

counseled: 31,675 (98.3%) people were counseled, voluntarily tested and received their results – the government facilities reported that 65% of those counseled were tested but it is not clear how many got results. Of all clients tested, only 4 (0.01%) had indeterminate results (confirmed with other tests). This data has helped in evaluating the efficacy of testing algorithms at the ANGAZA VCT sites. Due to a variety of biological but especially socio-economic and cultural factors, women are at least two times more likely to become infected with HIV than men of the same age. With more than 36% of Tanzanians living on less than a dollar a day, the extreme poverty hinders many Tanzanians but especially women and young people from accessing HIV/AIDS preventative or care and support services and commodities. Demonstrating the link between poverty and especially gender based poverty and HIV/AIDS will inform future campaigns under the ANGAZA VCT programme.

- d) Underlying gender disparities have been uncovered: Among first users, there have been more males (53.9%) than females (46.1%). In addition, HIV prevalence among male first users is 7.6% but 18.2% among first female users.
- e) Possible risk of sero-conversion during the window period has been documented: Of 3,998 or 12.4% (2,922 males and 1,076 females) tested in 2002 who returned for a second test, 1.6% of them had become positive. The women were twice as likely to become positive during this period. These data are important to other health care services, especially blood transfusion services that use the same kind of tests as ANGAZA to test their blood prior to transfusion.

Challenges:

Linking other programmes to the already established VCT sites is increasingly necessary. Without adequate care and support especially for those who test positive, VCT alone may not be a sustainable option and its utilization could decline. For this reason, a home-based palliative care approach is planned at some sites to examine sustainable models.

Conclusion:

The success registered in first year of the project emphasizes the need for quality in the provision of VCT. It is also clear that quality can only be provided under specific settings. The project has also demonstrated the important role that VCT plays as an entry point to many other HIV/AIDS interventions.

References:

1. TDHS (1996)
2. Voluntary counselling and testing: consumer baseline survey report (October 2001)

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The African Medical and Research Foundation

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Enhancing HIV Voluntary Counselling and Testing

Experiences and lessons learned from the AMREF “ANGAZA” Initiative. Tanzania.

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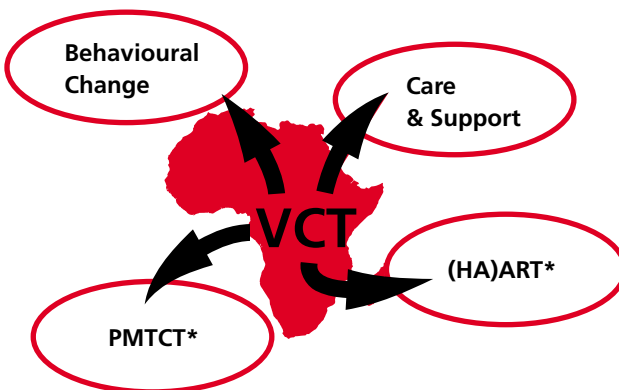
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Background

Tanzania is among the most HIV/AIDS-affected countries in sub Saharan Africa with an estimated prevalence of 12-13% among sexually active adults and with more than 2 million people currently living with HIV/AIDS.

Voluntary counselling and testing (VCT) provides an entry point to other HIV/AIDS prevention, treatment, care and support strategies. Documented evidence shows that (VCT) is also a cost effective, and yet feasible strategy in developing countries as a means of intervening in the spread of HIV/AIDS.



*PMTCT: Prevention of Mother-to-Child Transmission
*HAART: Highly Active Anti-retroviral Treatment

Why an AMREF response:

AMREF established a VCT programme in response to an unmet need. The 1996 Demographic and Health Survey (TDHS) had shown that up to 66% of Tanzanians wanted to know their HIV status and yet only 1% of the general population actually knew. Worse still, only one out of nine infected people actually knew. VCT service utilisation remained extremely low. An AMREF baseline survey in October 2001 showed that up to 88% of Tanzanians would go for an HIV test if there were a service available and they knew where to go. Affordability was also an issue for many, especially young people

At the same time, the high stigma that people associate with HIV/AIDS is a major hindrance to VCT utilisation. Therefore a person's wish to know their HIV status may not necessarily translate into an actual visit to a VCT centre. As a result, an innovative approach was necessary to increase VCT utilisation.

