVCTS over the first 15 months.

An expansion phase is now planned during which the number of ZVCTS centres will be increased from 37 to 60 nation-wide and a national data management system for VCT developed. Strategies will be developed to create demand for VCT in Zambia through community mobilisation and collaboration with other stakeholders, promote positive behaviour among persons tested through post test clubs (PTC), and to develop ZVCTS as a vehicle for MTCT, ARV provision and future vaccine trials. Each centre will operate as a semi-autonomous site with programmes developed within the DHMT strategy for HIV control. A technical working group will be established to provide technical support to the DHMTs through the HIV/AIDS/STD/TB council and secretariat. ZVCTS will co-ordinate VCT training, provide supplies and conduct monitoring and evaluation of VCT Services in Zambia.

Botswana National PMTCT Programme

Chewe Luo, UNICEF, Botswana

In 1999, Botswana initiated a PMTCT programme in the two major cities of Gaborone and Francistown, the first country in Africa to start a VCT/PMTCT national programme. A midterm review showed that the health services were of high standard and the program was fully integrated in Gaborone and Francistown. However, there were many shortcomings related to the quality of counselling and care provided by the health providers (nurses and midwives), with an estimated two-thirds of clients receiving insufficient counselling and sub-optimal ARV PMTCT therapy. In addition, uptake of the program was relatively low, there was lack of support for infected mothers from the community and a lack of involvement of men and family members.

A 2000 antenatal sentinel survey indicated a prevalence of 38.5%, which translated into 26 newborns infected each day. Subsequently, the PMTCT programme is being scaled up to all health facilities offering maternal and child health services by the December 2001 under an accelerated plan. Acceleration strategies include training, improving the quality of counsellor support, strengthening care and support services, and community and social mobilization. Programme management at district level will be strengthened, NVP introduced as a second drug and infant feeding practices evaluated to establish the impact on morbidity and mortality.

At the end of June the programme had been implemented in 9 out of 23 health districts. This programme enjoys political support from the president and the government. It also receives substantial government and donor funding, commitment from health care planners and relies on a well-established health infrastructure.

The three models presented demonstrate approaches from different settings with different HIV prevalence, funding and existing health infrastructure. All are VCT services integrated into existing medical services and all programmes aim to provide national coverage.

Key findings from these three examples of National VCT programmes are:

- **Ongoing monitoring and evaluation.** This has been found to be important to guide scaling up. In the Thailand VCT programme, which has been in operation for over 10 years, a recent evaluation highlights areas that need development and improvement to meet the changing needs of people attending VCT, the different therapeutic options available and the ongoing training and development needs of health and counselling staff. In Zambia and Botswana national VCT programmes have been developed rapidly and although high levels of coverage have been achieved, ongoing monitoring and evaluation has revealed problems that are being addressed as the scaling up programme continues.
- **Government commitment to VCT.** All three VCT programmes are supported by or managed within Ministry of Health structures. Although they rely to a greater or lesser extent on external donor funding all depend on strong government support.
- **Utilisation of existing health infrastructure and personnel.** All rely on government training and government supported health workers to carry out counselling and testing activities. All use existing government run health facilities.
- **Referral.** All report that ongoing support and care for people following VCT and linkages with NGOs and home based care organisations are not well developed. In the two high prevalence settings this is a serious drawback and is being addressed as scaling up continues.

VCT should be scaled up for a number of compelling reasons. VCT has been shown to be a cost-effective preventive measure, and it is central to HIV interventions such as PMTCT, access to care and IDU harm reduction. Options for scaling up range from establishing and expanding services to increase the numbers of people who have access to them, to expanding the range of services provided, to broadening geographical coverage. Scaling up is dependent on HIV prevalence, health priorities, available resources, existing services and infrastructure, and the expected role and focus of VCT.

