Voluntary Counseling and Testing: A Reference Guide

Responding to the Needs of Young People, Children, Pregnant Women and Their Partners

December 2001
# TABLE OF CONTENTS

GLOSSARY OF ABBREVIATIONS, TERMS AND DEFINITIONS ........................................ 3  
ACKNOWLEDGMENTS .................................................................................................. 5  
INTRODUCTION .......................................................................................................... 6  

BACKGROUND ........................................................................................................... 7  

SECTION 1: YOUNG PEOPLE AND VCT ................................................................. 13  
1. Young People and HIV Prevalence ................................................................. 13  
1.1: HIV Risk Factors Specific for Young People ............................................... 14  
1.2: Health-seeking Behavior ............................................................................... 16  

2. VCT and Subgroups of Young People ............................................................... 17  
2.1: Vulnerable and “At-risk” Young People ....................................................... 17  
2.2: Injecting Drugs Users .................................................................................. 17  
2.3: Uniformed Services ..................................................................................... 18  
2.4: Young Men Who Have Sex with Men ......................................................... 18  
2.5: Young People with Learning Disabilities .................................................... 18  
2.6: Hemophiliacs .............................................................................................. 19  

3. Approaches/Models for Counseling and VCT for Young People ................. 21  
3.1: Integrated VCT ............................................................................................ 21  
3.2: Tuberculosis and Antiretroviral (ARV) Service Access ............................. 26  
3.3: Free-standing VCT Services ...................................................................... 26  
3.4: Youth Clubs and Centers .......................................................................... 28  
3.5: Mobile VCT Services ................................................................................. 30  
3.6: Outreach ...................................................................................................... 31  
3.7: Social Marketing .......................................................................................... 32  
3.8: Home Testing .............................................................................................. 34  
3.9: Private Sector .............................................................................................. 35  

4. Factors Affecting Demand and Uptake of VCT among Young People ..... 35  
4.1: Attitude toward and Demand for VCT ....................................................... 35  
4.2: Uptake of VCT ............................................................................................. 36  
4.3: Motivation for VCT ..................................................................................... 37  
4.4: Return Rates (for HIV Test Result) ............................................................. 37  
4.5: Barriers to VCT .......................................................................................... 38  

5. Outcomes for Young People following VCT .................................................. 42  
5.1: Sexual Behavior Change following VCT .................................................... 42  
5.2: Access to Care for Young People ............................................................... 43  
5.3: Coping ....................................................................................................... 43  
5.4: Adverse Consequences following VCT and Disclosure ........................... 44  

6. Legal Issues ...................................................................................................... 44  

7. Challenges ......................................................................................................... 46
7.1: Summary of Issues to Consider for Acceptable and Ethical VCT for Young People ................................................................. 46
7.2: Approaches for Involving Young People in Design, Development and Promotion of VCT Services ................................................. 47
7.3: Availability of Ongoing Emotional and Support Services ................. 47
7.4: Access to Medical and HIV Preventative Care ................................ 47
7.5: Different Needs of Young Men and Young Women ............................. 48
7.6: Pre-marital Counseling (Legal and Religious Requirements) ............. 48
7.7: Mandatory Testing ............................................................................. 49
7.8: Outcomes of Young People following VCT ....................................... 50
7.9: Young Women and Violence................................................................. 51
7.10: Counselors for Young People ......................................................... 51
7.11: Peer Counselors versus Peer Educators .......................................... 52
7.12: Access to Health Education/Information/Skills Building
Outside of VCT ......................................................................................... 53

SECTION 2: INFANTS, CHILDREN AND VCT ...................................................... 60

1: Motivation for Testing a Child............................................................... 60
2: Consent ............................................................................................... 60
3: Policy Frameworks .............................................................................. 61
4: Infant and Child Diagnosis ................................................................. 62
5: Stigma ................................................................................................. 65
6: Training of Health Care Providers and Counselors ............................. 66
7: Challenges in Implementing Child Counseling Training ...................... 67
8: Linkages across Service Providers ...................................................... 67
9: Service Provider Supervision and Support ......................................... 67
10: Inadequate Cadres of Higher-level Providers Versed in Addressing the Psychosocial Needs of Children ........................................... 68
11: (V)CT for Symptomatic Children and Their Parents or Guardians ....... 68
12: Intergenerational Communication Initiatives and Skills Building ......... 69
13: Counseling and Support for Orphans and Vulnerable Children ........... 70
14: Counseling and/or VCT for Children Who Have Experienced Sexual Abuse .................................................................................. 72
15: Counseling for Parents as Part of HIV Diagnosis for Infants
Born to Mothers with HIV, including following PMTCT Interventions ......... 74

