

A COMMUNITY-BASED HIV COUNSELLING AND RAPID TESTING CASE STUDY IN ANTIGUA AND BARBUDA



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FOREWORD

It is with pleasure that the Caribbean HIV&AIDS Alliance presents this report 'A Community Based HIV Counselling and Rapid Testing Case study in Antigua and Barbuda'. The study was undertaken by the International HIV/AIDS Alliance (IHAA), the Caribbean HIV&AIDS Alliance (CHAA), the University of California, San Francisco (UCSF) and IntraHealth with funding from the United States Agency for International Development (USAID) as part of the Eastern Caribbean Community Action Project (EC-CAP). The overall aim of the EC-CAP is to work with vulnerable communities to increase access to HIV and AIDS services in four countries of the Eastern Caribbean; Antigua and Barbuda, Barbados, St. Kitts and Nevis, and St. Vincent and the Grenadines.

CHAA is a regional Non-Governmental Organisation (NGO) and recently became a linking organisation of IHAA. CHAA works specifically to mobilise vulnerable communities to carry out HIV prevention and education activities, counselling and testing and promoting access to care and support with three key populations: men who have sex with men (MSM), sex workers (SW) and people living with HIV and AIDS (PLHIV). The portfolio of the CHAA consists of five main elements, as follows: (1) prevention; (2) promoting and facilitating access to health services; (3) care, support and empowerment of PLHIV; (4) peer support; and (5) acceleration of the private sector response to HIV and AIDS.

In keeping with the philosophy that partnerships are a critical part of our strategic vision, this report was developed as a joint effort of a team of researchers from CHAA, UCSF and IntraHealth with the support of the Government of Antigua and Barbuda.

The goal of this case study is to assess and document the process and implementation of the Community-Based Counselling and Rapid Testing for HIV (CBCRT) programme in Antigua for MARPs. Strategic information gathered through the Case Study will enhance the knowledge of CBCRT implementation and provide a piloted CBCRT model for providing peer-based HIV counselling and testing service to MARPs in the EC-CAP region.

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LIST OF ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
amfAR	American Foundation for AIDS Research
APPA	Antigua Planned Parenthood Association
ABHAN	Antigua and Barbuda HIV/AIDS Network
ACRTT	Advanced counselling and rapid testing training
BCC	Behavioural change communication
BSS	Behavioural surveillance survey
CAREC	Caribbean Epidemiology Centre
CBCRT	Community based counselling and rapid testing
CBO	Community based organisation
C&C	Consent and confidentiality
CDC	US Centers for Disease Control and Prevention
CHAA	Caribbean HIV&AIDS Alliance
CHRC	Caribbean Harm Reduction Coalition
CT	Counselling and testing
CTTA	Counselling and Testing Technical Advisor
CVC	Caribbean Vulnerable Communities
DGA	The Directorate of Gender Affairs
EC-CAP	Eastern Caribbean Community Action Project
HIV	Human Immunodeficiency Virus
IDU	Injecting drug users
IHAA	International HIV/AIDS Alliance
IRB	Institutional Review Board
MARPs	Most at risk populations
MSM	Men who have sex with men
MOH	Ministry of Health
NAP	National AIDS Programme
NAS	National HIV/AIDS Secretariat
NGO	Non-governmental organisation

NL	National Laboratory
OECS	Organisation of Eastern Caribbean States
PAHO	Pan American Health Organisation
PANCAP	Pan Caribbean Partnership Against HIV/AIDS
PC	Palliative care
PEHRB	Persons engaged in high risk behaviours
PEPFAR	US President's Emergency Plan For AIDS Relief
PLHIV	People living with HIV/AIDS
QA/QC	Quality assurance/Quality control
RT	Rapid testing
STD	Sexually transmitted disease
STI	Sexually transmitted infection
SU	Substance users
SW	Sex worker
S&D	Stigma and discrimination
TOT	Training of trainers
UCSF	University of California, San Francisco
UNAIDS	The Joint United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development
VCT	Voluntary counselling and testing
WHO	World Health Organisation
WAR	Women Against Rape

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EXECUTIVE SUMMARY

Background

To prevent HIV and improve coverage and quality care and support, access to high quality HIV counselling and testing (CT) for most at risk populations (MARPs) is an important priority. These populations often do not have access to health care, information on HIV prevention and HIV CT. Even when CT services are available, people who are vulnerable to HIV infection may avoid them because they do not believe they are confidential and fear stigma and discrimination and possible repercussions of an HIV positive diagnosis such as rejection, violence and loss of income.

This report describes the process of implementing an innovative programme of community-based counselling and rapid testing for HIV (CBCRT) which aimed to increase access and use by MARPs in Antigua and Barbuda. Strategic information gathered through the case study will enhance the knowledge of CBCRT implementation and guide the provision of peer-based HIV counselling and testing service to MARPs in the Eastern Caribbean region. The specific objectives of the study were:

1. To understand the scope, nature and process of the roll-out of the CBCRT programme
2. To identify barriers and facilitators encountered during implementation of the CBCRT programme
3. To assess the acceptability of the CBCRT programme from the perspective of CBCRT providers
4. To provide evidence-based recommendations for enhancing the CBCRT programme in Antigua and Barbuda and for the expansion of these services to other Eastern Caribbean countries.

The study was undertaken by the International HIV/AIDS Alliance (IHAA), the Caribbean HIV & AIDS Alliance (CHAA), IntraHealth and the University of California, San Francisco (UCSF) with funding from the United States Agency for International Development (USAID) as part of the Eastern Caribbean Community Action Project (EC-CAP).

Methods

General background information was gathered through review of secondary data sources relating to the historical development of the CBCRT programme in the Eastern Caribbean. An audit was conducted of CBCRT training materials developed by several training institutions. One of the researchers also observed the five-day Advanced Counselling and Rapid Testing Training (ACRTT) conducted by CDC with participants from Antigua and Barbuda.

The background information provided context for the design of the data collection instruments for face-to-face in-depth interviews. These interviews were conducted with eighteen participants including CBCRT stakeholders from Antigua and Barbuda, regional stakeholders, and participants in the CBCRT training sessions. Five further interviews were conducted via telephone/ Skype with four individual CBCRT trainers and one Caribbean Regional Director representing an international organisation.

Results

Study participants' profile

The twenty-three participants represented the following organisations (in alphabetical order): the Antigua and Barbuda Planned Parenthood Association (APPA), Bell Laboratory Services, CHAA, the Caribbean HIV/ AIDS Regional Training Network (CHART), the US Centers for Disease Control and Prevention (CDC), the Directorate of Gender Affairs (DGA), the Antigua and Barbuda HIV/AIDS Network (ABHAN), the Ministry of Health (MOH) through the National AIDS Secretariat (NAS), the United Nations/ Pan American Health Organisation (UN/PAHO) and Women Against Rape (WAR). Four of the twenty-three interviews were conducted with CBCRT trainers who represented the CDC, CHART, and the Caribbean Harm Reduction Coalition (CHRC).

Process of implementation of CBCRT

The CBCRT programme was implemented via the following steps (IntraHealth International, 2010):

1. Conducting background research and determining the feasibility of launching a CT programme
2. Involving key stakeholders from different areas in assessment, design, and implementation
3. Drafting an implementation strategy that detailed the criteria for selecting collaborating organisations, sites for launching the programme, and the peer outreach workers in collaboration with relevant stakeholders
4. Developing, adapting, or updating national and state guidelines on HIV CT protocols
5. Training master trainers and peer and lay outreach workers on relevant topics and skills needed for the CT program
6. Planning for acquiring an adequate supply of HIV test kits and other necessary supplies
7. Launching a small-scale pilot of HIV counselling and rapid testing services
8. Providing support services for lay and peer outreach workers
9. Employing mobile testing drives with peer outreach workers and lay community workers
10. Creating a mechanism for referring clients for other care and support services, including palliative care.

11. Developing a system for quality assurance and monitoring and evaluating the programme evaluation
12. Collaborating with local governments and organisations to build a sustainable community-based HIV counselling and rapid test programme.

In relation to step 1, a regional assessment was conducted in four Organisation of Eastern Caribbean States (OECS) countries (Barbados, St Kitts and Nevis, St Vincent and the Grenadines and Antigua and Barbuda), and a feasibility study identified institutions that had the potential to roll out the CBCRT programme. Antigua and Barbuda was recommended to pilot the CBCRT programme at the existing NAS sites, including their mobile outreach sites, in preparation for an expanded national level roll-out to that would reflect a decentralised model of CT.

In relation to step 2, government stakeholders were involved and consulted extensively prior to the programme in Antigua and Barbuda, but the National Laboratory (NL) representative was not. The initial consultations included the Minister of Health but the government in Antigua and Barbuda was reshuffled in March 2009 and the level of support was not carried through by the new political administration. At the time of the case study, only the NAS pilot and the private laboratory pilot had been implemented. Expansion has been limited by various factors, including delays in the certification of CBCRT trained rapid testers by the NL.

Training Process

Training (step 5) took place via six training workshops conducted during the period of July 2009-September 2010:

- 1) Baseline Voluntary Counselling and Testing (VCT) training by CHART and Jhpiego;
- 2) CDC Advanced MARPs HIV Counselling and Rapid Testing training by CDC;
- 3) Harm Reduction training by CHRC;
- 4) Stigma and Discrimination training by the American Foundation for AIDS Research (amFAR) and Caribbean Vulnerable Communities (CVC);
- 5) Consent and Confidentiality training provided by CHART, and
- 6) Supportive Supervision training provided by IntraHealth.

Host institutions (CHAA and the NAS) identified the training participants who were drawn from local government and non-governmental organisation (NGO) representatives, CHAA peer outreach workers from MARPs (known as community animators) and private lab technologists. At the time of the case study, HIV Rapid Testing proficiency panel assessments were still being negotiated with the NL to occur as soon as an agreement was reached.

Perceptions of the Impact of the CBCRT programme

The following positive aspects of the CBCRT programme were highlighted by participants:

Expansion of Counselling and Rapid Testing Services: Participants perceived the CBCRT programme as having increased access to HIV testing and NAS counsellors reported an increase in the number of clients from on average 5 persons to between 10 -15 clients a day at the NAS testing site. The CBCRT programme was viewed as having the potential to reach hard-to-reach communities through decentralisation and avoidance of the fears of stigma and discrimination associated with testing at conventional health centres. The provision of CT by MARPs was also seen as a strategy to avoid instances of stigma and discrimination. A community-based change of this nature was said to have the potential to lead to change in social norms so that people recognise the importance of knowing one's HIV status.

HIV rapid testing: The ability to receive same-day HIV test results was considered as enabling HIV-positive clients to access supportive services and treatment faster. Rapid testing also removed the long waiting periods for test results.

Accessible services for immigrants: Community animators stated that the CBCRT programme has made services more accessible to Spanish speaking clients whose immigration status is not regularised and who are often reluctant to attend government public health services due to fear of arrest and possible deportation.

Institutional collaborations: The CBCRT programme has enhanced collaborations, built bridges and avoided duplication between HIV prevention stakeholders (government, CHAA, civil society and MARPs). Feedback received from CBCRT stakeholders also indicates that CBCRT training has improved the quality of CT services.

Referrals: Institutional collaboration improved referrals between agencies. Some remaining gaps in the referral system were identified, such as to address alcohol and drug abuse problems.

Perceived Barriers and challenges to the CBCRT Programme

Certification of rapid testers: Delayed certification of trained rapid testers was a major barrier to expanding the CBCRT programme in Antigua and Barbuda. The programme could not move forward until CBCRT sites were accredited and testers certified. Participants felt that non-certification had hampered the CBCRT objective of expanding CT services to the community at large, and particularly to MARPs.

Financial constraints & sustainability of CBCRT programme: NGOs willing to participate in the CBCRT programme were concerned about the ability of the government to provide continued funding. Due to their limited resources, NGOs would not be able to launch CBCRT without some financial assistance. Plans for sustainability appear to have been inadequate during the initial stages of the project.

Costly elements of the programme were identified, including HIV testing reagents and other lab supplies, hiring of tents to be used as CT spaces, transport and meals for CBCRT staff at testing venues.

During the course of the interviews information emerged that the CHAA EC-CAP project was coming to an end and CHAA was already preparing to wind down its activities in the CBCRT programme, including the animator activities. The NAS has submitted a Global Fund application to support mobile testing activities in 2011 and beyond. IntraHealth and CHAA also awarded the National AIDS Programme a small grant for specific materials which will assist in the rapid testing certification of the National AIDS Programme. This certification will meet quality assurance standards established by PAHO/CDC and the National Lab by expanding the current National AIDS Programme Office Pilot rapid testing practicum programme to community and governmental organisations targeting MARPs.

Language barriers for non-English speaking service providers: In order to address the language barrier faced by non-English speaking clients, the CBCRT programme trained Spanish speaking community animators. However, this appears to be causing some tensions between English-speaking NAS counsellors and Spanish-speaking animators, with one of the Spanish speaking counsellors reporting having had her CT activities curtailed at the NAS. At the time of the interview, this issue was being discussed by the relevant programme partners.

Institutional Collaboration: One of the major challenges in the implementing the CBCRT programme has been the inability for every relevant stakeholder to maintain continued commitment and support of the programme, particularly the continued involvement of the NL. This has resulted in the stalling of the accreditation of non-clinical/ lay counsellors to conduct HIV rapid testing. CBCRT providers trained in rapid testing over a year ago were still waiting to be assessed and certified as proficient rapid testers. Non-certification of providers has stalled plans to roll out the CBCRT programme at district level. This protracted delay will result in the gradual loss of skills as people do not put into practice what they were trained to do.

Quality assurance for trainers: Some CBCRT trainers expressed concerns about the shortage of CBCRT trainers in Antigua and Barbuda and the Eastern Caribbean region at large as this would limit both the expansion and sustainability of the programme. The current shortage of qualified trainers limited the number of people who were qualified to oversee the quality assurance process. Trainers of Trainers (TOT) recently trained and certified by the CDC were said not to be receiving adequate supervision from the MOH/NAS and NL.

Quality assurance for HIV Counselling: Concerns were expressed about the effectiveness of dual supervision of community animators by both the NAS and CHAA. There were reports of conflicting supervision styles and claims that NAS senior counsellors were “pulling rank” with the community animators.

Some shortcomings in the overall supervision and monitoring of CBCRT staff were also identified. NAS currently has oversight of the QA process for both counselling and rapid testing but due to current staff shortages, they were experiencing some challenges in fulfilling this responsibility. We were however informed that a QA plan developed for use by the NAS would be implemented when a NAS deputy director is hired to oversee QA for both CT and rapid testing (RT). This will include an Observation Checklist to be used to evaluate counsellors.

