Background

HIV testing and counseling (HTC) is part of the World Health Organization’s (WHO) recommended minimum package of services for Voluntary Medical Male Circumcision (VMMC) (WHO, 2007). HTC is clinically relevant for HIV-positive patients with low CD4 counts, as it may be beneficial for these patients to forego VMMC services. It is also a critical way to ensure counseling on abstinence during the period after VMMC to prevent subsequent transmission by clients who test positive. By including HTC as a component of VMMC services, more men may be reached with testing services in the 14 priority countries selected for scale-up of VMMC in Eastern and Southern Africa. Despite support for the integration of these two services, there exists a gap in documentation of how integration is implemented in practice, and the challenges this may present for counseling and the efficient implementation of VMMC services.

In this study, current practices for the integration of HTC/VMMC, and mechanisms to support quality, efficiency, and linkages between services are examined in Tanzania as a means of addressing this gap. Study sites included the Iringa and Njombe regions of Tanzania, which have significantly higher HIV prevalence rates compared to the rest of the country.

Key Findings

Protocols and practices for HTC at VMMC service sites

In the Iringa and Njombe regions of Tanzania, VMMC services are offered through fixed and outreach service delivery models. Outreach sites usually operate during periods referred to as “VMMC campaigns,” when demand creation activities (radio advertisements, peer education, etc.) are conducted to motivate men to seek VMMC services. Across outreach sites, there are large differences in the client load. In this analysis we compared fixed sites, with outreach sites that had both high and low client loads.

The protocol for the provision of HTC/VMMC counseling is the same at all sites. Clients are registered upon entrance to the facility and then move through a series of four counseling stations (usually facilitated by nurses): group, individual, post-operative, and 48-hour follow-up counseling. During these sessions, information about HIV testing and VMMC services is delivered using standardized visual aids. All sites performed well in relation to critical criteria that evaluated the adequacy of existing structures and key processes to support the provision of HTC, with scores ranging from 86-96 out of a possible 100.

Quality of counseling

In terms of consent, a provider explained that the test is optional in 66% of observations, and that a client who declines the test can still get circumcised in 59% of observations. In 65% of observations, all counselors who attended to the client showed respect for confidentiality and privacy. This was more likely for clients at OL (87%) sites compared to fixed (56%) or OH sites (58%). In 66% of all observations, the provider explained that the test was confidential. This also happened more often in OL sites (57%) compared to fixed (38%) or OH sites (23%), although the difference was not statistically significant.

In addition to observing consent and confidentiality, a composite measure of quality was constructed to include three domains of counseling: information about HIV prevention, information about HIV testing, and interpersonal skill. “Outreach Low” (OL) sites had the highest overall quality mean score of all service provision models, and a statistically significantly higher overall quality mean score when compared to fixed sites (OL 0.46 vs. fixed 0.38). When assessing quality by counseling type, OL sites had higher overall quality mean scores for all counseling ses-
Efficiency of service delivery

The average total time spent at the VMMC site on the day of the circumcision procedure for all clients across study sites was 216.4 minutes (3.6 hours), starting from when the client arrived at the clinic to the end of their post-operative counseling. The duration of time was trending towards being statistically significantly (p<0.10) longer at “Outreach High” (OH) sites compared to fixed sites (222.1 minutes vs. 208.5 minutes).

In general, longer counseling sessions had a higher quality score. For example, average time in minutes of group counseling was 36.1 minutes for clients receiving the highest quality, 34.6 minutes for clients receiving medium quality, and 25.2 minutes for clients receiving lower quality. This difference was statistically significant for clients receiving high vs. low quality (p<0.01). This same pattern was observed for individual and 48-hour follow-up counseling, but not post-operative counseling.

Client outcomes in relation to quality and efficiency

Uptake of HIV testing was high: only 7% of the VMMC clients surveyed declined to take the HIV test. The most important reasons for not testing among these participants were having previously tested and knowing their HIV status (n=10), and not being prepared to test for HIV on the day of VMMC (n=4). All six clients who tested positive for HIV were linked to care and treatment services by counselors. In half of these cases, the counselor introduced the client to the provider that they were referred to, or set up a time to do so.

Client satisfaction was also high, with 100% of clients reporting to “agree” or “strongly agree” that they would recommend both the facility they visited and the counselors they saw to friends. The overall client satisfaction score was highest among OL sites (mean=3.8, p<.01), followed by OH sites (mean=3.6, p<.05) as compared to fixed sites (mean=3.5).

Higher quality counseling was related to greater retention of HIV prevention information. Clients at OL sites also demonstrated greater retention of HIV prevention information than clients at fixed sites (p<.05). Repeated messaging (e.g., across multiple counseling stations) was beneficial for retention of the message about partial protection of MC.
CONCLUSION
It is feasible to achieve quality counseling and efficient service delivery for provider-initiated testing and counseling in the context of VMMC. Quality is most likely to be achieved in outreach settings with low client loads where the client load allows for sufficient duration of counseling sessions. Quality counseling can achieve higher client retention of HIV prevention knowledge. It is particularly important to ensure that consent and confidentiality for HIV testing are maintained in the VMMC context—there is room for improvement in this area. There is a need for a revised referral system in the HIV service system as a whole. Referrals for HIV prevention services for HIV-negative clients in addition to counseling and testing for people living with HIV should be emphasized as important, especially referrals from HTC to VMMC services. Changes to the referral system, including the movement towards shared confidentiality, are needed and should be informed by providers already implementing innovative strategies to serve their clients.

RECOMMENDATIONS

Programmatic and policy recommendations
• Increase the number of key personnel at outreach high sites
• Emphasize consent and confidentiality in counselor trainings
• Provide ongoing education and information about VMMC to HTC providers outside the VMMC program
• Revise policies and establish a formal system to support referrals
• Provide counselors with specific and up-to-date information about accessible HIV services
• Ensure a continuous supply of HIV test kits
• Provide repeated messaging through sequential counseling stations

Research recommendations
• Establish definitions of “referrals” from both client and provider perspectives
• Explore a contextually appropriate mechanism for obtaining consent
• Determine the effect of provider-initiated testing and counseling /VMMC integration on future testing behavior
• Examine the potential for HTC to deter VMMC clients who do not wish to test for HIV

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