SECTION 3: VCT SERVICES FOR PREGNANT WOMEN AND THEIR PARTNERS .......................................................................................... 76

1: Background .......................................................................................... 76
2: Approaches to VCT in the Antenatal Setting ......................................... 78
3: Challenges to the Provision of VCT in Antenatal Settings ................. 86

APPENDIX: COST FACTORS FOR VCT .......................................................... 103
REFERENCES ................................................................................................ 105

GLOSSARY OF ABBREVIATIONS, TERMS AND DEFINITIONS
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>Acquired immunodeficiency syndrome</td>
</tr>
<tr>
<td>ANC</td>
<td>Antenatal clinic</td>
</tr>
<tr>
<td>ANONYMOUS TESTING</td>
<td>The specimen is labeled with a code without a name or identifiers that could reveal the person’s identity. Limited demographic information is obtained and no identifying documentation is recorded.</td>
</tr>
<tr>
<td>ARV</td>
<td>Antiretroviral</td>
</tr>
<tr>
<td>BCC</td>
<td>Behavior-change communication</td>
</tr>
<tr>
<td>CBO</td>
<td>Community-based organization</td>
</tr>
<tr>
<td>CONFIDENTIAL TESTING</td>
<td>A person agrees to have an HIV antibody test with the assurance that the test result will be kept confidential and only selected health care providers may be informed. This method allows for the collection of more detailed and in some cases, identifying information (such as name and/or contact details) to be obtained with the client’s consent.</td>
</tr>
<tr>
<td>EIE</td>
<td>Information, education and communication</td>
</tr>
<tr>
<td>EGPAF</td>
<td>Elizabeth Glaser Pediatric AIDS Foundation</td>
</tr>
<tr>
<td>ELISA</td>
<td>Enzyme-linked immunosorbant assay</td>
</tr>
<tr>
<td>FHI</td>
<td>Family Health International</td>
</tr>
<tr>
<td>FP</td>
<td>Family planning</td>
</tr>
<tr>
<td>HIV</td>
<td>Human immunodeficiency virus</td>
</tr>
<tr>
<td>IDU</td>
<td>Injecting drug user</td>
</tr>
<tr>
<td>LIFE SKILLS</td>
<td>Life skills is a term used to describe the particular type of psychosocial and interpersonal skills addressed in skills-based health education, along with knowledge and attitudes.</td>
</tr>
<tr>
<td>MCH</td>
<td>Maternal and child health</td>
</tr>
<tr>
<td>MSM</td>
<td>Men who have sex with men</td>
</tr>
<tr>
<td>MTCT</td>
<td>Mother-to-child transmission: Transmission of HIV to a child from an HIV-positive woman during pregnancy, delivery or breastfeeding. The more technical term is vertical transmission. Use of the term MTCT does not imply blame whether or not a woman is aware of her own infection status. A woman can acquire HIV through unprotected sex with an infected partner, through receiving contaminated blood or through unsterile instruments or medical procedures. However, HIV may possibly be introduced into the family through the woman’s sexual partner</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-governmental organization</td>
</tr>
<tr>
<td>NVP</td>
<td>Nevirapine</td>
</tr>
<tr>
<td>OIs</td>
<td>Opportunistic Infections</td>
</tr>
<tr>
<td>OVC</td>
<td>Orphans and vulnerable children</td>
</tr>
<tr>
<td>PCR</td>
<td>Polymerase chain reaction</td>
</tr>
<tr>
<td>PLHA</td>
<td>Person living with HIV or AIDS</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention of mother-to-child transmission</td>
</tr>
<tr>
<td>SRH</td>
<td>Sexual and reproductive health</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually transmitted infection</td>
</tr>
<tr>
<td>SW</td>
<td>Sex worker</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>TBA</td>
<td>Traditional birth attendant</td>
</tr>
<tr>
<td>TOP</td>
<td>Termination of pregnancy</td>
</tr>
</tbody>
</table>
**VCT**  Voluntary counseling and testing: HIV testing with pre- and post-testing counseling, which is voluntary, with fully informed consent and confidential. This means the same as the term voluntary and confidential counseling and testing (VCCT).