Enhancing VCT

The ANGAZA¹ VCT programme funded by USAID began in April 2001 and will continue for at least three years. The program aims to enhance VCT through:

- Developing the capacity of public and voluntary sectors to provide VCT
- Creating and sustaining demand for VCT

Developing and establishing continuous quality improvement systems for VCT

Approaches used to achieve the objectives:

- 1. Capacity building**
 - New training curricula/manuals were developed because of a lack of consistency in content, length or quality of existing training programmes.
 - In the first year 88 VCT counsellors, 7 VCT site managers, 4 lab technicians and 7 receptionists were trained.
 - Two private companies and five NGOs received technical assistance to improve their own VCT services.
 - Government structures were strengthened to enable them to supervise VCT within their own district health systems

2. Creating and sustaining demand

- Social marketing of the VCT idea was applied using private sector models.
 - A consumer survey was carried out to inform a communication strategy
 - The communication strategy was developed under the ANGAZA title, and the same strategy now informs the government's own strategy for HIV/AIDS
 - Mass media: The ANGAZA VCT is clearly branded, a high profile launch is conducted at the opening of every new ANGAZA VCT site, different types of promotional materials including fliers, T-shirts, caps etc, are distributed, billboards are located at strategic locations in program areas, TV and radio presentations and talk shows are regularly broadcast.
 - An ANGAZA website has been launched on the internet for free access to VCT and HIV information (www.angaza-vct.org).

Addressing the wider needs of people who test positive for HIV, a network of providers of care and support has been established at every ANGAZA site to facilitate referrals of VCT clients. Information on referrals are some of the data collected routinely to guide the management of the networks.

Post test clubs will soon be established. The model for post test clubs has been worked out. For HIV negative clients, post test clubs will focus on staying HIV negative through the use of peer support and life skills. For HIV positive clients, peer support and living positively will be the main focus.

3. Developing and sustaining quality improvement systems

Standards setting: AMREF has designed and established standards for the delivery of quality VCT. The standards concern the infrastructure for VCT services, the number and skills of human resources, the quality and quantity of equipment. A definition of quality at the ANGAZA sites include – accuracy of results, affordability of the service, same day results, friendliness and empathy in service delivery, confidentiality and privacy of the results and the client. Data-based monitoring is emphasised: Data is collected through routine data targeting all aspects of program inputs, outputs and processes. Program data is computerised and easily accessible.

- Quality assurance systems for both counselling and testing are established. Apart from routine data and other ad-hoc surveys, routine supervision collects data on quality of service delivery.
- Counsellors and other service providers meet once in two weeks to discuss their experiences and support each other. Self-support is important to prevent counsellor burnout, a well documented and frequent occurrence among VCT counsellors.
- Regular supportive supervision of counsellors ensures quality of counselling sessions are maintained and burnout is minimised.
- Exit interviews and mystery (dummy) client surveys have been done twice to measure client satisfaction.
- Blood samples are delivered to the central AMREF laboratory from all ANGAZA sites for quality control (The AMREF laboratory also provides quality control for the majority of public hospitals in Tanzania – a national equivalent should be used if possible.)
- The AMREF laboratory evaluates new HIV rapid test kits before they are approved by government for use in the country – two such tests have been evaluated in the past one year.
- Work has been initiated to link VCT management and quality assurance in district supervisory systems. AMREF has started with sensitising and building a partnership with districts to achieve this objective.
- Cost effective analysis of the program is planned in the coming months

4. Various models of VCT service set-ups are being evaluated:

Although the models are still being evaluated, preliminary data shows that:

- Stand-alone sites are used heavily and attract clients from the general population. The HIV positivity among clients visiting stand-alone VCT sites reflects the rates estimated for the general population – about 11-13%. In addition, stand-alone sites do not discourage clients from attendance as would be expected because of the high degree of stigma and discrimination associated with HIV. There are at least twice as many clients attending stand-alone sites as integrated sites.
- Integrated sites (sites linked to medical services/facilities) tend to attract clients with a higher rate of HIV infection – probably many are patients who already have a high suspicion of being infected.
- Public (government) sites experience huge management challenges and tend to require much more management support as compared to NGO or private sites. They tend to be less flexible and less responsive when clients come in large numbers. In addition, the hierarchical and bureaucratic supervisory mechanisms are de-motivators to service providers.
- The youth prefer their own sites and use is much greater where VCT is designed for them specifically. However, the youth are also price sensitive, responding mostly to free services.
- According to client satisfaction surveys, the \$1 equivalent that adults (above 24 years) pay for VCT at the ANGAZA sites is not a hindrance to use.

The Outcomes and lessons learned:

The Outcomes and lessons learned:

The program is grounded in good data for program management but also for the documentation of results and lessons learned:

- Capacity has been (and continues to be) created: Up to a year ago, Tanzania had less than 20 counselors professionally trained to provide VCT. ANGAZA has trained not only 88 counselors in one year but also lab technologists, VCT program managers and receptionists. ANGAZA has shown that all VCT site staff must be caring and sensitive to users.
- A consumer-based, attractive and high profile launch has created enormous demand. A total number of 32,224 first time users attended the seven ANGAZA VCT sites in six months compared to only 11,000 in all of Tanzania during the entire year of 2002. At project design, it was expected that each VCT site would see not more than 100 clients in a month. This figure has been exceeded by 6 to 10 times in all the 7 ANGAZA VCT sites. Luckily, additional resources were quickly mobilized from the donor to meet the demand.
- Clients must be assured of confidentiality, caring and a guarantee that they will receive test results and be

¹ ANGAZA is a Swahili word for “Shed light on”