Psychosocial Support for counsellors and testers: Even though the psychosocial needs of peer-based peer outreach workers were being addressed by CHAA, a support system was not yet standard practice for all CBCRT counsellors and testers. CHAA engaged a therapist to provide clinical support to peer-outreach workers and help them deal with burn-out and other stressors associated with their work.

Recommendations

Getting Buy-in from stakeholders: While initial consultations were extensive, the lack of involvement of the NL at an early stage along with the change in the level of support from the Minister of Health's office may have prevented a full roll out of the programme. **All stakeholders should have an appreciation of the importance of decentralising skills and services into the community. This may mean repeating processes of consultation when new stakeholders are appointed.**

Identifying adequate funding for the programme: **The government should show long term financial commitment to the sustainability of the CBCRT programme.** It is not cost-effective to spend money training providers and then not to launch the programme as planned. Uncertainty with future funding can de-motivate programme implementers and cause anxiety among the service providers, which might in turn affect their performance.

Quality assurance at all levels: Programme planners should assess and plan for adequate supervision and monitoring of the CBCRT activities. **Monitoring systems for quality assurance should be in place for both counselling and rapid testing, including a systematic documentation of the quality assurance process.**

Provision of psychosocial support for service providers: Service providers working in the area of HIV can burn-out from the stress of working in this field. **A good support system to help providers deal with these stressors should be put in place at all CBCRT sites.** This psychosocial support can be provided either by a therapist who can be a clinical psychologist or an experienced senior counsellor. It is important for staff to have regular individual or group debriefing sessions.

1. INTRODUCTION

To prevent HIV and improve coverage and quality care and support, access to high quality HIV counselling and testing for most at risk populations (MARPs) is an important priority. The goal of the case study presented in this report is to assess and document the process and implementation of the community-based counselling and rapid testing for HIV (CBCRT) programme in Antigua and Barbuda for most at risk populations (MARPs). The study was conducted as a collaboration between the International HIV/ AIDS Alliance, Caribbean HIV and AIDS Alliance (CHAA), the University of California, San Francisco (UCSF) and IntraHealth with support from the United States Agency for International Development (USAID).

The Caribbean has the second highest regional HIV prevalence, after sub-Saharan Africa. In 2009 the Caribbean region had a total of 240,000 people living with HIV (PLHIV), with national HIV prevalence rates ranging widely from 0.1% in Cuba to 3% in the Bahamas around a regional average of 1% (UNAIDS, 2010).

The burden of HIV among MARPs in the Caribbean is considerable. No seroprevalence studies among MARPs have been conducted in the Eastern Caribbean, though some are in advanced stages of planning. Data from surveys in other Caribbean countries show high vulnerability. Recent surveys with MSM in Trinidad and Tobago and Jamaica found HIV prevalence rates of 20% and 32% respectively, and with SWs in Guyana and Jamaica rates of 27% and 9% respectively were found (UNAIDS, 2010).

In the Eastern Caribbean, higher HIV prevalence among males appears to suggest concentration of the epidemic among MSM along with other high-risk sexual activities by some men. In Barbados, 25% of men diagnosed with HIV who completed HIV surveillance forms reported that they had sex with men or with both men and women. A further 22% did not report the sex of their partners (Barbados Ministry of Health, 2010). This echoes epidemiological findings across the Caribbean, where there appears to be substantial underreporting of MSM activity and homosexual preference (De Groulard, Sealy, Russell-Brown, Wagner, O'Neil, & Camara, 2000). Research in Eastern Caribbean countries among MSM has shown that there are important class and other social divisions between MSM, with differing levels of openness about sexual orientation and practices (Murray, 2009; Russell-Brown & Sealy, 1998). These findings were echoed in the EC-CAP I study to assess the feasibility of an evidence-based intervention (EBI) for gay men in Barbados (Caribbean HIV&AIDS Alliance & University of California San Francisco, 2010). That study noted the difficulty in outreach to middle-class MSM, who appear particularly reluctant to participate in activities that might publicly identify them as homosexual. Innovative strategies may be necessary to reach “hidden” populations of MSM.

SWs are similarly affected by considerable marginalisation and discrimination that necessitate the use of innovative strategies to reach them. Violence against sex workers is associated with

their social marginalisation and the illegality of their activities, both of which lead perpetrators of violence to believe they can act with impunity. In the Caribbean context, violence against sex workers has been perpetrated not only by clients and partners but by some law enforcement officials and SW business operators (Kempadoo, 2010). The risks associated with SW are particularly high among the many economic migrants in the Caribbean, many of whom have limited access to sexual and reproductive health care services available to nationals of their destination countries (Borland, 2004).

Country Profile

The first case of HIV in Antigua and Barbuda was recorded in 1985 and by 2009, a total of 815 people were living with HIV. The main mode of transmission is heterosexual contact, with the highest numbers in the 15-49 years age group who are the most economically active and reproductive age group. AIDS is the eighth leading cause of death in the country and the epidemic is concentrated in the 15-49 years age group with an infection ratio of 1.1 male for every female. However, in the 15-34 year age group, more women than men are HIV infected. The following factors have been noted as driving the epidemic in Antigua and Barbuda, 1) the movement of people due to immigration and migration, 2) sex tourism, 3) commercial sex work, 4) unprotected sex, 5) gender inequality, and 6) transactional sex (Ministry of Health Antigua and Barbuda, 2010).

MARPS in Antigua & Barbuda

Seroprevalence studies in Antigua and Barbuda have not been conducted with MARPs, though the vulnerability of MARPs is suggested by evidence from elsewhere in the Caribbean (see above). A Behavioural and HIV Seroprevalence Survey (BSS) piloted by the Ministry of Health (MOH) among MSM and SWs was considered not very informative as it proved impossible to identify adequate numbers of participants (Ministry of Health Antigua and Barbuda, 2008). Reasons given for this included lack of networking within these groups, fear of stigma and discrimination and concern with being identified as associated with illegal activities.

Deterrents for those seeking to take an HIV test include real and perceived stigma and discrimination from health care professionals at government services, and fear around lack of confidentiality (Abell, Rutledge, McCann, & Padmore, 2007; Aggleton, Parker, & Maluwa, 2003; Rutledge, Abell, Padmore, & McCann, 2009). In smaller Caribbean islands HIV-related stigma is attached to specific sites and clients are reluctant to access services at these locations for fear of being labelled HIV positive (Abell et al., 2007; Rutledge et al., 2009). Further specific barriers exist for each key population. For instance, migrant sex workers experience language barriers when accessing services and fear being reported to immigration authorities if they test HIV positive (International HIV/AIDS Alliance, 2009). Gender also influences uptake of HIV testing, with almost double the number of women testing over men in islands such as Antigua.

Practical barriers also exist, for example, few testing sites in the smaller Eastern Caribbean islands offer out-of-hours testing.

The Eastern Caribbean Community Action Project (EC-CAP)

The EC-CAP was established to enhance the response to the Caribbean HIV/AIDS epidemic by increasing the use of strategic information to promote sustainable, evidence-based HIV/AIDS community services and to increase access to HIV/AIDS community services. It is a continuation of the 2006 IHAA innovative programme to increase access to HIV prevention services in the Eastern Caribbean and was implemented as a collaboration between the Caribbean HIV&AIDS Alliance (CHAA), in partnership with IntraHealth International and the University of California, San Francisco (UCSF). The three year project (2007-2010) funded by the USAID focuses on four Eastern Caribbean countries (Antigua and Barbuda, Barbados, St. Kitts and Nevis and St. Vincent and the Grenadines). EC-CAP work is co-ordinated with many international and regional partners who are also members of the Pan Caribbean Partnership against HIV/ AIDS.

The premise of EC-CAP is that significant access to HIV services for MARPS can be achieved through evidence-based programming, community and civil society involvement, stronger engagement with national programmes and enhanced behaviour change interventions. EC-CAP has helped expand the scale and diversify the HIV prevention services offered in the EC region, including making HIV testing accessible. In Antigua and Barbuda, there was some on-going HIV prevention activities towards MARPs that EC-CAP sought to strengthen and build upon. For instance, the well established peer outreach workers programme implemented by the CHAA in Antigua provides HIV outreach and education to MARPs as well as delivering behaviour change communication interventions and referral to care and support services. A key EC-CAP mandate was to implement a community-based counselling and rapid testing (CBCRT) programme in at least one island.

Advantages of CBCRT

UNAIDS considers HIV testing a critical element in the HIV response, an element that can facilitate HIV treatment and care (The Voluntary HIV-1 Counselling and Testing Efficacy Study Group, 2000). Making CBCRT widely accessible by decentralising services has the potential to increase HIV social awareness and help reduce stigma and discrimination in communities (Sanjana, Torpey, Schwarzwald, Simumba, Kasonde, Nyirenda et al., 2009). CT can be made more accessible through the provision of mobile services which have the potential to normalise HIV testing and in turn reduce stigma associated with the testing process. Best practice shows that decentralised, HIV community-based counselling and testing increases the numbers of people getting tested and gives people the knowledge to manage their health and sexual and reproductive lives (Khumalo-Sakutukwa, Morin, Fritz, Charlebois, Van Rooyen, Chingono et al., 2008).

Utilising frontline workers such as community based peer counsellors who have established good relationships with community groups is key to increasing HIV testing among marginalised populations (Morisky, Malow, Tigalo, Lyu, Vissman, & Rhodes, 2004). Community based peer counsellors make client-centred, sensitive HIV counselling and testing (CT) more accessible to these populations (Murrill, Liu, Guilin, Rivera-Colon, Dean, Buckley et al., 2008). HIV Rapid testing which provides same day test results promotes uptake of testing by reducing delays resulting from laboratory-based testing (Duke, Samiel, Musa, Ali, Chang-Kit, & Warner, 2010; Guenter, Greer, Robinson, Roberts, & Browne, 2008; The Voluntary HIV-1 Counselling and Testing Efficacy Study Group, 2000). Decentralised peer based CBCRT (including mobile CT) also supports government services by freeing up health care professional to focus their expertise on clinical care and support (Plate, 2007).

For several Eastern Caribbean countries, with the exception of Antigua, VCT is now part of the national response strategy and regarded as an entry point to prevention and case finding for treatment. The Caribbean Regional Strategic Framework 2008-2012 of the Pan Caribbean Partnership Against HIV/ AIDS (PANCAP) commits Caribbean nations to universal access goals and to increasing access and utilisation of HIV testing services. It specifically recommends decentralised models to increase uptake of treatment, care and support (Pan Caribbean Partnership Against HIV/ AIDS, 2008).

The US Government's Caribbean Regional HIV and AIDS Partnership Framework 2010-2014 also lists this strategic objective: „Increase access to and use of targeted HIV prevention information and services by MARPs and PEHRBs (Persons Engaged in High Risk Behaviours) through expanding HIV testing and counselling and STI treatment services, using a wider array of community-based workers and facilities'. According to the Partnership Framework, Caribbean national governments are prepared to support policy changes to „expand existing national policies on counselling and testing to allow for the accreditation of non-medical personnel and the use of non-traditional sites for rapid HIV testing' (Government of the United States of America/PEPFAR, 2010). CHAA and IntraHealth International support these aims and maintain that decentralised HIV Community-Based Counselling and Testing, when coupled with a Peer-Based Model, can be highly effective for reaching key populations.

Although Eastern Caribbean countries are implementing different models of CT services which are provided by professional and clinically trained counsellors and testers, none of the countries have extended HIV testing to lay, non-medical providers. Demand for HIV testing also remains low in these countries. Data from the NAS in Antigua shows that in 2009 only 3.54% of the population aged between 15-49 years received an HIV test (Ministry of Health Antigua and Barbuda, 2010). Research has shown that uptake of CT can be increased by providing community based CT services designed to remove structural barriers to testing (fees, inconvenience, and waiting time for test results). In fact, a study in sub-Saharan Africa and Thailand providing community based VCT showed a 4-fold increase in HIV testing rates during

the first year of the study. The study also indicated the feasibility and acceptance of a CBCRT model with increased confidentiality and high quality of CT services (Khumalo-Sakutukwa et al., 2008).

2. BACKGROUND

A regional needs assessment looking at the feasibility of rapid testing and other HIV prevention services was conducted in Barbados, St Kitts and Nevis, St Vincent and the Grenadines and Antigua and Barbuda recommended conducting a pilot of the CBCRT services in one of the four countries (Cohen, Dowling, Facente, & Hardy, 2007).

In 2008, based on country-level conversations and analyses, EC-CAP determined that each country was at a different level of capacity in terms of being able to provide CT and implement the CBCRT model that was being proposed. This determination was made after a technical analysis and review was conducted for various areas including what was then known as community counselling and testing (CCT), rapid testing (RT) and palliative care (PC), existing guidelines, curriculum and trainings. In 2009, a review to assess the readiness of each of the four countries to implement the CBCRT programme was also conducted by analysing country reports and existing CT guidelines; meeting with the Pan American Health Organisation/Caribbean Epidemiology Centre (PAHO/CAREC) and other stakeholders; and making in-country visits to assess National AIDS Programmes and other stakeholders in Antigua, Barbados, Guyana and St Vincent and the Grenadines. Guyana, a country outside the Eastern Caribbean, was included in this assessment because it had introduced HIV rapid testing in 2003 and was also beginning to implement CBCRT using lay outreach workers and mobile testing to support decentralisation of CT in order to reach high risk groups.

In 2008 a study tour by the Counselling and Testing Technical Advisor (CTTA) revealed that Guyana, Jamaica, and Trinidad and Tobago had started to incorporate RT in their Voluntary Counselling and Testing (VCT) programmes. Only one country in the Eastern Caribbean, St. Vincent and the Grenadines, had rolled out RT in clinical settings. Guyana was selected as a best practice for CBCRT. The Guyana country assessment suggested that rolling out CBCRT is both feasible and acceptable to clients and contributes to community normalisation of HIV due to availability of widespread testing in a range of different sites and models (e.g. integrated, quasi-integrated, and mobile) and of same day results. Preliminary data in Guyana suggested that widespread availability and acceptability of VCT and RT is contributing to a decrease in national HIV prevalence (Pettrak, 2008).

Further discussions to introduce the CBCRT programme, a relatively new concept in the Caribbean, revealed that among the four EC-CAP countries, only one (St. Vincent and the Grenadines) had completed the nationally and regionally recognised protocols and the Caribbean Epidemiologic Centre (CAREC) certification requirements for offering rapid testing. A CTTA was appointed to assess the CT structures and services in each of the four countries. The CTTA would also assess the readiness of each country to introduce a CBCRT programme which would provide an opportunity for better counselling and testing services for MARPs, and to collect much needed data on the number of MARPS accessing CBCRT services.