**YFHS**  Youth-friendly health services

**ZDV**  Zidovudine, an antiretroviral drug, also known as AZT, a nucleoside reverse transcriptase inhibitor

### DEFINITIONS

<table>
<thead>
<tr>
<th>Definition</th>
<th>Age Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescent</td>
<td>10-19 years</td>
</tr>
<tr>
<td>Youth</td>
<td>10-24 years</td>
</tr>
<tr>
<td>Young person</td>
<td>15-24 years</td>
</tr>
<tr>
<td>Infant</td>
<td>0-2 years</td>
</tr>
<tr>
<td>Child</td>
<td>&lt; 15 years</td>
</tr>
<tr>
<td>Pregnant woman</td>
<td>May be in categories described as adolescent, youth and extending up to age 49 years.</td>
</tr>
</tbody>
</table>
ACKNOWLEDGMENTS

This document was written by Deborah Boswell (FHI) in collaboration with Rachel Baggaley (Consultant).

Invaluable consultative support and wisdom were provided by:

Dr. Eric Van Praag (FHI), Dr. Claudes Kamenga (FHI), Dr. Gloria Sangiwa (FHI), Dr. Gina Dallabetta (FHI), Ann McCarley (Horizons), Dr. Dirk Buyse (EGPAF), Dr. Nathan Schaffer (CDC), Dr. Donna Futterman (Montifiore Medical Center), Dr. Doreen Mulenga (UNICEF), Nicola Bull (UNICEF), Mark Connelly (UNICEF), Amaya Gillespie (UNICEF), Dr. Matthew Hodge (UNICEF), Kristina Noggaard (UNICEF), Kathleen Casey (WHO), Julitta Onabanjo (UNFPA), Dr. Ninad Desai (BPAN) and Peter McDermott (USAID).

Sincere gratitude must be expressed to many other colleagues, including those in the field who took time out of their busy schedules to share the fruits of their labor:

Peggy Henderson (UNICEF), Cecilia Rachier (KAPC), Dr. Bhanva Patel (PAWC South Africa), Mags Beksinska (RHRU), Dr. Buhle Ncube (PSI ZIMBABWE), Andrew Boner (PSI ZIMBABWE), Catherine Sozi (UNAIDS), Dr. Chewe Luo (UNICEF), Dr. Connie Osborne (UNAIDS), Lisa Simutami (PSI RWANDA), Georgina Mutale (Kara Counselling and Training Trust), Sheila Dutta (World Bank), Prue Borthwick (UNICEF), Amanda Kruger (LifeLine/Childline Namibia), Dr. Robert Thomson (WHO), Mary Henderson (WHO), Susan Allen (University of Alabama), Monica Fitzgerald (Maryland Department of Health and Mental Hygiene, UJIMA Project), Thomas Liang (Maryland Department of Health and Mental Hygiene, UJIMA Project), Jane Chege (Population Council), Enous Chang’ana Nkhoma (Central Hospital, Malawi), Prawate Tantiwatunuskul (Department of Mental Health, Thailand), Chris McLanachan (International AIDS Alliance), Robert Magnani (Tulane University), Tammy Moody (Firelight Foundation) and Elisabeth Preble (Consultant).

Thanks are also due to Wesen Kifetew, Tiffany Lefevre, Gretl Cox and Robert Ritzenthaler for their editorial and administrative assistance.

For further information, please contact:

Family Health International (FHI)  UNICEF
2101 Wilson Boulevard, Suite 700  UNICEF House, 3 United Nations Plaza
Arlington, VA 22201 USA  New York, NY 10017 USA
Phone: 703-516-9779  Phone: 212-326-7000
Fax: 703-516-9781  Fax: 212-887-7465
www.fhi.org  www.unicef.org
INTRODUCTION

The psychosocial needs of young people and children in relation to HIV/AIDS have been sadly neglected to date. There is a paucity of experiences and practical documentation from non-industrialized countries to further inform programming. However, there is need for immediate action.