Increasing access to VCT in the context of a generalised epidemic is a major priority. Within each country an initial needs assessment and inventory is necessary so that existing resources such as community-based organisations and private sector facilities can be utilised. VCT staff should not only be limited to counsellors but also extend to include community mobilisers and social workers to ensure ongoing support to clients. Advocacy for VCT is important and should be incorporated in the planning. Staffing and sustainability are key issues, and governments – not donors – should take development and co-ordination responsibility. A national level planning group consisting of stakeholders should be established in countries. Advocacy is also needed for increased funding, especially due to the high VCT start-up costs. UN agencies should outline the steps for the guidelines to scaling-up, at a global, regional and country level.

Scaling up should be undertaken in the context of a framework that consists of

1. A national VCT policy to guide activities
2. A strategic plan with specific objectives, targets, timeframes, approaches and mechanisms for implementation
3. An operational plan with clearly identified activities in the areas of technical support, counselling, testing, community involvement, and linkages to care and support services.

Four possible approaches to scaling up VCT services have been described and these are discussed in full in the accompanying document on scaling up:

- **Phased/planned expansion** - Following development of pilot site/s the number of sites and the number of people served by a particular VCT model is increased once this model has been refined following pilot testing.
- **Accelerated approach/explosion** - This is sudden implementation on a large scale. This type of scaling up is usually of high profile and depends on considerable political and financial commitment. This approach is the most effective way of quickly establishing a national VCT programme.
- **Association** - This involves expanding an existing programme's size and coverage through a network of organisations. This form of scaling up is often driven by local communities and involves adapting the VCT service to the local context.
- **Integrated approach/grafting** - This means adding a new VCT initiative to an already existing programme or services

Scaling up approaches will depend on whether the epidemic is generalised or concentrated, and the level of prevalence. For example, an accelerated approach may be selected under conditions of a generalised epidemic, whereas a phased or integrated approach may be more appropriate for situations with low HIV prevalence.

9. Affordability, cost effectiveness and sustainability

9.1 Unit cost

VCT remains a relatively expensive health intervention. HIV test kits alone are usually estimated at 3-5 US\$ and the costs of VCT per client tested range from 4-29 US\$ from various published and unpublished studies from developing countries. Costs from industrialised countries are usually much higher.

Cost of VCT from New start

Andrew Boner, PSI, Harare, Zimbabwe

New Start operates 9 integrated and 1 free-standing centres at an average annual total cost of US\$1.2m. The 9 sites account for 10% of this total cost, while the free-standing site accounts for 90%. Rapid testing is available at 5 out of the 10 centres, including the free-standing site which handles 55-60% of total monthly clients.

The New Start sites can be classified under 3 categories, based on clients per month:

1. Direct site (free-standing) averaging 1383 clients/month
2. Indirect (integrated) >100 clients/month (5 sites averaging 195 clients/month)
3. Indirect (integrated) <100 clients/month (4 sites averaging 35 clients/month)

Costs per client (excluding fully allocated management salaries and other consulting fees) ranges from US\$ 16 to US\$ 60. Cost recovery is at 2.4% on site costs, and 0.6% on total costs with about 75% of clients paying an average US\$0.80 fee.

The cost to the VCT client consists of the fee for service, transport to the site and time away from office, childcare, etc. New Start price policy only applies to those who can pay, and free promotions are run regularly. Transport costs are minimised because with the use of rapid tests clients have same day testing and results. The direct site is open from 8 am to 8pm, 7days/week to enable clients to attend after work to minimise their opportunity costs.

Costs of providing VCT will depend on

Start up costs - will usually be much higher in free-standing sites compared to integrated sites where infrastructure is available

Geographical location - unit costs of providing VCT to remote and smaller communities will be higher due to small client numbers and transport costs

Cost sharing/cost recovery - if clients can contribute to the costs this may reduce the unit cost needed to provide the service. In high prevalence developing countries this has not been a significant factor. In industrialised countries and in the private sector costs may be met fully by clients or covered by medical insurance. Workplace VCT allows much of the cost to be met by employees and may be a way of increasing access in some settings.