EC-CAP partners subsequently developed a CBCRT model which uses peer-based and lay health workers to reach people at high-risk of HIV infection with community-based HIV counselling and rapid testing and, when needed, referral for other services. The CBCRT model was designed under the premise that peer outreach workers (called “animators” in the EC-CAP) had the capacity to bring CT services to the people. Peer outreach workers who work with MARPs together with community-based groups could reach out to marginalised groups to enable them to access HIV prevention services. Further, this CBCRT model built upon the HIV/AIDS outreach and Behavioural Change Communication (BCC) training peer outreach workers have received, and was in line with the overall EC-CAP goal to strengthen BCC, CBCRT and PC services to form a more holistic approach to providing services for MARPs.

2.1 The CBCRT programme in Antigua

Antigua and Barbuda and St Kitts and Nevis were selected as the first countries with a potential to roll-out the CBCRT programme. They had in place strong VCT structures and services which EC-CAP could build upon. EC-CAP selected Antigua and Barbuda to pilot the first round of the CBCRT programme, based on high interest and willingness to collaborate shown by local government agencies such as the MOH and the NAS.

At that stage, it was noted that different models of CT services (VCT, provider-initiated testing (PIT) and non-medical providers testing) were being offered in the country. PIT refers to HIV testing and counselling which is recommended by health care providers to persons attending health care facilities as a standard component of medical care. Non-medical provider testing refers to peer and lay outreach workers who provide CT.

VCT services were available at all community health centres as well as private medical offices and hospitals. The government was also providing free HIV testing for all pregnant women and their partners, and Anti-Retroviral Treatment (ART) was available at no cost at the hospital for PLHIV.

Prior to the initiation of the CBCRT programmes, meetings were held between the MOH (including the Chief Medical Officer and Deputy Chief Medical Officer), the NAS, CHAA, IntraHealth, the US Centers for Disease Control and Prevention (CDC), local NGOs and CHAA peer outreach workers. CDC brought global expertise in rapid testing while CHAA brought

expertise in meaningful involvement of communities and MARPs in the HIV response. The country's MOH and the NAS reached agreements with EC-CAP, signalled in a letter of approval from the Minister of Health, to develop a CBCRT programme strategy to increase access to HIV testing, treatment and care services to MARPs. The MOH and NAS would work together with stakeholders including CHAA, IntraHealth and the CDC to provide counselling and rapid testing training to MOH, NGO providers, private laboratory providers, and clinicians in private testing facilities.

The plans for the CBCRT programme included:

- **Training peer outreach workers from the most-at-risk populations as well as lay outreach workers from other organisations** as community health workers and counsellors to talk to their peers and/or people at high risk of infection about the risks of HIV infection, the availability of HIV counselling, testing, and the availability of treatment and care.
- **Training employees at private laboratories and key local organisations** to provide counselling as an essential, linked component with the rapid HIV tests that may already be available.
- **Employing a community-based approach** that involves community members as full partners and incorporate their feedback from the design phases of the programme through the programme implementation.
- **Creating a decentralised approach to providing HIV counselling and testing**, which reaches more people including those at high-risk of infection by training and employing lay and community health workers not previously engaged in this work and launching mobile testing units in urban and rural settings.
- **Connecting peer and lay outreach workers with other services and support structures**, by ensuring bi-directional referral systems between them and existing preventive and clinical services, including those available at government clinics.

Various training curricula were reviewed, including the CHART voluntary counselling and testing (VCT) training curriculum primarily used in the Caribbean (Sebikali, Rabathaly, & Guilin, 2009) and Protocols for Project Accept conducted in Africa and Thailand (University California San Francisco). The CDC also shared its training curriculum which includes enhanced post-test counselling skills focusing on behaviour change communication and motivational interviewing. A rapid testing best practice site visit was also conducted in Guyana.

With the assistance of the CDC, a CBCRT training model was developed that merged a counselling and a rapid testing curriculum to enable providers to address both aspects of the

CBCRT programme (Guilin, 2010). The CDC representatives were invited by CHAA and IntraHealth to pilot this training in Antigua. After the CBCRT training, CBCRT services were rolled out in the communities.

2.2 IntraHealth assessment of CBCRT

As one of the key stakeholders to the CBCRT programme, IntraHealth collected some preliminary data to document the CBCRT model in Antigua in September 14-18, 2009, two months after the CBCRT training and the small scale launch of the programme. CBCRT services were being provided by the NAS, including mobile HIV testing activities. The data collection documented the CBCRT model as well as assessing how the programme was being implemented. The report highlighted some favourable factors, such as, the MOH exhibiting commitment to the programme and NAS taking leadership of it. The report also indicated that positive collaborations between MOH, CHAA and other regional and international organisations enhanced the implementation process. Some obstacles were also noted. For instance, there was limited funding for the roll-out of the mobile outreach component of CBCRT and due to staff shortages in the MOH/NAP, there was lack of capacity to sustain such a comprehensive programme (Sebikali et al., 2009). The CBCRT case study is designed to build on the IntraHealth assessment and provide more information related to the planning and implementation of the CBCRT programme.

2.3 Description of CBCRT Trainings

The CBCRT training programme was composed of six major training protocols. Training using the first five of the following protocols was implemented during the period of July 2009-September 2010:

- 1) Baseline Voluntary Counselling and Testing (VCT) training by the Caribbean HIV/ AIDS Regional Training Network (CHART) and Jhpiego;
- 2) CDC Advanced MARPs HIV Counselling and Rapid Testing;
- 3) Harm Reduction;
- 4) Stigma and Discrimination;
- 5) Consent and Confidentiality, and
- 6) Supportive Supervision.

The trainers were regarded as regional and international experts in the training protocols that they provided. At the time of the case study the training in Supportive Supervision had not yet been carried out. The training was attended by peer and lay outreach workers from CHAA,

representatives from the National AIDS Programme, Gender Affairs Office, NGOs, and faith-based organisations. Additional details on the number of trainees and the organisations they represent are outlined in the sections below which describe each training curriculum. It should be noted that although the majority of participants attended all the CBCRT trainings that were offered, participants from the laboratories did not attend the rapid testing training because they were already certified HIV testers.

2.3.1 CHART/Jhpiego VCT Baseline 5-Day Training

This training was offered to the NAS counsellors and peer outreach workers prior to the CDC Advanced MARPs HIV Counselling and Rapid Testing Training. The training was modified from its original content to specifically address MARPs and requires a medium level of literacy (being able to read and write). Participants are required to complete a specified number of days of training and attain an 80% pass rate for certification. If a participant failed to meet the minimum requirements for certification, they were given a second chance to complete the training and re-write the exams. Jhpiego VCT training includes modules on stigma and discrimination and on consent and confidentiality.



This was the first time in Antigua and Barbuda that peer-based outreach workers had been trained in counselling and testing and the first time Spanish speakers had been trained on-island. Another pioneering step was the certification of representatives from community-based organisations, including HHHN. A laboratory technician was also certified, setting a new precedent and path for integrating counselling into tests performed at private labs, thereby ensuring that CT is also a prevention intervention, which helps clients assess their risks and reduce these in their future behaviours.

2.3.2 CDC Advanced MARPs HIV Counselling and Rapid Testing Training

This four-and-a-half day counselling and rapid testing training was developed and facilitated by the CDC in partnership with CHAA and IntraHealth. A total of 16 participants included peer and lay outreach workers from CHAA, representatives from the National AIDS Programme, Gender Affairs Office, NGOs, and faith-based organisations. For the first time in Antigua and Barbuda, lay peer outreach workers- were trained not only to conduct HIV counselling and testing but also rapid testing. The counselling training has 3 modules addressing the different MARPs - MSM,

SWs and intravenous drug users (IDUs) and includes components of stigma and discrimination and consent and confidentiality. The modules also address service providers' personal feelings and beliefs towards MARPS; how they may impact on the providers' interaction with the clients.

The objective of the training is to provide advanced HIV counselling training and HIV- rapid testing training to non-clinicians. The training is also meant to sensitise counsellors and testers on working with MARPs, in particular around issues of stigma and discrimination and the importance of consent and confidentiality in order to create a safe forum for the clients. The risk reduction assessment adopted during counselling is based on the „client-centred' counselling model which focuses on assessing client's attitude and readiness to change certain behaviours and setting goals to behaviour change. The client-centred counselling model builds on the basic counselling protocol that simply gives information on transmission and prevention modes of HIV infection. The counselling training was conducted simultaneously with CDC's rapid testing training. The training covered quality assurance for HIV rapid testing, proficiency testing, how to handle dried tube specimens and a new EQA method introduced for the first time in the OECS. CHAA's Antigua and Barbuda and Barbados programme officers attended the training, both providing supervision for the lab component of the rapid testing training, while the Barbados programme officer also delivered modules of the classroom training, namely ethics in rapid testing for HIV

This MARPS HIV counselling and rapid testing training model is still being piloted in Africa, South-East Asia and the Caribbean (Antigua was part of the piloting process). It is a collaborative effort between PEPFAR and the WHO.

2.3.3 Harm reduction training

This was a two-day training developed and delivered by an expert from the Caribbean Harm Reduction Coalition (CHRC) who has fifteen years experience working with drug use and HIV risk. The harm reduction curriculum was designed to improve counselors' understanding of drug use, the causal relationship between illicit drug use and blood-borne infections, including such as HIV and Hepatitis B and C, patterns of drug use in the Caribbean, principles and practices of harm reduction and their application in the Caribbean as well as the social and policy context of harm reduction in the Caribbean. A total of 19 people participated who included government representatives, staff from faith-based organisations and other NGOs and FBOs, as well as already trained counselors. The training grounded participants in some of the challenges of working with the most-at-risk populations and offered them practical approaches to counselling clients who struggle with substance abuse.

As such, the harm reduction training content was evidence-based with a dual focus of promoting HIV testing to drug users (DU) and equipping counsellors and testers with skills to work with this group of MARPs.

2.3.4 Stigma and discrimination training in collaboration with the American Foundation for AIDS Research (amfAR) and Caribbean Vulnerable Communities (CVC)

In September 2009 CHAA/IntraHealth partnered with amfAR and CVC to conduct stigma and discrimination training. The curriculum was shared by amfAR who brought global expertise in HIV and AIDS and working with vulnerable communities. The two-day training is designed to deepen community counsellors understanding of stigma and discrimination associated with MARPs, explore professional and personal attitudes and values related to MARPs issues, build skills effectively to provide comprehensive services for MARPs and develop action plans for more MARPs-friendly CT services. Eighteen members of CBCRT programme participated in the training and were able to identify both personal and professional action plans for reducing stigma and discrimination.

2.3.5 Consent and Confidentiality Training

CHART provided the consent and confidentiality training as a follow up to the five-day Basic VCT training. Twenty (20) participants attended the CHART C&C training programme. Confidentiality training is important particularly in working with communities in the small Caribbean islands where breach of confidentiality in the context of HIV testing is reported to have occurred in the past, with some of the incidents reported in the local newspapers (Antigua Observer.com March 10, 2010).

2.3.6 IntraHealth Supportive Supervision Training

This training is part of the CBCRT training package that was conducted in 13th-15th September 2010 after the case study interviews had taken place. Ten (10) CBCRT participants attended the training and were drawn from HIV counsellors and testers from a range of community and government organisations. The purpose of the training is to build supervisors' knowledge, skills and attitudes to enable them to apply a supportive approach to supervision and coaching in order to improve the performance of CBCRT staff and the quality of CBCRT services in terms of M&E. Participants utilised CT and RT Observation and Evaluations Check List Forms developed to monitor CBCRT participants and staff as part of an overall quality assurance (QA) programme.

3. METHODS

3.1 Study Design

This study used secondary data sources and qualitative in-depth individual interviews as well as observation of the *Advanced Counselling and Rapid Testing Training* (ACRTT). Qualitative methods were adopted to gain the perspectives of the research participants to the planning and implementation processes of the CBCRT programme. This method of inquiry also elicited participants' experiences of the CBCRT training process.

Two investigators from UCSF and CHAA with backgrounds in social sciences conducted the interviews. The investigators adopted a rapid appraisal approach using multiple methods of inquiry to gain a holistic perspective of the CBCRT programme. Both investigators attended all interviews, this approach being recommended because it provides different perspectives to enhance understanding of a particular situation in a short time (Beebe, 1995).

3.2 Study Aim

The aim of the case study is to gather strategic information that will highlight the process of planning and implementing a peer-based CBCRT programme for MARPS in the Eastern Caribbean region.

3.3 Specific Study Objectives

1. To understand the scope, nature and process of the roll-out of the CBCRT programme
2. To understand pre-implementation issues and needs of the CBCRT trainees and other stakeholders
3. To identify barriers and facilitators encountered during implementation of the CBCRT programme
4. To assess the acceptability of the CBCRT programme from the perspective of CBCRT providers
5. To provide evidence-based recommendations for enhancing the CBCRT programme in Antigua and Barbuda and for the expansion of these services to other Eastern Caribbean countries.

3.4 Data Collection

Data for this study was collected in two phases. Phase 1 involved the review of secondary data sources available on CT programmes in the Caribbean in general and on plans for the CBCRT programme in Antigua. This process began in 2008 when the case study was in its planning

phase up to the time fieldwork began in August 2010. Phase 1 also included an observation of a „*Advanced Counselling and Rapid Testing Training*’ (ACRTT) in July 2009. Phase 2 of data collection involved conducting qualitative in-depth interviews with CBCRT stakeholders and service providers between August 28th and September 3rd, 2010.

Phase 1

Prior to fieldwork, we gathered general background information and reviewed secondary data sources relating to the historical development of the CBCRT programme in the Eastern Caribbean (EC). These included reports from discussions among various stakeholders (MOH, NAS, CHAA, USAID, CDC and IntraHealth). We also reviewed several stakeholders’ technical reports on HIV prevention and CT programmes and also conducted an audit of the CBCRT training materials, including the NAS CT data collection forms. These data sources helped us understand issues and activities surrounding the planning and roll-out of CBCRT and provided greater context in which to conduct interviews and analyses. A series of collaborative discussions between CHAA, IntraHealth and UCSF provided useful information that helped to guide and refine the research questions and the selection of participants to include in the study.