Young people are the hope for the future. Young people, however, remain vulnerable as a result of HIV/AIDS. Their vulnerability is perpetuated by social, cultural and biological factors. Orphans and vulnerable children (OVC) attempt to survive often in the absence of adequate parenting and psychosocial support to address the multiple losses occurring in their lives. In addition, the field has realized that children and young people with HIV/AIDS are living longer than had previously been anticipated. The need for counseling and other interventions that adequately respond to the psychosocial needs of young people and children are crucial. This is a major necessary investment in addition to voluntary counseling and testing (VCT) services.

It is not possible to provide instant prescriptions on how to address the numerous controversial and ethical complexities related to the provision of VCT and counseling for young people and children, as well as VCT for pregnant women and their partners. There will be need for further learning by doing and expanded partnerships in action.

Furthermore, program managers have a pivotal role to play in advocacy for addressing the psychosocial needs of young people and children within family and community contexts. It will be important to ensure that these needs are not addressed in isolation. VCT is part of a package, and more general needs of young people, children, families and couples will also require address, as will clinical management needs and the range of programs to be covered under the prevention of mother-to-child transmission (PMTCT). Further attempts to deconstruct programs must be discouraged. Communication strategies and materials that relate only to VCT, PMTCT, antiretroviral (ARV) drugs or stigma without consideration or speaking to the related themes will quickly become obsolete, as they do not correspond with the field reality.

The purpose of this document is to provide guidance for program managers who are planning, implementing and monitoring the development and scaling up of:

- VCT and counseling for young people (15-24 years), **Section 1**;
- VCT-related issues for children (<15 years) and infants (0-2 years), **Section 2**;
- VCT for pregnant women and their partners in association with PMTCT interventions, **Section 3**.

The document includes a discussion of the rationale for VCT and a description of VCT approaches for each group. Guidance on the factors and issues to consider has been included to assist program managers to plan and strategize according to their individual country context in relationship to governing bodies and the infrastructure available. The challenges in developing and scaling up VCT services have been considered and practical recommendations have been made. *It is hoped that the document will provide guidance on how to move forward in order to service the VCT-related needs of young people, children, pregnant women and their partners in a meaningful manner.*
BACKGROUND

1. The Importance of VCT for Young People

Many approaches to HIV prevention and care require people to know their HIV status. High-quality VCT enables and encourages people with HIV to access appropriate care and is an effective HIV-prevention strategy.\(^1\)\(^2\) Studies have also demonstrated that VCT is effective as a behavior-change intervention (Allen et al, 1992; Campbell et al 1997; Kamenga et al 1991; Van der Straten et al 1995; Voluntary HIV-1 Counselling and Testing Efficacy Study Group 2000). VCT is a key component of HIV programs in industrialized countries, but until recently it has not been a major strategy for developing countries.\(^3\) The importance of its role in HIV prevention and improving access to care means that VCT services are now being more widely promoted and developed, particularly in sub-Saharan Africa, and many countries in Africa are gradually instituting VCT as an essential part of their primary health care package.\(^4\)

However, very few countries have VCT services that have been specifically developed or adapted for young people. This is important, as the reasons for attending VCT and outcomes following VCT can be different for young people. Some countries and donor agencies are at last acknowledging the importance of targeting youth in their HIV care and prevention strategies and including provision of VCT for youth in this agenda. Draft National Guidelines of the Republic of Ghana state that it shall “seek to ensure the expansion of the access of young people to youth-friendly facilities and services including HIV and STI (sexually transmitted infection) prevention, management and testing, counseling and the provision of care and support services.”

Both supply of and demand for appropriate and “friendly “ testing and counseling services for youth in the Eastern and Southern African Region are grossly inadequate, and improving them should be a priority for UNICEF support.\(^5\)

The definition of “young people” varies between studies and between countries. For the purpose of this document, young people will include people aged 15-24 years. The majority of young people in this age group who would be at risk of HIV infection are those who engage in unsafe heterosexual sex. However, young people often start sexual activities before this age and this will be discussed in relation to considering the legal and ethical dilemmas associated with VCT for this age group. Young people may also be at risk of HIV infection from unsafe injecting drug use (IDU), unsafe homosexual sex and through HIV transmission from unscreened blood and blood products or from unsterile skin-piercing procedures (e.g., tattooing, traditional medical practices such as scarification).

Because of the long latent period between HIV infection and symptomatic HIV disease, deaths from infections that occurred in the early 1990s are only now being experienced. Significant mortality in the 20-24 year age group is yet to be experienced in many countries, particularly within new and emerging epidemics, such as Nigeria.