Quality of services offered - if in-depth individual counselling, ongoing counselling and support services are available this will increase the cost of the service.

Promotion and advertising - a significant proportion of VCT costs at the New Start and Macro sites is due to promotional activities and radio advertising.

9.2 Cost effectiveness

Data from a randomised controlled trial of the efficacy of VCT in Kenya and Tanzania was presented. The HIV prevalence in both groups was approximately 20%. VCT in this study was found to be feasible and cost effective compared to other health interventions in developing countries.

Cost effectiveness of VCT - data from the multi-centre trial

Michael Sweat, Assistant Professor of International Health, Johns Hopkins University School of Public Health, USA

- The cost of VCT provisions, per DALY, was \$12.77 in Kenya and \$17.78 in Tanzania.
- This compares well to:
 - \$10 - Enhanced STD Services
 - \$5.25 - \$10.51 Nevirapine for all pregnant women in high prevalence setting
 - \$12 - \$17 Childhood Measles Vaccine
 - \$30 - \$50 Management of Sick Child Program
- The World Bank recommends support of health interventions when the cost per DALY is \$50 or less.
- Provision of VCT in high prevalence settings is more cost effective as it has the potential to prevent more HIV infections. It is therefore most cost-effective to target high prevalence countries and populations or high prevalence populations with large numbers of sexual partners such as sex workers where a multiplier effect makes VCT and condom promotion highly cost-effective. The cost to avert 1 HIV infection in emergency rooms with HIV prevalence of 1% is \$60,000 in USA. In Tanzania and Kenya, \$60,000 would avert 173 and 241 HIV infections respectively.
- Lower costs per DALY saved can also be achieved by targeting more women than men, increasing the proportion of couples, and targeting higher HIV prevalence settings and populations.
- There may be significant costs to the client of receiving VCT, in terms of time, transport, lost wages and fees.

11. Meeting statement

In line with the UNGASS Declaration of Commitment in which UN member states resolved to provide VCT services as a critical component of HIV prevention, care and support services.

The meeting recognises VCT as:

- A public health and developmental priority
- A “human rights” imperative
- A cost-effective preventive measure particularly in high prevalence communities
- Central to interventions such as PMTCT, access to care and support, and IDU harm reduction
- Providing individuals with an opportunity to plan for the future and access appropriate health and support services
- Enhancing de-stigmatisation, normalisation of HIV, and empowerment of HIV-positive people in the community
- A mechanism that enhances the capacity of health systems to deliver appropriate services

We recommend the rapid scaling up of VCT within the following context;

1.) Development of a global framework for VCT service provision outlining key strategies for scaling up, including

- Clear goals and targets
- Technical, ethical and operational guidelines¹²
- Multi-sectoral linkages¹³
- Mobilisation of adequate human and capital resources
- Re-organisation of health services to better respond to the needs of VCT clients

2.) Advocacy for increased resource mobilisation for VCT

3.) Development of centres of excellence and identification of models of best practice to inform the ongoing development of VCT services

¹² Technical, ethical and operational guidelines to inform the development of a basic package of VCT service provision

- 1.) Counselling
- 2.) HIV testing policy (kit selection, testing algorithms etc.)
- 3.) Quality control
- 4.) Laboratory standards
- 5.) Monitoring and evaluation

¹³ Establishment of VCT within a context that includes linkages to support services

- 4.) **Active mobilisation and participation of community** - including PLHA groups - in planning, development, implementation and monitoring and evaluation of VCT

- 5.) **Recognition of counselling as a specialised profession** with a comprehensive package for counsellor selection, training, support, and development
 - Standardised training content including counselling protocol
 - Institutionalised support and supervision mechanisms
 - Clear career development structure
 - Certification of different cadres of counsellors

- 6.) **Creation of an enabling environment that allows individuals to seek VCT**

- 7.) **Special focus on young people and couples in all VCT interventions**