An observation of the four-and-a-half day ACRTT was conducted by the UCSF researcher in order to get a better understanding of the content and process of the CBCRT training programme. The ACRTT was selected for observation because it was considered the key training protocol which would equip CBCRT service providers with the basic skills in counselling and rapid testing. This visit also provided the UCSF researcher with the opportunity to meet and have informal discussions with some of the CBCRT stakeholders, trainers and training participants. The non participatory observation was non-intrusive, and the observer sought consent from both participants and trainers to observe the sessions. The observation process also helped the researcher identify potential participants for the Case Study interviews. Brief notes taken during the observation of the training sessions did not contain any data that would potentially identify individuals participating in the training.

Phase 2

After the initial planning discussions and review of data, participants for the in-depth qualitative interviews were selected using a purposive and convenient sampling strategy. This selection strategy ensured that, in the limited time for data collection, at least one person from each of the key sub-groups was selected for an interview. Selected participants included CBCRT in-country stakeholders, regional stakeholders, participants of the CBCRT training who included CBCRT service providers, and CBCRT future service providers from local NGOs (see Section 4.1 for complete participants’ background information). It is important to note that some of the participants who had been invited to participate were not interviewed during the data collection visit to Antigua due to a hurricane storm which forced businesses to shut down for one-and-a-half days.

The interviews took place in privacy, either in the participant's work setting or at a designated venue. The interviews lasted approximately 60-90 minutes and were audio-recorded with the consent of the participant. Verbal consent was obtained from all individual participants prior to the interview. The consent process involved explaining the purpose and procedures of the study informing participants of their rights as research participants, including the risks and benefits of participation.

We also conducted telephone/Skype interviews with individual trainers and a representative of CDC between September 14th and October 21st. Researchers took hand written notes during these interviews.

An interview guide developed for each sub-group (peer-outreach workers, CBCRT programme managers, MOH and other Stakeholders, and CBCRT trainers) of participants was used to structure the discussion with participants. The questions for each of the subgroups focused on the roles and responsibilities of each sub-group in the CBCRT programme. The interview guides each covered some of the following domains:

- 1) Role in the CBCRT programme;
- 2) Perceptions and experiences related to the training for the CBCRT programme;
- 3) Opinions and experiences related to implementation and rolling out of the CBCRT programme;
- 4) Perceived barriers and facilitators of the CBCRT programme, and
- 5) Recommendations and lessons learnt which may be used to enhance the CBCRT programme.

Participants were also asked to elaborate on testers' acceptability of CBCRT its potential impact on stigma and discrimination.

3.5 Data Analysis

Data analysis was an iterative process which began during the data collection period. At the end of each interview day, the two researchers de-briefed, discussing observations related to the day's interviews. They made interpretations of data collected on that day and documented issues and themes arising from it. This process helped the team to strategise for the following day's interviews. All audio-recorded data from the in-depth interviews was downloaded and stored in a computer programme and summaries were generated from both the audio recordings and the hand-written notes. Themes and concepts that emerged from the interview summaries were used to generate a structure for the report which was primarily based on the topics outlined in the interview guides.

Secondary data generated from the desk review during Phase 1 of the study was primarily used to compile the background section of the report which highlights the historical background of CT in the Eastern Caribbean and of CBCRT in Antigua.

In addition, notes from the observations of the ACTT helped give the researchers a deeper understanding of the CBCRT training process and some of the concepts behind the training protocols.

3.6 Human Subjects Protections

The study was reviewed and approved by the Committee of Human Research, University of California, San Francisco and the Government of Antigua and Barbuda, Ministry of Health.

3.7 Limitations of the study

At the time of the study, the Supervision and Support Training was still pending, so the impact of this training protocol was not assessed. The travel schedule of the trainer for the Stigma and Discrimination training prevented an interview being carried out with him.

A hurricane and flooding led to closure of business on Monday and part of Tuesday during the five-day fieldwork period and prevented the completion of some scheduled interviews. Unsuccessful attempts were made to re-schedule the interview with the Chief Medical Officer (CMO) for Antigua. As such her opinions, or those of her office, are not represented in this report.

A major limitation of this study is that, at the time of interviews, the CBCRT programme had not yet been rolled out to all the proposed sites due to lack of certification of CBCRT trained rapid testers. The impact of decentralising the CBCRT programme has therefore not been assessed. Assess. There was no opportunity to interview the director of the NL in order to gain insight of the issues involved in the delays in certification of testers but the study team learned that discussions between the MOH, the NL and the CDC regional laboratory advisor were in progress.

4. RESULTS

A total of eighteen people were interviewed face to face in Antigua, sixteen individually and two jointly. Phone/ Skype interviews were carried out with four trainers and a representative from CDC. Copies of each interview guide are included in the Annex of this report.

4.1 Background Information on Participants

4.1.1 Organisations represented in the sample

Table 1 below provides details of the work carried out by each agency in the study, their clientele and their involvement in the CBCRT programme. The organisations represented by the participants in the interviews were (in alphabetical order):

Antigua and Barbuda Planned Parenthood Association (APPA)
Antigua and Barbuda HIV/AIDS Network (ABHAN)
Bell Lab Services
Directorate of Gender Affairs (DGA)
Caribbean HIV&AIDS Alliance (CHAA)
Caribbean HIV/AIDS Regional Training Network (CHART)
Ministry of Health (MOH)
National AIDS Secretariat (NAS)
United Nations /Pan American Health Organisation (UN/ PAHO)
US Centers for Disease Control and Prevention (CDC)
Women Against Rape (WAR)

Three interviews were conducted with independent consultants who were trainers for the programme for the Caribbean Harm Reduction Coalition (CHRC) and Caribbean Vulnerable Communities (CVC) and CDC.

4.1.2 Roles of respondents within their organisations

When asked about their role in their organisation, interviewees self-defined as:

Acting director (2 people)
Animator¹ (5)
Clinical care coordinator/ Medical doctor (1)
Counsellor and rapid tester (2)
Consultant trainer (1)
Country Programme Officer (1)
Director (2)

¹ Animators are the peer outreach workers employed by CHAA

Epidemiologist (1)
Lab technologist (1)
Licensed clinical psychologist (1)
Nurse/Midwife (1)
Outreach worker (1)
Programme officer (1)
Regional laboratory adviser (1)
UN/PAHO representative (1)

4.1.3 Existing collaboration and referral

Participants highlighted the absence of an integrated and functioning referral system between organisations, but acknowledged the existence of informal referral from one organisation to the other as they “all know each other”. Thus HIV positive clients are referred from the NAS to Clinical Care Coordinator to access treatment, and the DGA refers clients at risk for testing to the NAS. This is in spite of the DGA having developed a protocol for referral of clients at risk of HIV. It was not clear from the interview when this referral protocol was developed or why it was not systematically used by all local stakeholders. Most interviewees informed that clients “came on their own” or heard of services via word of mouth.

CHAA had developed a referral network strategy that was set to be launched in 2010. This involves bi-directional referrals between community organisations, CHAA animators, and private and public health services. The referral system is designed as a process of coordinating service delivery through EC-CAP where animators would link clients to treatment and care. Special referral forms have been developed for this purpose.

Table 1: Information on the organisations included in the study

<i>Organisation represented in the sample and number of people interviewed</i>	<i>Organisation's offered services</i>	<i>Key clients</i>	<i>Existing collaboration and referral</i>	<i>Involvement in CBCRT</i>
<p>Antigua and Barbuda HIV/AIDS Network (ABHAN)</p> <p>1 person</p>	<ul style="list-style-type: none"> • Drop-in centre where PLHIV and other people can meet and build friendship. • Provide information to increase knowledge of HIV to make people more comfortable with being around PLHIV. • Delivery of cooked meals for PLHIV in financial need. • Peer/buddy programme promoting treatment adherence. The buddies are students from the medical school of Antigua. Peers are other PLHIV clients. Buddies and peers call PLHIV members on a weekly basis to motivate, offer moral support and encourage them to adhere to treatment. • Support programme to increase treatment literacy and empowerment 	<p>Mostly PLHIV</p>	<p>Collaboration:</p> <p>NAS</p> <p>MOH</p> <p>CHAA</p> <p>Referral to:</p> <p>- the Clinical Care Coordinator for treatment</p> <p>- the rehabilitation centre (for drug users)</p> <p>FBO (for clients needing spiritual support)</p>	<p>Three persons of the organisations including the executive director received the full CBCRT training.</p> <p>Although they are not providing the service because of lack of certification, ABHAN hopes to be offering HIV counselling and Rapid Testing in the future has already dedicated a private space to be used for this purpose once the certification will be given.</p>
<p>Antigua and Barbuda Planned Parenthood Association (APPA)</p> <p>1 person</p>	<ul style="list-style-type: none"> • Provide health care services (Blood pressure, blood glucose level, contraceptives etc.) • Since 2006 provide VCT and PICT² • Pre and post test HIV counselling • Give lectures at the school of nursing, the school of police and in prison on sexual and reproductive health lectures • On demand, offer counselling in school 	<p>Entire community</p>	<p>Refer HIV positive clients to Clinical Care Coordinator when needed</p>	<p>Two nurses from the APPA (including the acting director) received the full CBCRT training.</p> <p>Although they are not providing the service because of lack of certification, APPA was identified by the needs assessment study as the best site to be the first decentralised institution to offer the CBCRT after the certification is granted.</p>

² VCT: Voluntary Counselling and Testing; PICT: Provider Initiated Counselling and Testing;

Organisation represented in the sample and number of people interviewed	Organisation's offered services	Key clients	Existing collaboration and referral	Involvement in CBCRT
Bell Lab Services 1 person	<ul style="list-style-type: none"> • Private laboratory that does a variety of testing, including HIV testing. (Walk-in clients with no appointments) • Draw blood and conduct rapid HIV testing. • The lab began rapid HIV testing in 1999 using 2 parallel tests (Unigold & Determine) • They give out negative results on the spot but refer all positive results to the central lab for confirmatory tests. • Pre and post test counselling depending on the availability of trained lab technologists. 	<p>Entire Community</p> <p>Clients do not self identify as MARPS but the lab is aware of SWs accessing services.</p> <p>The interviewee did not mention use by MSM or drug users.</p>	<p>Clients referred from other health centres, physicians and organisations</p>	<p>Although the lab is offering rapid testing since 1999 there was no pre and post test counselling associated.</p> <p>Two lab technologists were trained for the CBCRT programme in order to complement the service by the pre and post counselling.</p>
Caribbean HIV&AIDS Alliance (CHAA) 1 Programme Officer and 5 animators	<p>Peer outreach workers (animators) provide:</p> <ul style="list-style-type: none"> • Peer counselling and rapid testing 2 days a week at NAS • Peer outreach work with MARPS groups (SWs, MSM & PLHIV) • Provide HIV education • Accompany clients to health care & support services (buddy system) 	<p>PLHIV</p> <p>MSM</p> <p>SW</p> <p>People from the Spanish-speaking community (mostly from the Dominican Republic)</p>	<p>NAS</p> <p>Clinical Care Coordinator</p> <p>DGA</p>	<p>All peer outreach workers were trained in counselling and rapid testing</p> <p>Provide peer counselling and rapid testing 2 days a week at NAS</p>
Caribbean Harm Reduction Coalition (CHRC) 1 trainer	<p>Advocacy around drug use and conduct research on the overlap of HIV and drugs</p>	<p>Drug users (notably crack users)</p> <p>MSM</p> <p>SWs</p>	<p>N/A</p>	<p>Provided the Harm Reduction Training for the CBCRT programme</p>
Caribbean HIV/AIDS Regional Training Network (CHART) 1 trainer	<p>CHART/ Jhpiego VCT training</p>	<p>Not applicable (N/A)</p>	<p>N/A</p>	<p>Provided basic VCT training using CHART/ Jhpiego model to CBCRT training participants.</p>
US Centers for Disease Control and Prevention (CDC) 2 people	<p>The general aim of CDC-Caribbean is to strengthen the health system in the Caribbean region. This includes strengthening HIV prevention services for MARPS.</p>	<p>N/A</p>	<p>N/A</p>	<p>As it pertains to the CBCRT programme they provided training for the 5 day rapid testing training.</p> <p>The CDC intervened to solve the competency assessment and the certification issues between the MOH, the NAS and NL</p>

<i>Organisation represented in the sample and number of people interviewed</i>	<i>Organisation's offered services</i>	<i>Key clients</i>	<i>Existing collaboration and referral</i>	<i>Involvement in CBCRT</i>
<p>Directorate of Gender Affairs (DGA)</p> <p>2 people</p>	<ul style="list-style-type: none"> • 'Crisis centre' counselling for cases of domestic violence, rape and other forms of sexual violence. • Marital interventions, child maintenance and other family related issues • 24 hour crisis hotline • Skills training, gender sensitisation • Advocacy for the eradication of violence against women • Community outreach programme • Trauma centre at the hospital • HIV counselling • Provides training to government agencies and NGO on gender issues, violence etc. • Participate in the test drives, with NAS • Legal assistance when necessary 	<p>Mainly victims of gender, domestic and sexual violence; but also reach some MARPs</p>	<p>Collaborate with:</p> <ul style="list-style-type: none"> - CHAA in a programme looking at the link between gender based violence and HIV - NAS (refer clients for HIV testing and supported NAS in the mobile outreach during which they offered the counselling) - Collaborate in an unofficial manner with WAR 	<p>Three staff of the DGA attended the CBCRT training, but only two completed the counselling and rapid testing curriculum.</p>
<p>Independent</p> <p>1 doctor, 1 psychologist</p>	<p>Doctor:</p> <ul style="list-style-type: none"> • Performs rapid testing (oral test and finger prick) at a cost. • Treats PLHIV free of charge. 	<p>Entire community</p> <p>PLHIV</p> <p>MSM</p>	<p>Get referral for treatment from:</p> <p>NAS</p> <p>HHH</p> <p>ABHAN</p>	

<i>Organisation represented in the sample and number of people interviewed</i>	<i>Organisation's offered services</i>	<i>Key clients</i>	<i>Existing collaboration and referral</i>	<i>Involvement in CBCRT</i>
	Psychologist <ul style="list-style-type: none"> • Provides counselling for CHAA peer outreach workers. Also responsible for quality assurance for CHAA's outreach counselling 			
National (NAS) 4 people	AIDS Secretariat <ul style="list-style-type: none"> • Drop in and mobile outreach HIV rapid testing • Pre-post test counselling using the risk reduction model 	Entire Community. MARPS who come for services sometimes self-disclose as SW, MSM or PLHIV. NAS counsellors and testers shared the belief that through the CBCRT programme the NAS reaches out mostly to SWs, since there were three SW peer counsellors and only one MSM peer counsellor	Collaboration with: <ul style="list-style-type: none"> - CHAA in CBCRT programme management - Clinical Care Coordinator for treatment - DGA (Refers client for HIV testing) 	Provide counselling and rapid testing
UN/PAHO 1 person	Assist countries with technical cooperation in order to implement health prevention/ promotion programmes.	N/A	N/A	Advocate for CBCRT to government as a regional stakeholder
Women Against Rape (WAR) 1 person	Support group for survivors of sexual violence. Advocacy work with the Ministry of Health and the police.	People who have been survivors of sexual violence	In contact with the ABHAN, HHH (Provide counselling), APPA	One member received the CBCRT training. WAR hope to be offering HIV counselling and rapid testing once the certification is obtained.