The aim of Section 1 is to review current literature on models of VCT for young people and assess the effectiveness, benefits and cautions of different approaches. It will also provide insights into factors that might motivate or discourage young people from seeking VCT and discuss the outcomes for young people following VCT.

2. Infants and Children
More than 600,000 children become infected with HIV annually, largely due to MTCT. More than 4 million children have already died of AIDS and there are over 1.3 million children under the age of 15 infected with HIV. Furthermore, an estimated 13.2 million children have been orphaned due to HIV/AIDS, many of whom will not be HIV infected. The majority of HIV-infected and affected children live in sub-Saharan Africa.

Without PMTCT interventions, between 20-45 percent of children born to mothers with HIV will be infected. Even where ARV PMTCT interventions are available, up to 10 percent may be infected. There are benefits for parents and infants of ascertaining infants’ HIV status as this may play an important role in addressing clinical management and be an important factor in future planning.

Many children who acquire HIV through MTCT will die before they reach the age of 15, but some will survive and may require VCT and have other counseling needs. In countries where ARV therapy is available, increasing numbers of children who were infected through MTCT are reaching adolescence and beyond. Data from the Centers for Disease Control and Prevention (CDC) on the U.S. experience suggest that before the mid-1990s children with HIV lived to an average age of nine years. With breakthroughs in ARVs, since 1996 the average age has risen to 13-15 and is still rising. In the United States, there are now 2,400 adolescents who were born with HIV infection and thousands more who will turn 13 over the next five years. Such children and young people may have counseling needs (relating to disclosure, negotiating safety, care and support, etc.) as they reach new stages in their development and lives.

Section 2 will address the counseling and VCT needs for children and infants, including:

- VCT for symptomatic children and their parents/guardians to help with clinical management and psychosocial support for the child;
- Counseling and/or VCT for orphans and vulnerable children;
- Counseling and/or VCT for children who have experienced sexual abuse;
- Counseling for parents as part of HIV diagnosis for infants born to mothers with HIV, including following PMTCT interventions.

For the purpose of this document, infants are defined as being less than two years (UNICEF).

3. Pregnant Women and Their Partners

Much has been learned in recent years about PMTCT through ARV drugs and other interventions, in addition to primary prevention of HIV infection among women of childbearing age. These interventions rely substantially on identifying pregnant women who are infected with HIV. VCT is therefore an essential component of PMTCT programs.

The United Nations General Assembly Special Session on HIV/AIDS (UNGASS) declaration reflects a commitment to:

“. . . by 2005, reduce the proportion of infants infected with HIV by 20 percent, and by 50 percent by 2010, by ensuring that 80 percent of pregnant women accessing antenatal care have

---

i “Orphans” are defined as children who lost their mother or both parents due to HIV/AIDS when they were under the age of 15.
information, counseling and other HIV-prevention services available to them, increasing the availability of and providing access for HIV-infected women, including voluntary counseling and testing, access to treatment, especially anti-retroviral therapy and, where appropriate, breast-milk substitutes and the provision of a continuum of care.ii

Section 3 of this document will address the VCT needs of pregnant women (and their partners) in the context of PMTCT, including:

- Approaches/models of VCT delivery;
- Challenges to the provision of VCT in antenatal settings:
  - Broadening the scope of VCT in the antenatal clinic (ANC);
  - Improving uptake;
  - Increasing the involvement of partners/husbands;
  - Benefits and cautions of couple counseling;
  - Adverse consequences following disclosure;
- Barriers to VCT in antenatal settings.

4. Limitations of the Document

Although a literature review was undertaken, the range of documented global experiences to adequately inform approaches to scaling up VCT in relation to the needs of young people, children and pregnant women is limited. The document focuses on practice and experience in sub-Saharan Africa given the nature of the epidemic including the prevalence rates of MTCT and the growing numbers of orphans requiring care and support on the continent. Well-established and documented VCT experiences from Asia (beyond Thailand and India) and Latin America (beyond Brazil) that relate to young people, children, pregnant women and their partners are limited in number, and many countries in these regions are now looking to commence generic VCT program development. The document has practical application for high-prevalence countries with generalized epidemics, countries experiencing emerging epidemics and looking to scale up services and low-prevalence countries with pockets of high prevalence among subpopulations.