4.2 Planning

The planning for the CBCRT programme began in 2008 with CHAA, IntraHealth and the NAS, after IntraHealth carried out a regional needs assessment in four OECS countries, recommending conduct of a pilot of the programme in Antigua (Cohen et al., 2007). A feasibility study followed, which identified public institutions (the NAS and the DGA), a nongovernmental organisation (the APPA) and private lab (Bell Lab Services) to roll out the CBCRT programme. Initial consultations were held between CDC, CHAA, the NAS and MOH but the NL director was not included at that stage.

With the collaboration of regional and international organisations (CHART, CDC, CVC, CHRC and amfAR), training was conducted with local stakeholder representatives, community animators and private lab technologists were trained using the protocols described above.

The original planning involved the piloting of the programme to the NAS (through drop-in and mobile testing) with the objective of expending certification to other pilot testing sites in order to prepare for rapid testing roll out at a national level utilising a decentralised model. Since then, however, only the NAS pilot and the private lab pilot have been implemented while CBCRT trained counsellors from other proposed testing sites are waiting rapid testing certification by the NL.

4.3 Training

As noted above, at the time of the case study five of the six training protocols had been implemented.

4.3.1. CBCRT training from the trainers' perspective

Training experts who provided CBCRT trainings were interviewed to get an understanding of the objectives and approach of their training protocols and also to get their perceptions of the training outcomes. We describe below each individual trainer's perceptions on these issues.

a) CHART/ Jhpiego VCT Baseline 5-Day Training

According to the trainer, this training was designed to identify HIV/AIDS issues that CT service providers in Antigua might encounter in their dealings with MARPs. These issues included logistical and institutional barriers MARPs encounter in accessing CT services, including experiences of S&D. The trainer believed that training peer outreach workers would allow hard-to-reach groups to access CT services more easily. The training was also a capacity building strategy to provide peer outreach workers with counselling skills.

The trainer was of the opinion that the training protocol matched the participants' literacy levels and their basic understanding of HIV issues. She believed participants should have undergone a one day training session in HIV 101 prior to participating in the 5-day baseline VCT training

skills. It was important for participants to have a basic knowledge of the concepts of HIV, such as, modes of transmission and prevention strategies.

The training was said to offer different HIV stakeholders and service providers the opportunity to participate in trainings together which enabled cross agency exposure and promoted a networking environment for future partnerships.

b) *CDC Advanced MARPS HIV Counselling and Rapid Testing Training (ACRTT)*

The ACRTT was led by two CDC co-trainers who provided the counselling and rapid testing training. One of the trainers was a laboratory specialist. The other, who was interviewed for the study, developed the MARPs HIV prevention counselling and rapid testing curriculum which is being used to train CT service providers internationally. She considered this training to be appropriate for all levels of HIV/AIDS service providers, whether or not they had a clinical background. Participants grasped the rapid testing techniques with ease even though a few were squeamish at the sight of blood.

The trainer was pleased to note that all participants passed the rapid testing practicum exam. She also highlighted the following advantages of the CBCRT MARPs training:

“It allowed for ‘taskshifting’ on the ground among the counsellors and testers, such as making it possible for peer outreach workers/counsellors who are non-clinicians to provide HIV rapid testing to MARPs, [who are] less likely to use health care services.”

The length of the training sessions was perceived as adequate, but the testing protocol steps were said to need more time for practice. The trainer was pleased to note that all participants passed the practicum exam.

The UCSF researcher who observed this training was impressed by the trainees’ level of enthusiasm and expression of commitment to working with MARPs. The researcher also noted the participatory nature of the training which encouraged trainees to express their opinions and share their valuable fieldwork experiences.

c) *Harm Reduction (HR) Training*

This training was developed and conducted by a behavioural scientist and director of drug and alcohol abuse at CHRC. The trainer said that most CBCRT participants who were not familiar with working with drug users expressed concerns for their safety when dealing with this type of client. These participants were also not sure how effective it would be to counsel clients who were high on some substance. However, the trainer believed the participants responded positively to the training and that the training had changed the participants’ attitudes towards

drug users. According to him, the HR training protocol was appropriate for participants with limited educational levels. He did not consider the low educational level of some service providers, i.e. peer outreach workers, as posing a barrier to grasping the HR training since it was pitched to the level of lay people.

d) Consent and Confidentiality Training

This training was especially developed for MARPs in the Caribbean by a consultant with CHART. She said that it was important for a trainer to be aware of the professional background of participants so that the training could be adapted to suit all participants. The trainer found that participants who had basic counselling skills understood the consent and confidentiality training better. The trainer also said it was important for a consent and confidentiality trainer to be familiar with in-country laws and regulations relevant to HIV testing, such as laws on age of consent. On the whole, the trainer said she received positive feedback about the training from the participants.

e) Stigma and Discrimination

It was not possible to interview the stigma and discrimination trainer due to his business travel schedule and therefore his perspective on that training is not provided in this report. However, through the interviews we were able to elicit participants' perceptions of this training (see below).

f) Support and Supervision training

The trainer and participants in this training were not interviewed as it was yet to be conducted at the time of the interviews.

4.3.2 Challenges for Trainers

CBCRT trainers highlighted a number of the challenges experienced in the planning and implementation of the CBCRT training.

It was challenging to schedule suitable times for the training given the work schedules of the trainers, the NAS and the CBCRT participants. Once the training was underway, trainers were frustrated by interruptions when some participants left sessions to attend to work commitments. It would appear that some participants had difficulty being absent from their work stations for training that lasted up to 5 days. Trainers noted that some participants would arrive late for sessions and others left early to catch public transport to their homes. One trainer suggested that providing in-house training venues with accommodation for participants might minimise disruption as participants would be less likely to leave during training sessions.

A CT trainer noted that that some participants had not done any counselling before. This put them at a disadvantage to the rest of the group and it at times slowed down the pace of the training sessions. There was a need for more time to conduct role plays during the counselling

and rapid testing training. The trainer felt it was necessary to deliver a training that was more interactive with lots of activities and less didactic.

Because the training was conducted in English, this became a barrier to two Spanish speaking participants, even though a translator was provided. The two participants did not perform well in the evaluation test which was in the English language, even though the translator assisted them. One of the trainers said that the two Spanish speakers had difficulty following the training and she felt that some information could have been lost during translation. The trainer also felt that the Spanish to English verbal translations were disruptive to the other participants. There were suggestions that maybe a separate training could be conducted for Spanish speakers.

4.3.3 CBCRT Participants' Perspectives

a) *General Perceptions of CBCRT Training*

Most participants considered the CBCRT training to be very relevant in their work context and also to the prevailing HIV situation in Antigua. This perception was highlighted by a peer outreach worker who said that, *“information acquired during this training is not just for use with my clients but also with my family.”*

Peer outreach workers perceived the trainings as having enhanced their skills and professionalism. They said they noticed that their clients and the community at large now treat them with more respect and that there is increased disclosure and openness from clients. Increased disclosure was attributed to CBCRT services which helped remove the fear of deportation of Spanish speaking clients, most of whom are reported by peer outreach workers to be people with non-regularised immigration status. Some peer outreach workers said they found the training empowering and the CDC certification had opened doors for them to work in other countries. To enhance the knowledge gained during the trainings, CHAA appointed one peer outreach worker to attend the 2010 Vienna International AIDS conference and participate in a Human Rights session advocating for immigrant rights

Peer outreach workers believed it was important for them as providers to model positive health behaviours so as to gain respect and emulation from their clients. Acquiring professional skills appeared to have a positive impact on some peer outreach workers' personal lives.

“(...) the training benefited my personal life too, it helped me turn my life around and realise that SW is a dead-end job.” [Peer outreach worker]

Participants from service organisations expressed appreciation of the skills acquired which they said would give them the confidence to serve their clients better. An NGO representative who was trained remarked,

“I think it was very good, I think they touched all the bases, and individuals would have left it really prepared [to perform rapid testing]”

b) *Counselling and Rapid Testing Training*

Peer outreach workers perceived the training as enhancing their confidence to discuss personal and sexual issues with their clients and were excited about the ability to conduct HIV testing and provide timely results to their clients. Participants from service organisations considered the CT training to be of benefit even though their organisations' mandate was not to provide HIV CT. Training in counselling was useful to their clients who needed counselling on a wide variety of issues while training in rapid testing would enable them to offer HIV testing and enhance the services they offered.

c) *Consent and Confidentiality Training*

All participants viewed this training as beneficial in their work settings. Participants from service organisations perceived it as being more important to their front-office staff who were the first point of contact for their clients.

d) *Harm Reduction Training*

While participants from some of the service organisations felt that this training was not relevant to their clientele who did not include substance abusers, the majority of participants felt that the harm reduction training had given them the necessary skills to deal with drug users. The benefits of the training were particularly expressed by peer outreach workers and counsellors from the AIDS Secretariat whose client base includes substance abusers.

e) *Stigma and Discrimination Training*

Most participants considered this training to be very useful. They noted that, because Antigua and Barbuda is a small country, many people are afraid of stigma and discrimination because “*everybody knows everyone*”. A Spanish speaking peer outreach worker explained that stigma and discrimination training helped them view their clients in a different light. Another noted,

“I didn’t understand stigma and discrimination before and now I can help clients understand.... that they (clients) also discriminate against other people.”
[Peer outreach worker]

Another peer outreach worker who is living with HIV explained that S&D was still a big issue among PLHIV and also in the community at large, further adding that, “*PLHIV are still in limbo*” as most are reluctant to access HIV care and treatment from public health care centres. Another PLHIV who is also an MSM said it was important to teach people coping mechanisms for stigma and discrimination because it will “*always exist*”.

f) *IntraHealth Supportive Supervision Training*

Questions about this training were not asked because it had not been conducted at the time of the interviews.

g) Recommended Additional Trainings

Most participants felt that they would need some refresher training six months into the programme to minimise loss of skills and maintain proficiency. Participants from service organisations that had not yet rolled out CBCRT services said they would like refresher training before they launch the programme. They acknowledge that there might be loss of skills if it took a long time to implement the programme.

Participants also proposed some additional training that could be included in future CBCRT training protocols. These included, advocacy training, first aid, human rights, group facilitation skills, phlebotomy skills for drawing venous specimens for HIV testing and for quality assurance, and general updates on the latest information on HIV prevention. Trainings that would address the needs of specific MARPs clientele were also identified, such as:

- Training on how to deal with victims of violence, particularly for peer outreach workers who encounter many rape victims in their work.
- A PLHIV participant suggested training in how to work with PLHIV who are in denial of their HIV status

„Denial kills lots of people because they do not access treatment, they are afraid to go public’ [PLHIV peer outreach worker]

- Peer outreach workers said they needed training on how to counsel sexually abused women because they encounter these women during their work
- Peer outreach workers who encountered more clients with substance abuse issues also said they could benefit from an expanded *„harm reduction training’* which would help them understand better how to work with drug abusers

There was also a proposal to add more time to the training schedule to allow for more practicum and role plays.

4.4 Implementation

4.4.1 Implementation Process

a) Logistics

At the time of the study, the CBCRT programme had not yet been fully rolled out in Antigua and NAS was the sole provider of free-of-cost CT services. As such, data presented below pertains to NAS CT services only, that are provided from Monday to Friday at a site in the city and also quarterly through a pilot mobile outreach strategy in the community. CBCRT trained peer outreach workers are seconded to NAS for at least two days a week to provide CT under the direct supervision of NAS.

The quarterly one-day mobile outreach CT services are offered in different parishes by a team of approximately twenty to twenty-five counsellors and rapid testers. The teams are composed of

CBCRT trained staff from NAS and its NGO partners, such as, DGA, Health, Hope and HIV Network (HHHN), APPA, and peer outreach workers from the CHAA. The services are provided in tents at venues that are known to be high HIV risk areas.

Participating NGOs identified and trained as future providers of CBCRT services reported that they were making preparations to implement CBCRT at their respective sites. Some of the preparations involved allocating space at their premises or looking for suitable, larger premises for CT and writing grant proposals to request funding of the CBCRT programme.

b) Counselling and rapid testing services

Because CBCRT trained rapid testers are not yet certified, only NAS-certified counsellors conduct the rapid testing. NAS counsellors are part of a group of twelve health care workers who were trained and certified by the NL with the support of CAREC under a prior national CT programme in December 2008. All other CBCRT trained counsellors (CHAA peer outreach workers and NGO counsellors) are currently only conducting pre- and post-test counselling.

c) Certification of rapid testers

At the time of interviews, CBCRT participants trained in rapid testing had not been assessed by the NL for rapid testing competency. The participants who had not received certification were not authorised to conduct rapid testing. Additionally, though the NAS counsellors were offering rapid testing, they were still required to submit to the NL two hundred HIV positive samples for confirmatory ELISA testing. Per NL protocol, this was considered the first phase of the competency assessment procedures. The testing protocol required NAS to forward all HIV positive test samples to the NL for confirmatory testing. The inability to provide same day test results to those testing HIV positive was viewed by both current and prospective CBCRT service providers as defeating the whole purpose of rapid testing.

Through informal discussions during the planning stages of this study, we were made aware of a change in government organisational and reporting structures which were put in place after a government reshuffle in 2009 that changed the Minister of Health. Some of the CBCRT programme plans which all stakeholders agreed to before a change of government were not completed as planned. CBCRT participants reported some disagreements between CBCRT planners, particularly, with regards to the role of the NL in assessing CBCRT sites for accreditation and providing rapid testing proficiency assessments to CBCRT trainees.

d) CBCRT Client Profile

It is estimated that approximately 400-500 clients receive CT at the NAS per month and that more women than men access these services. A recent increase in the uptake of services was attributed to the introduction of rapid testing which provides same day results. Prior to the introduction of rapid testing in 2009, it would take three to four months to get an HIV test result because the blood samples would be transported to the NL for HIV testing using ELISA tests.

Mobile CBCRT outreach activities were reported as having been very successful in that as many as 200 clients per day would received HIV testing. It would appear that non-clinic settings were becoming more accessible with the public, such as the Scotia Bank mobile CT site.

e) Referral services

Most organisations refer their clients to the NAS and to private laboratories for HIV testing. There is also a well established inter agency referral system with the participating service organisations. During the CBCRT training, reference was made to the existence of Directories of Social Services and of Friendly Services which were expected to be available to all service providers. During this training, participants were provided with more information about referrals and how to refer appropriately. It was important for all service providers to be familiar with all HIV prevention networks in the country. As mentioned above, CHAA has also developed a bi-directional referral network strategy for use by peer outreach workers.

Most clients who are HIV positive are referred to the Clinical Care Coordinator for treatment, CD4 counts, dental, and eye care. Some are referred to other organisations, such as:

- DGA for domestic and sexual violence services and others such as sewing and cooking lessons
- APPA for STI treatment and pap smears
- HHHN for ongoing counselling, support groups and food packs

f) Decentralisation of CBCRT services – Participants’ perceptions

The majority of participants considered decentralisation of HIV prevention services, such as the CBCRT programme an excellent strategy that “takes services to the people.” The general perception was that decentralising would improve access to HIV testing. It would also offer more choices of HIV testing facilities in the community. Antigua is experiencing a shortage of health care providers and so a programme like CBCRT that allows for training of laypersons would alleviate the problem. Allowing local NGOs to participate in the CBCRT programme and provide services in the community was also perceived as a positive step towards improving relationships between the government and in-country service organisations. It would also allow the government to divert some of its manpower and financial resources to other much-needed services.

One participant also suggested that decentralisation of CBCRT services would be more cost-effective if densely populated lower socio-economic areas were targeted. The participant was of the opinion that upper class communities would shun CBCRT services in preference to private health care services.

One of the major benefits of decentralisation of CT services was the perception that CBCRT removed the stigma that is attached to HIV testing, particularly getting tested at the NAS facility in the city. However, even though most participants recognised more benefits to decentralisation,

some participants were concerned that CBCRT sites might be labelled as centres for people with HIV and that some participants would shun these centres and opt to go to the city for HIV testing, where they would not be easily recognised.

“there are definitely more pros than cons, I think the bottom line is that ... not everyone will feel comfortable... most people don't feel comfortable going to the AIDS programme office, not a lot feel comfortable going to Dr [X] either, because you know... [it is considered] the “hot spot.” You go there, somebody see you in there means you „gottahave it’ so they are afraid to go. They wanna go, but they are afraid to go. If they can go any place that is not 100% perceived as being that [i.e. related to HIV] (...) they would feel more comfortable”

[NGO representative]

g) Possible barriers to decentralisation

A participant representing an international NGO strongly felt that if both the government and its NGO stakeholders do not consider the CBCRT programme a priority in their HIV prevention plans, the programme will not succeed. She emphasised that the MOH should be motivated to get involved and initiate the programme.

Some programme managers from NGOs also impressed that getting buy-in from all critical stakeholders can also be a challenge. This can slow down progress between the planning process and implementation. Programme planners should be aware that approval processes for some aspects of the programme can be laborious. Staff shortages may also be a barrier to decentralisation of the programme.

4.4.2 Documentation Process / Data Capture

a) HIV Risk Assessment Form

Until recently, Antigua did not have a systematic way of capturing data that defines MARPs. This prompted the development of a Risk Assessment Form for use by NAS and its partners during CT. Service providers we interviewed highlighted the many benefits of this form, particularly Section 3 which identifies Risk/Exposure Factors and captures self disclosure of MARPs behaviours. However, some participants indicated that clients were often reluctant for counsellors to indicate their sexual orientation on the form or that they have multiple sexual partners. Most clients were not comfortable disclosing that they were SWs, MSM or PLHIV for fear of stigma and discrimination by service providers. Clients were however willing to disclose to the counsellor if the information was not captured on the forms.

b) Perceived Benefits of the Risk Assessment Form

Participants thought that the form would indicate which sub-groups in Antigua were at highest risk. The data would be used to strengthen and expand services for those particular sub-groups and service organisations would also be able to target these groups with the relevant information.

c) *Challenges associated with the use of the Risk Assessment Form*

There is some controversy about whether this form should be self-administered by clients while they wait for their turn at testing sites or be counsellor-administered in private. We were informed that during mobile outreach, clients were often allowed to self-administer the form as a way of keeping them occupied while they wait for the turn with the counsellor. Some CBCRT stakeholders expressed concerns about the quality and fidelity of the data if the form is client-administered. The concerned stakeholders indicated that this might be a training issue that needs to be reviewed by the programme stakeholders. However, our secondary data sources indicate that the CDC training protocol recommends that clients who complete the form independently have the opportunity to review it with the counsellor during pre-test counselling. It would appear that there is need to ensure that the actual implementation of data collection protocols meet the objectives of the programme, which is to ensure high quality of the data collected.

d) *Counselling and Testing Data Collection Form*

This form primarily collects indicators required by funding agencies. Its indicators address service utilisation and quality assurance issues.

4.4.3 Perceived Barriers/Challenges of CBCRT Program

a) Certification of rapid testers: Delay in certification of trained rapid testers was viewed as the major barrier to expanding the CBCRT programme in Antigua.

“Without rapid test certification, we can’t move forward with the programme”
[Programme manager]

Participants felt that the CBCRT programme could not meet its objective to expand counselling and testing services to the community at large, and particularly to the targeted MARPs.

b) Financial constraints & sustainability: The MOH in Antigua procures all its HIV test kits from Trinidad and this importation process makes the test kits very costly. It was reported that the supply of test kits has been inconsistent and that recently, the supply chain for ELISA test kits was disrupted due to a shortage of funding. This subsequently has a negative impact on the CT programmes.

In addition to the costs for procuring testing reagents and other lab supplies, mobile outreach activities were also reported to be very costly. Outreach activities required supplies, equipment and other incidentals, such as hiring of tents to be used as CT spaces; buses to transport CBCRT staff to and from the testing venues; meals for field staff; etc. All these costs need to be considered during the planning stages of the programme.

It was also found that there is a lack of long-term financial planning for the CBCRT programme. We were informed that the original plan was for the CBCRT programme to be implemented as a pilot, with CHAA providing the initial financial support. The NAS would subsequently assume

financial responsibility of the programme with assistance from the Global Fund Against TB, AIDS and Malaria. During the course of the interviews information emerged that funding sources for both CHAA and the NAS were exhausted and CHAA was already preparing to wind down its activities in the CBCRT programme, including the peer outreach worker activities. However, after the interviews, we became aware of secondary sources which indicated that some additional grants would be awarded to the NAS and to the Nat Lab to continue the CBCRT programme (IntraHealth International, 2010). It is important to note that uncertainty with funding can de-motivate programme implementers and cause anxiety among the service providers, which might in turn affect their performance.

c) Language barriers for Service Providers: In order to address the language barrier to non-English speaking clients, the CBCRT programme trained Spanish speaking peer outreach workers to provide CT services to non-English speaking clients. However, this appears to be causing some tensions between English-speaking NAS counsellors and Spanish-speaking peer outreach workers. One of the Spanish speaking counsellors reported her frustration at having her Spanish-speaking CT activities curtailed because of her inability to provide counselling in English. At the time of the interview, this issue was being discussed by the relevant institutions.

d) Institutional stigma and discrimination against MARPs: Participants perceived some institutionalised discrimination of migrant communities, particularly at MOH health centres and NAS testing sites. Peer outreach workers reported that immigrants feared the possibility of being arrested if they produced their foreign passports as identification and would be subsequently deported.

4.5 Community Perception of the CBCRT

The fieldwork period did not allow for assessment of client perceptions, but participants were asked to share feedback they received from their clients about the CBCRT programme. In general, programme managers and service providers (NAS counsellors and testers and CHAA animators) all praised the programme and reported having received positive feedback from the community about it.

“(...) for the most part they are satisfied, we get positive reviews.”

[Counsellor and tester at the NAS]

The reduced time period to obtain HIV test results and the absence of cost were identified as factors contributing to the programme being well received by the community. The absence of cost was said to be especially appreciated by MARPs and by low income clients. Mobile testing was reported to improve convenience, making the programme accessible to those unable to travel to the city/ AIDS Secretariat for HIV testing. The programme was also said to have reduced the community's perceptions of stigma and discrimination and increased perceived confidentiality,

especially through the work of peer outreach workers, who have gained their peers respect and trust.

“My peers trust me and feel that the programme provides confidentiality”

[Peer outreach worker]

“The community never used to respect me but now they do. Peers ask me how I became a counsellor, how I got out of sex work”

[Peer outreach worker]

Interviewees from the NAS also stated that choosing not to display any identifying sign on the outside has provided an anonymous testing place to clients, reducing the stigma attached to entering a testing facility.

“People feel much more comfortable entering” [Counsellor and tester at the NAS]

Having Spanish-speaking peer outreach workers, able to target the non-English speaking population also made the programme more acceptable to Spanish speaking community

“This is definitely something well perceived and accepted by the community because since its implementation a lot more people come forward to get tested for HIV” [Spanish speaking peer outreach worker]

4.5 Quality assurance (QA)

Participants were asked to express their desired level of supervision in their respective organisations and also during their CBCRT programme activities. They were also asked to identify any existing shortcomings or gaps in the supervision process. Participants who indicated some gaps in the levels of supervision highlighted various levels of desired QA, such as for HIV rapid testing, for counsellors and for trainers.

QA for Trainers: Some CBCRT trainers were concerned about the sustainability of the CBCRT programme if the Antigua or the Eastern Caribbean region at large did not have enough trainers to conduct the required trainings. Due to the shortage of qualified trainers, there is no manpower to oversee QA of people who are trained to be trainers (TOT). As a result of this shortage, we were informed that, even though some local TOTs were trained and certified by the CDC, most trainers are not certified and so need direct supervision to assess their training skills.

QA for HIV Counselling: The NAS currently oversees the day-to-day supervision of the CBCRT activities which are conducted under the NAS auspices. Currently, NAS supervises counsellors and testers operating from their town site, peer outreach workers and other NGO staff who participate in mobile outreach.

However, peer outreach workers receive dual supervision from both CHAA and NAS. On the days that peer outreach workers are seconded to NAS as counsellors, they are directly supervised

by NAS senior counsellors. This dual supervision strategy has presented a few challenges for the peer outreach workers. It was indicated that dual supervision presented conflicting supervision styles and expectations and that NAS senior counsellors were “pulling rank” with the peer outreach workers. This conflict was also linked to a perception that NAS counsellors, who have more experience in HIV counselling, tended to maintain an old style of counselling which is not client centred whereas the newly CBCRT trained peer outreach workers adhered to the CBCRT training protocol. It was noted that, in spite of the NAS counsellors having received new counselling techniques during the CBCRT training, they were struggling to do away with “old habits.”

Concern was expressed over some shortcomings in the overall supervision and monitoring of CBCRT staff. The original plan was for the NAS to have oversight of QA for both counselling and rapid testing, however due to current staff shortages at the NAS, there was no one to fulfil this responsibility. There was a strong feeling that if QA systems were not put in place now, this problem would be magnified when proposed CBCRT sites roll out the programme in full force. The lack of QA systems to monitor programmes appears to be a problem affecting most organisations, as expressed by programme managers of some of the NGO stakeholders. Our secondary data review, however, identified a QA plan developed for use by the NAS. The QA plan includes the hiring of a NAS deputy director who would oversee QA for both CT and RT. It also includes an Observation Check list to be used to evaluate counsellors. At the time of writing this report, the deputy director had been hired by the NAP to oversee the QA process

QA for HIV Rapid Testing: We were informed that a QA model for HIV testing was in place. The acting director of the NAP, who is a certified rapid tester and received the CDC training-of-trainers (TOT) certificate, is the overall supervisor of rapid testers at NAP. The original plan was to appoint a laboratory technician from the NL to oversee the QA for rapid testing at all the CBCRT sites. At the time of fieldwork, CHAA, and IntraHealth had begun working with the CDC and the NL to retrospectively validate the rapid testing algorithm after which the NL would conduct competency assessments for all CBCRT testers. The CDC regional laboratory adviser explained that the CDC had a quality assurance system that included both external and internal quality assessment protocols for HIV rapid testing. He also supported the plan for the NL to oversee the monitoring of rapid testing at all CBCRT sites. The regional advisor also impressed on the importance of training to ensure good quality of services.

Psychosocial Support for counsellors and testers: The psychosocial needs of peer outreach workers were being addressed. CHAA had engaged a therapist to provide clinical support to peer outreach workers. This helps the peer outreach workers deal with burn-out and other stressors associated with their work. Peer outreach workers are offered bi-monthly group sessions and individual sessions when a need arises. While all HIV counsellors and testers would benefit immensely from psychosocial support, we understand that this support system is not yet standard practice for all CBCRT counsellors and testers.

4.6 Impact of the CBCRT

The case-study participants were asked about the impact of the CBCRT programme in the HIV response in Antigua and all expressed a positive view.

Expansion of Counselling and Rapid Testing Services

The most common view shared by the participants was that the CBCRT has increased access to testing. The NAS counsellors and testers said that since the rapid testing has been available there has been an increase in the number of people they see daily, from on average 5 persons, to 10 -15 clients a day. They further stressed that this did not include the number clients reached through mobile testing. The CBCRT programme was viewed as having the potential to mobilise hard-to-reach communities through decentralisation of the CT services. Participants felt that individuals, including MARPs, who were often reluctant to access CT services at the NAS and also from Clinical Care Coordinator's clinic due to fear of stigma and discrimination, would be more willing to access services in their communities.

HIV rapid testing

Another perceived advantage was having same-day results, leading to HIV-positive clients having access to supportive services faster. All participants acknowledged the benefits of providing same day results, such as being able to refer clients who needed to be assessed for treatment in a timely manner. Clients would not have to wait for weeks or months to get their HIV test results. With treatment now widely available in Antigua, availability of rapid testing would motivate people to seek HIV testing from the CBCRT sites. According to a programme manager the CBCRT programme will in the long term contribute to reduce institutionalised stigma and discrimination of MARPS and enable them to access CT services within their communities.

Accessible services for immigrants

Peer outreach animators particularly felt that the CBCRT programme made services more accessible to Spanish speaking immigrants, including SWs, who were afraid of being arrested and deported if they attended government public health services.