Experiences have been included from lessons and practices occurring in the United States, as these have been widely documented. These insights have been included in the hope that they offer lessons and attempts to respond to the needs of some young people and children, some of which may be translated or transformed into other contexts.

Some innovative interventions from other parts of the world have been captured, though it was challenging to request for partners in the field to take time out from their busy work to document the richness of their efforts. Some stakeholders had not collated their experiences. Hard data-based evidence was found to be lacking, although anecdotal examples of what works in some instances were located. Some interventions are also in the early stage of piloting and will require considerable monitoring over the next 6-12 months in order to glean lessons learned for application to new programmatic areas.

**Rationale for VCT**

- **VCT** is much more than drawing and testing blood and offering a few counseling sessions. It is a **vital point of entry to other HIV/AIDS services** including PMTCT, prevention and clinical management of HIV-related illnesses, tuberculosis control and psychosocial and legal support.

- **VCT** offers **benefits to those who test positive as well as those who test negative**. VCT alleviates anxiety, increases client’s perception of their vulnerability to HIV, promotes behavior change, facilitates early referral for care and support, including access to ARV therapy, and assists reduction of stigma in the community.

- Given the benefits of VCT, the international community has a responsibility to **advocate for the availability of quality VCT services** (ensuring minimum requirements are met) for potential beneficiaries.

- **There is demand** (people want to know their HIV serostatus), and demand can also be created when comprehensive services are made available and stigma is reduced.

- **VCT** offers a **holistic approach** that can address HIV in the broader context of peoples’ lives, including the context of poverty and its relationship to risk practice.

---

**Lessons learned** from experience in VCT programming to date:

- **VCT** is a service that can be offered by government, non-government, community and private sectors.

- The **gold standard** for VCT follows a regimen of pre-test counseling, testing (as desired by the client and after informed consent is provided) and post-test counseling (which may involve one or more sessions depending on the client’s needs). Individual risk assessment and risk-reduction planning are integral components of pre- and post-test counseling. However, **approaches to working with young people, children and pregnant women may require development of novel adaptations to the gold standard** in order to make VCT more user-friendly. This is particularly true of the desired approach and content to be covered within the pre-test session/s.

- A **range of innovative service delivery models can be applied** depending on the context. Models include free-standing sites and mobile services. Some models that are receiving promising uptake by young people include free-standing and outreach models.

More information is required on integrated non-health care setting models as well as mobile services for vulnerable youth populations. More piloting and “learning though doing” is also required in relation to efficacy of models for PMTCT both within and outside of ANC services.

- **The model of choice must ensure adequate cost consideration** to guarantee sustainability of services. Service sustainability still remains a challenge in many settings, especially non-integrated sites in which initial start-up costs are often provided by external international donors.

- **VCT is a public health intervention**, so governments and donors need to subsume some of the associated costs of VCT to ensure the widest possible access.

- **Health sector strengthening** is an essential part of facilitating better implementation of VCT services. VCT is most effective as part of an integrated delivery system where related psychosocial, spiritual and medical services are part of the package of services immediately available to people presenting for VCT.
- National HIV/AIDS policies and strategies should ensure adequate coverage of VCT services and set national VCT service provision standards.

- VCT must be accessible and affordable for those at highest risk of HIV infection or those suspected to have HIV-related illness. VCT should be available to the range of clients who may benefit from knowing their HIV serostatus, including couples, individuals and young people.

- Sites must be adequately staffed by individuals with high-quality training in counseling and testing practices.

- Management of sites must support staff to sustain high-quality service provision, retain skilled staff and prevent burnout of the counselors.

- VCT for couples must be widely encouraged and promoted. Couple pre- and post-test counseling has significant benefits for addressing risk assessment and risk-reduction planning, including within PMTCT programs — in particular for women in countries where there is substantial gender inequity. In addition, targeting couples is cost-efficient.

- VCT design must address service promotion in the planning and establishment of high-quality VCT services. This includes identifying or strengthening other care and support services, and community- and hospital-based referral networks.

- The design and establishment of VCT services must be tailored to the unique epidemiological, behavioral and socio-economic context of each country and setting. Such designs must also take into account stigma-reduction and demand-creation interventions.

- In developing new VCT sites or scaling up VCT, a coordinated response by all stakeholders — including partnerships among donors, government and non-governmental organizations (NGOs) — is crucial to ensure a standardization of services in terms of quality of care and support offered to clients and to avoid duplication of services within regions.