Stigma and discrimination

The roll out of the CBCRT programme was perceived as a way to deal with stigma and discrimination associated with CT at traditional public centres. Almost all participants indicated that stigma and discrimination were deterrents for accessing CT at the NAS site in the city. Participants thought that CBCRT would make services more accessible to clients in their communities, especially as it would be provided by peers. An employee from the NAS noted that stigma and discrimination were problems of Antigua and Barbuda as a whole rather than being problems of the NAS. She elaborated,

“S&D remains a challenge. Some people prefer to access CBCRT services outside their communities where they are not known” [NAP Outreach Worker]

According to a programme manager, the CBCRT programme will in the long term contribute to reduce institutionalised stigma and discrimination of MARPs and enable them to access CT services within their communities.

Institutional collaborations

The CBCRT programme made it possible for CHAA to successfully build bridges between in-country partners (government, civil society and MARPs). This collaboration strengthened the country's response to the HIV epidemic. The collaborations enhanced through the CBCRT strategy also minimised the chance of duplication of HIV prevention services in the country. Feedback supported a positive impact of the training on strengthening HIV work and collaborations:

“The CBCRT training will forever change the way counselling and testing is done in the country” [Programme Officer]

“It gave peers a greater purpose, (...) trying to reduce HIV infection among their fellow peers” [Trainer]

Referrals

Participants said that referrals are largely determined by clients' needs. Peer outreach workers said that they visited most referral agencies to check if they offer services to MARPs. Some gaps were also identified in the referral system. Peer outreach workers expressed a need for agencies to refer clients with alcohol and drug abuse problems, particularly those who are immigrants because these clients often cannot afford to access fee-paying treatment or rehabilitation centres for drug abuse.

4.6.1 Programme Limitations

There are two major issues that set limitations to the implementation and expansion of the CBCRT programme in Antigua.

- 1) Full-scale rolling out of CBCRT was largely limited by lack of certification of trainees by the NL, which meant that they could not provide the services they were trained
- 2) Funds allocated to this programme appear to have been limited only to a pilot programme with nothing set aside for long term activities. CHAA assisted the DGA and APPA to develop funding proposals to pilot CBCRT through these organisations, but the plans were not implemented since the lack of certification of testers made it impossible for CHAA to award the grants.

4.7 Recommendations and lessons learnt from the perspective of study participants

Planning

Most interviewees considered planning to be the most critical part of a programme like the CBCRT, which if overlooked, can prevent the programme implementation or success. CHAA engaged in substantial preparatory negotiations with local stakeholders prior to implementing the programme but during this process the leadership of the NL was not included. This may have been important in contributing to the ongoing delay in certification of the CBCRT trainees. However, a limitation of the current study is that it proved impossible to include a representative of the NL among the interviewees so the critical views of the leadership of this organisation are not reflected.

A common recommendation was to make sure there is a “buy-in” from both the government and the laboratory in charge of certification. Institutional differences of opinion were said to have impeded the certification of CBCRT.

“I think the one thing I’ll recommend that we have to work towards improving [is that] when you go in country for „x’ activity you want to have a buy-in; have the key players involved”

[Regional laboratory advisor]

The UN/ PAHO representative believed that increasing “buy-in” from top level officials was important:

“One of the things I find to overcome institutional barriers is to start from the top. Coordinate at the higher level through correspondence and have them be alerted to what is being done prior to coming down to the level of lets say of the „ADS Alliance’. So you start at the top and you filter it down and encourage involvement. But when you start at the bottom and you filter up it creates a natural barrier. For example if you want to do something and you find out you want the ministries.... you have to come from the donor agency to the ministry. And then say to the ministry that this particular organisation is going to be involved in doing whatever it is on the ground.” [UN/PAHO Representative]

It was widely believed that the NL should develop and verify rapid testing algorithms and conduct competency assessments in a timely manner in order to minimise delays in rolling out the programme. Everyone participating in the CBCRT programme, (e.g. implementing partners, stakeholders, etc.) should fully understand the model.

Participants from a government service provider and an NGO recommended that a standard protocol for the implementation of the CBCRT programme in Antigua should be developed during the planning process. This should address issues pertaining to legal aspects of service

provision (such as age of eligibility for HIV testing). Other recommendations from government service providers included ensuring that implementing partners strike a balance between providing the CBCRT services and keeping with their organisation's mandate. Additionally, it was recommended that candidates who provide CBCRT services should receive psychosocial support from a clinical psychologist to ensure that they cope with the challenges of working in the stressful field of HIV.

Training

The advanced counselling protocol that was provided in the CDC training was different from the one participants were trained in through the CHART/Jhpiego baseline counselling training programme. The new protocol from the CDC was designed to be client-centred and to focus on MARPs, while the CHART/ Jhpiego protocol provided more basic orientation in counselling and testing. Participants initially found it hard to grasp the new concept and it took them longer to adapt to the new client centred counselling protocol. The CDC trainers recommended that CT trainers should be aware of what counselling protocol participants have been trained in so that they (i.e. trainers) can modify the training to suit the level of the participants. Trainers should also allow for more time during the training to familiarise participants towards the client centred counselling approach.

It was recommended that training protocols be adapted to suit the type of audience/trainees. For instance, one trainer thought that if participants are government personnel, the training would focus more on policy around confidentiality in HIV testing, such as disclosure issues. Another trainer thought that the CBCRT training provided was more comprehensive than necessary and should be simplified.

“If I had to do it again, I might have geared it down a little bit. I might have adjusted the level of the presentation and made it a little bit more simplistic (...) it was too comprehensive” [Trainer]

Participants recommended that future trainings include more role plays to enable participants to practice the skills taught during training. Refresher courses were also deemed necessary in order to maintain quality of service.

“The refresher [training] should at least come within a six month period. Because you have to give them a chance to get trained; get some practice, and even get out there in the community once or so. And then do the refresher [and at the same time assess with the participants] „Where are you now? How confident do you feel? And how do we move forward?” [NGO representative]

Interviewees also recommended extending training on care and confidentiality to healthcare services staff.

Peer outreach workers were concerned about the increased reports of domestic violence and sexual assault from their Spanish-speaking clients and believe there is a need for Spanish speaking support groups addressing such violence. Adding training on violence against women was therefore perceived as something that would be an asset in their work. They also proposed the formation of support groups among Spanish speakers to enable them to share experiences and find ways to seek both protection and restitution from the law enforcement. Because most of these clients are immigrants whose status has not been regularised, they are often reluctant to report abuse to law enforcement for fear of being arrested and deported.

Supervision/QA

According to programme managers, supervision for the CBCRT Programme is very intense and trained lay people (as peer outreach workers) require frequent one-on-one supervision. Planners should therefore not underestimate the demand for supervision in this model.

NAS counsellors and testers also pointed out the limited support existing for them. There is a need for professionals to take care of mental health among counselling and testing providers who can suffer from burnout in the field of HIV.

“I think this is an area of concern, „Who counsel the counsellors?”
[NAS counsellor and tester]

A clinical psychologist who supports the peer outreach workers suggested that such support should occur once monthly as a group and individually as needed.

Accessibility

Two interviewees mentioned that access to services is an area of concern, further adding that what is free is not necessarily accessible for all. Barriers persons may face to prevent them from accessing services needs to be addressed. Language barriers were mentioned by a peer outreach worker who supports the need for more Spanish speaking counsellors and testers, and for a location, where counselling and testing could take place that would be set up for non English speakers.

Peer-outreach

Peer outreach workers noted that building trust with clients is critical and must be maintained by confidentiality by CBCRT providers. Peer outreach workers also believed that they needed to have specific characteristics to ensure success of the CBCRT programme, such as having a “commitment and passion for the job”, being “willing to learn”, and being non-judgmental. Such qualities should be sought when selecting peers.

Sustainability

Planning for the sustainability of programmes was said to be essential, with prior agreements with the range of responsible agencies on the amount and distribution of financial and human

resources. The government should ring-fence budgets with financial commitments to the programme. It was also recommended that programme planners have a three to four year plan for the programme before starting implementation. A National Strategic Framework would ensure that there is both government commitment and funding for HIV prevention programmes.

4.8 SUMMARY AND CONCLUSION

This case study highlights some of the critical issues to be considered by policy makers and other stakeholders in HIV prevention programmes when seeking to implement CBCRT in the Caribbean.

The major challenge in implementing CBCRT in Antigua has been the inability to maintain the support of every relevant stakeholder for the roll out of the programme. CBCRT stakeholders were unable to secure support from the NL to oversee the rapid testing component of the programme. Participants reported some tensions between CBCRT planners and the NL arising from reluctance to train and accredit non-clinical/ lay persons to conduct HIV rapid testing. CBCRT providers trained in rapid testing over a year ago were still waiting to be assessed and certified as proficient rapid testers. Non-certification of providers has stalled plans to roll out the CBCRT programme at district level in the parishes. This protracted delay will result in the gradual loss of skills as people do not put into practice what they were trained to do.

NGO stakeholders who were trained in CBCRT expressed concerns about the ability of the government to sustain funding for the programme. They indicated that their organisations would not be able to launch the CBCRT programme without some financial assistance from the government or other sources. NGOs reported experiencing poor funding and noted that most of their service providers were volunteers. They emphasised the need for the government to have a long term funding strategy to sustain national programmes such as CBCRT, especially as the initial funding was only for a pilot programme.

Effective monitoring and supervision of CBCRT sites will be a challenge as most NGOs do not have adequate and skilled manpower to take on this responsibility. It was reported that the NAS was given the mandate to supervise CBCRT activities at all sites, however, this is a challenge as NAS is currently experiencing manpower shortages. However, plans to hire a new deputy director to oversee CT and RT M&E are underway and may alleviate the current manpower problem. It is critical that all CBCRT activities be consistently and closely monitored to minimise harmful effects of poor quality services. Frequent supervision would also minimise margin of error in the rapid testing process. Poor quality services would negatively impact both client satisfaction and uptake of services.

There were indications that the CBCRT training was launched in Antigua as a pilot which would be evaluated for fidelity at a later stage. The CDC trainer mentioned that they would be

spearheading the piloting and evaluation of the training curriculum. The need to collect and document data on MARPs was cited as one of the objectives of the CBCRT programme. Both regional and local stakeholders indicated that there was very little data on MARPs in Antigua, and in the EC region in general. Absence of data has made it difficult to develop programmes that specifically target MARPs. A risk assessment form was recently introduced for use at all CT sites. This counsellor-administered form captures client risk sexual behaviours and sexual orientation, among other things. However, the biggest challenge to collecting this data is that MARPs were reported as often reluctant to disclose to counsellors their sexual orientation or their risky sexual behaviours. Providing CBCRT training to peer outreach workers familiar with working among MARPs may encourage disclosure of those behaviours and enhance the data collection process. However, since sex work and homosexual acts remain illegal it remains challenging to collect valid data on these behaviours.

If the CBCRT programme is rolled out according to plan, with the involvement of both the NAS and local service organisation, it has the potential to streamline HIV prevention activities in the country and to minimise duplication of services by various stakeholders. The CBCRT programme also has the potential to change people's attitudes towards HIV/AIDS and thus minimise stigma and discrimination towards PLHIV. A community-based change of this nature can lead to change in social norms to HIV testing so that people recognise the importance of knowing one's HIV status. The programme should have an impact at both community and at national level.

5 RECOMMENDATIONS

Getting Buy-in from stakeholders

In order for the CBCRT programme to move forward, it will be necessary to improve collaborations between the key stakeholders by increasing the participation of the NL and other relevant government sectors. Traditional service providers, i.e. laboratories, should not feel like their professional roles are being usurped and assigned to non-professionals, but should be made to understand the importance of decentralising skills and services into the community. These critical collaborations should be negotiated at the onset of the programme planning process.

Identifying adequate funding for the programme

It is necessary to plan ahead for programme funding, to know where the funds will come from before launching a nationwide programme such as the CBCRT. The government should also show long term financial commitment by allocating ring-fenced funding and planning for CBCRT over a number of years.

Quality assurance

Adequate supervision and monitoring of the CBCRT activities is needed, especially as it relies on fidelity to the protocol by trained laypersons. Monitoring systems for quality assurance should be in place for both counselling and rapid testing, including a systematic documentation of the quality assurance process.

Provision of psychosocial support for service providers

A good support system to help service providers deal with the stress of working in the HIV field should be put in place at all CBCRT sites. This psychosocial support can be provided either by a therapist who can be a clinical psychologist or an experienced senior counsellor. It is important for staff to have regular individual or group de-briefing sessions.

Annex: Interview Topic Guides

Interview Guide for MOH and other Stakeholders

This guide will be used to interview candidates involved in the planning and implementation of the CBCRT programme, such as, MOH, NAP, CHAA, IntraHealth and the Laboratories.

Introduction

My name is and I am working with CHAA, IntraHealth and UCSF to conduct a Case Study on the rolling out of the Community Based Counselling and Rapid Testing (CBCRT) programme for HIV prevention in Antigua.

The purpose of the interview is to determine your role in the planning and implementation of the CBCRT programme and to document your experiences and perceptions of the programme. We value your knowledge and insight into this important HIV prevention programme.

The strategic information gained through this interview will be used to enhance and strengthen the planning and implementation of the CBCRT programme in Antigua and also to provide best practices of the programme which can be replicated in other Eastern Caribbean countries.

CBCRT programme planning process

Which organisation do you represent and what is your position in the organisation?

What factors prompted the need to develop a CBCRT HIV prevention programme for MARPS in Antigua? Probe for public health needs of MARPS, National guidelines for HIV prevention in Antigua, etc.

Who did you or your organisation collaborate with in the planning of the CBCRT programme? Can you briefly tell us what role your collaborative partners played?

Which community stakeholders or special-interest groups were consulted in the planning process and how was the consultation process conducted, and by whom?

Can you tell us how you or your organisation got involved in the CBCRT programme and what role you played in the planning and implementation of the programme?

Probe for developing CBCRT model, setting timelines for trainings and programme implementation, identifying trainers, overseeing registration and certification of CBCRT sites, certification of counselors and testers, developing and/or approving rapid testing algorithm.

What challenges has your organisation encountered in the planning process of the CBCRT programme? What attempts are being made to resolve these challenges?

CBCRT Training program

What are your impressions of the CBCRT training programme? Probe for quality and relevance of training, including duration of trainings.

If you were to re-design the training programme, what aspects of the trainings would you change or improve?

Would you recommend any additional trainings? If yes, what trainings would you recommend and why?

Were you or your organisation involved in the identification of trainers and trainees? If, yes, what criteria was used to identify these incumbents?

CBCRT programme implementation

What support does your organisation provide to organisations that are implementing the CBCRT programme? Probe for management, technical and financial support, supplies, equipment, etc.

What support systems have been put in place to enhance the health and welfare of individuals who get tested for HIV at the CBCRT sites, irrespective of their HIV status?

Who is providing those support services and how accessible are the services to MARPS? Probe for referral systems

In your opinion, are the currently available support services meeting the needs of CBCRT clients? If there are shortcomings, what is your organisation doing to address these unmet needs?

What are people in the community saying about the services provided through the CBCRT programme? Probe for community stakeholders' expressed opinions of CBCRT, such as, acceptability, confidentiality, client satisfaction and stigma-related issues.

What are your perceptions of the CBCRT programme? Probe whether programme meets the needs of MARPS, whether it is responding to the HIV epidemic trends in Antigua, and etc.

What challenges has your organisation encountered in the implementation process of the CBCRT programme? What attempts are being made to resolve these challenges?

Supervision of CBCRT sites

What aspects of the CBCRT programme does your organisation oversee / monitor? Probe for frequency of supervision, and by whom

What monitoring systems has your organisation put in place to ensure high quality of services provided? Probe for staff performance levels. Probe for non-adherence to MOH guidelines by sites

How is the supervision process documented and by whom?

How are problem areas resolved?

Supply Chain *(Ask only if applicable to stakeholder)*

What supplies or equipment does your organisation provide to the CBCRT sites? Probe for rapid test kits, and other equipment?

How well is the supply chain working for your organisation? Probe for delays, shortages, receiving expired test kits, etc.

Based on your experiences, what inputs are required to implement a successful CBCRT programme? Probe for financial, human resources and technical inputs.

Tracking and Documentation of CBCRT programme services

What systems has your organisation put in place to track and document the CBCRT programme?

Which specific aspects of the programme are you tracking and documenting? Probe for service utilization, staff supervision and quality control, and client referrals.

What forms are being used to document these aspects of the programme? Ask to see a sample of the forms.

What do you do with the data that you collect from the CBCRT sites? Probe if it is submitted to the govt/MOH, or programme funders.

How does your organisation plan to utilize the data that you are collecting?

Decentralisation of CBCRT services

What do you consider to be the critical elements of decentralisation of HIV prevention programs, such as the CBCRT programme? Probe for level of collaboration with other stakeholders in the planning and implementation of the programme e.g. selection of testing sites, training,

Can you please share the lessons learnt from decentralisation, i.e. collaborating with Govt, private labs and NGO organisations?

In your opinion, what do you consider to be the advantages and disadvantages of decentralisation?

What areas could be improved, how?

Conclusion

What are your perceptions of the CBCRT programme? Please elaborate on your experiences in the planning and implementation of CBCRT programme, highlighting successes and challenges. What do you account for some of the successes?

What lessons learnt can you share with other stakeholders or EC countries who might be planning to implement the CBCRT program

From an organisational perspective, what would you recommend to organisations wishing to set up CBCRT services? Probe for aspects in both the planning and implementation process?

How do you see the CBCRT programme impacting on the National HIV response to HIV?

Thank you for your participation

Interview Guide for Peer Outreach Workers

This guide will be used to interview peer outreach workers (a.k.a. animators) who have undergone CBCRT training and are currently providing counselling and/or rapid testing services

Introduction

My name is and I am working with CHAA, IntraHealth and UCSF to conduct a Case Study on the rolling out of the Community Based Counselling and Rapid Testing (CBCRT) programme for HIV prevention in Antigua.

The purpose of the interview is to determine your role in the planning and implementation of the CBCRT programme and to document your experiences and perceptions of the programme. We value your knowledge and insight into this important HIV prevention programme.

The strategic information gained through this interview will be used to enhance and strengthen the planning and implementation of the CBCRT programme in Antigua and also to provide best practices of the programme which can be replicated in other Eastern Caribbean countries.

Participants Role in Organisation

What is your role in this organisation? Probe for how long participant has been working for the organisation and in what role i.e. counselling, HIV rapid testing or both.

What other HIV-related work have you done prior to joining this organisation? Probe for work experience as community outreach/ animator, counselor, etc.

Participants Trainings

What trainings have you received before CBCRT trainings? Probe for training in Basic HIV Counselling and any other semi-professional, or professional training.

What CBCRT-related trainings have you received? Ask participants to mention all the CBCRT trainings she has attended, when and where she/he was trained?

What are your perceptions of the CBCRT trainings? Probe for each of the trainings participant attended.

How do you think the training prepared you to do CBCRT?

Programme Implementation

What is the profile of your CBCRT clients? Probe for gender, age, sexual orientation, and place of origin i.e. local or from other islands.

On average, how many counselling sessions do you do a week?

How many HIV rapid tests do you do a week?

What are your busiest days, time of day, i.e. when you see more clients?

What are your perceptions of the CBCRT programme? Ask participant to elaborate on her/his experiences in providing CBCRT services.

What do you do to balance your personal/social life and your work as a CBCRT animator? (Probe for challenging situations).

What aspects of the CBCRT programme do you think are working well? Explain what makes those aspects work well?

What aspects of the programme do you like least? Probe for challenges and constraints encountered in implementing the programme. Are those challenges being addressed, by whom and how?

Client Referrals

What referrals do you do for your CBCRT clients and what resources are available in the Govt health care setting? Probe for access to ARVs, primary health care, other post-test support services and the Buddy support programme.

What other referral resources are available in the community? Probe for home based care (HBC) and support groups.

What special services are available in the community for PLWHA?

What other resources/referrals would you need to have in place that would facilitate your job on CBCRT?

Do these services meet the needs of PLWHA? If not, what other support services would you recommend and who would be the best organisations/partners to provide these services?

What do you do as an animator to make sure that you're the CBCRT clients you refer for treatment adhere to the treatment programme, i.e. ARVs? Have you encountered clients with adherence issues? If yes, what are the issues that may result in non-adherence?

What role can the CBCRT programme play to improve client adherence to treatment programs?

Supervision

What type of support / supervision do you receive from your employer/ programme manager for your job on CBCRT? Probe for observation sessions, de-briefing sessions, staff meetings.

Who supervises you, and how often?

What aspects of supervision and support would you like to see improved, and how? Probe for frequency of supervision.

What training have you received in support and supervision skills?

What additional trainings do you think you need in order to efficiently conduct counselling and/or rapid testing?

Client& Community perceptions of CBCRT services

From your perspective, how do clients perceive the CBCRT services that are provided by your organisation? Probe for testers' expressed opinions of CBCRT, i.e. acceptability, confidentiality, client satisfaction and stigma-related issues.

Has the Consent & Confidentiality (C&C) training and Stigma and Discrimination (S&D) training helped you to address S & D issues? Please provide examples of how these trainings have helped you to respond to these issues.

How does the community perceive you as a counselor? Probe for trust, confidentiality and respect by community members and by peers.

What are people in the community saying about the CBCRT programme?

What recommendations do you have to improve the CBCRT programme?

What lessons learnt would you share with other animators who might want to get involved in the CBCRT programme?

Thank you for your participation.

Interview Guide for Programme Managers

This guide will be used to interview managers/advisors/programme officers who oversee CBCRT programs at CBCRT sites, such as NAP, CHAA, Gender Affairs, Planned Parenthood, and private laboratories.

Introduction

My name is and I am working with CHAA, IntraHealth and UCSF to conduct a Case Study on the rolling out of the Community Based Counselling and Rapid Testing (CBCRT) programme for HIV prevention in Antigua.

The purpose of the interview is to determine your role in the planning and implementation of the CBCRT programme and to document your experiences and perceptions of the programme. We value your knowledge and insight into this important HIV prevention programme.

The strategic information gained through this interview will be used to enhance and strengthen the planning and implementation of the CBCRT programme in Antigua and also to provide best practices of the programme which can be replicated in other Eastern Caribbean countries.

Programme Manager's Role in the Organisation

Which organisation do you represent and what is your position or role in the organisation?

What services/ programs does your organisation provide in this community, besides CBRT?

Which communities or sub-populations does your organisation serve?

Can you tell us how your organisation got involved in the CBCRT programme? Probe for how the organisation was identified to participate as a CBCRT site?

How long has your organisation been participating in the CBCRT programme, i.e. when was the CBCRT programme implemented?

Staff training

Did you participate in the CBCRT trainings? If yes, which trainings did you attend? Probe if he/she participated as an observer or a trainee.

How many of your staff have received CBCRT trainings? What trainings, where and when did they get trained?

How were your staff identified and selected for CBCRT training? What criteria were used? Probe for required minimum education and work experience.

What aspects of CBCRT do your animators provide, i.e. counselling, rapid testing or both?

Is there any additional training you think your staff requires? If yes, what trainings would you recommend?

Are there plans to provide refresher trainings to the animators? Who would provide the refresher trainings?

Did the CBCRT trainings meet your expectations as a programme manager? Can you elaborate on your expectations, highlighting which aspects were fulfilled or not fulfilled?

How has the CBCRT training impacted your organisation? Ask if trainings have helped the organisation provide better services or helped provide new skills for the organisation.

Programme implementation

Please elaborate what steps your organisation has taken to set up CBCRT services, such as identification of site, registration and certification of the testing site, certification of counselors and rapid testers? What challenges have you encountered in this process and how have these been resolved? What other issues still need to be resolved?

What is the profile of your CBCRT clients? Probe for gender, age, sexual orientation, and place of origin i.e. local or from other islands.

Which days of the week do you see most clients? What time of the day are you most busy?

Which MARPS groups utilize your services the most?

What strategies has your organisation introduced to create awareness of CBCRT services among MARPS and in the general community?

Has your organisation experienced any challenges and constraints in the planning and implementation process? How is your organisation addressing those challenges?

Has your organisation adapted any aspects of the CBCRT programme to suit, your client needs, your site location, or your organisation structure and mandate? Please elaborate on the adaptations that have been made.

Supervision and Quality Control

What monitoring systems do you have in place to ensure high quality of counselling and rapid testing services, i.e. quality control procedures for proficiency? Probe for staff supervision strategies and frequency of supervision, proficiency monitoring systems.

Who provides supervision and monitoring services? Probe for both internal and external supervision such as central lab and private lab

What strategies do you have in place to correct animators who deviate from the counselling and rapid testing protocols? Probe for retraining, increased supervision, etc.

What additional supervision strategies would you like to see in place for both counselors and rapid testers? Who would be the ideal persons to provide this supervision and how frequently?

What would be the ideal staff complement for your organisation that would enable you to provide CBCRT services effectively? Probe for ideal number of counselors and rapid testers.

Supply Chain

Who supplies your organisation with counselling and rapid testing kits, including equipments? How well is the supply chain working for your organisation? Probe for delays, shortages, receiving expired test kits, etc.

Based on your experiences, what inputs are required to implement a successful CBCRT programme? Probe for financial, human resources and technical inputs.

Client Referrals

What referral resources are available in the community for CBCRT clients after testing? Probe for access to ARVs, primary health care, home based care support groups and other post-test support services.

In your opinion, are there adequate support services for PLWHA in the community? If not, what other support services would you recommend and who would be the best partners to provide these support services?

Tracking and Documentation of CBCRT programme services

Which aspects of the CBCRT programme are you tracking and documenting? Probe for service utilization, staff supervision and client referrals.

What forms are you using to document the services? Ask to see a sample of the forms.

What do you do with the data that you collect from your CBCRT sites? Probe if it is submitted to the govt/MOH, or programme funders. What is the data used for?

Client & Community perceptions of CBCRT services

From your perspective, how do clients perceive the CBCRT services that are provided by your organisation? Probe for testers' expressed opinions of CBCRT, i.e. acceptability, confidentiality, client satisfaction and stigma-related issues.

Has the Consent & Confidentiality (C&C) training and Stigma and Discrimination (S&D) training helped your staff (counselors and testers) address S & D issues? Please provide examples of how these trainings have helped them to respond to these issues.

How does the community perceive your CBCRT programme? Probe for trust, acceptability, confidentiality, client satisfaction and stigma-related issues. Also probe for community stakeholders' expressed opinions of the CBCRT programme.

Conclusion

What are your perceptions of the CBCRT programme? Please elaborate on your experiences in the planning and implementation of CBCRT programme highlighting successes and challenges.

What do you consider as successes and main achievements of the CBCRT programme? What do you account for those successes?

What lessons learnt from planning and implementing the CBCRT programme can you share with other programme planners who might want to implement the CBCRT programme?

If you had to do this all over again (planning for implementation of CBCRT), what would you change or do better?

From a manager's perspective, what would you recommend to organisations wishing to set up CBCRT services?

How do you see the CBCRT programme impacting on the National HIV response to HIV?

Thank you for your participation

Interview Guide for Trainers

This guide will be used to interview persons who were involved in planning and implementing CBCRT trainings, such as, CDC, MOH and Consultant Trainers.

Introduction

My name is and I am working with CHAA, IntraHealth and UCSF to conduct a Case Study on the rolling out of the Community Based Counselling and Rapid Testing (CBCRT) programme for HIV prevention in Antigua.

The purpose of the interview is to determine your role in the planning and implementation of the CBCRT programme and to document your experiences and perceptions of the programme. We value your knowledge and insight into this important HIV prevention programme.

The strategic information gained through this interview will be used to enhance and strengthen the planning and implementation of the CBCRT programme in Antigua and also to provide best practices of the programme which can be replicated in other Eastern Caribbean countries.

Which organisation do you represent and what is your position or role in the organisation?

What aspects of the CBCRT/CBCT training did your organisation provide in Antigua and what was your role in the training programme?

How did you or your organisation, or yourself, get involved in the CBCRT/CBCT training?

What was the planning process for the CBCRT training? Who were your partners?

What in-country approval processes were you required to complete during the planning process prior to the training?

How were the trainees selected and by whom? Probe if trainer was involved in the selection and what criteria were used.

Can you elaborate on the objectives of the CBCRT/CBCT training programme?

What training strategies and training models did you use for your trainings? Probe for training manuals and training techniques.

What was the duration of your training? Do you feel that this was adequate? If not, how many days would be ideal?

Can you elaborate on the type of exams the trainees took and the certification process?

Did the trainees' results reflect an understanding of the elements of the training? If not, please elaborate which aspects were not well understood and how the training could be improved to enhance the trainees' understanding?

What challenges and constraints were experienced during your training (by the trainees or by you)? How were these challenges addressed?

What evaluation tools did you use for your training? Probe for pre/post training evaluations.

In your opinion, do CBCRT animators need any additional trainings to equip them with adequate skills to provide CBCRT? If yes, what trainings would you recommend?

Can you share any lessons learnt from planning and implementing the CBCRT trainings?

In your opinion as a trainer, which aspects of your training can be replicated in other settings, i.e. other EC countries?

What areas of your training would you recommend to be adapted for use in other EC countries?

Thank you for your participation

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