- Monitoring and evaluation systems should be established from the onset for both counseling and testing components. Counseling and testing protocols may vary from one program to another based on the goals and objectives of the program. The VCT intervention must be regularly evaluated to determine whether it is provided in accordance with the predetermined protocol and satisfies client needs.

- Innovative approaches to VCT that respond to country-specific needs should be developed. These include VCT services for adolescents, and the integration of VCT practices within antenatal sites that might employ group pre-test information sessions in settings with high client load as part of a comprehensive strategy for PMTCT.

5. Overview of VCT Service Delivery Models in Use

When responding to the needs of specific populations, including young people, children, pregnant woman and their partners, the VCT package may look different. An overview of general prevailing models is presented in order to further inform the reader of the current developments in a field that is undergoing a rapid metamorphosis. The following views prevail:
**VCT:** VCT is a generic “gold standard/classic” model that ensures that knowledge of serostatus is voluntary (involving assurance that informed consent is obtained from the client/s by the service provider). Pre-test counseling is offered in the form of one or more sessions, after which the client may choose to test on the same or different day. The client who chooses to test may return on the same or different day for a post-test counseling session that includes giving the HIV test result. Note that voluntary and confidential counseling and testing (VCCT) is a semantic modification of VCT, used primarily in the United States to denote the confidential nature of VCT. However, the term VCT as it is envisaged by most assumes that confidentiality is one of the necessary conditions of the package.

**VCT Plus:** VCT Plus is espoused by FHI and features all of the VCT gold package requisites, yet acknowledges the numerous value-added services to be offered (in or out of house) as a result of undertaking VCT. The “plus” factor is comprised of services such as referral for or provision of clinical care (TB/PCP prophylaxis, ARV access as appropriate and available), post-test clubs, support groups, access to PMTCT services, home care, etc.

This model promotes a comprehensive approach to care and support, while ensuring a client-centered model with emphasis on quality service provision. Global experiences suggest that many client groups, including young people and pregnant women, find comprehensive services (which can include “one-stop shopping”) appealing. This approach also reduces the cycle of ongoing referral that occurs in many sites to date.

**VTC:** This practice occurs in many settings although it is not encouraged by the global community, including the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organization (WHO). Such practice usually consists of testing followed by a post-test session or sessions. It does not include pre-test counseling, therefore denying individuals assistance in making informed decisions on whether or not to test and offering test preparation. The role of pre-test counseling in assessing risk is also overlooked. This practice is still common in some private medical practices.

**CTR:** This model is being applied for use in PMTCT to promote a routine approach to knowing one’s HIV serostatus, where HIV is screened for along with the battery of regular ANC diagnostics. After testing, the client is effectively linked to the range of prevention, care and support services from which she/he may benefit. This approach might also be referred to as RCT (routine counseling and testing). Issues for further consideration under this model include management of “informed consent” and ensuring prevention of harm to clients through efforts to reduce stigma and discriminatory practices. The notion of “voluntarism” within this model is undergoing ethical and moral debate. There are many forms of implementation within the CTR model that warrant further address, including the fundamental principles that might guide an “opt out” or more “routine” approach to HIV testing for PMTCT. (See Section Three.)

**VC (optional T):** This is a major shift from the medical model focus on testing, which historically has been the focal point of the package. This model is being promoted for young people. For young people, access to informed decision-making and opportunities for quality counseling services may be more beneficial even on their own (in confronting risk behavior and promoting behavior change) than completion of the test itself. From documented experiences of young people both in Africa and the United States, there is anecdotal evidence that supports the vision behind this model. That is, to strengthen and increase access for young people to services that offer voluntary and youth-friendly counseling. Under this model, HIV testing is an optional adjunct that could be explored with young people depending on their needs and perceived added value of knowing their serostatus.
SECTION ONE. YOUNG PEOPLE AND VCT

1. YOUNG PEOPLE AND HIV PREVALENCE

Our world currently has its largest group of teenagers ever: 1.1 billion adolescents aged 10-19 years, 85 percent of them living in developing countries.12

Young people aged 15-24 account for more than 50 percent of all HIV infections occurring worldwide (excluding perinatal cases). Over 7,000 new HIV infections each day in the world occur among young people. In Africa, an estimated 1.7 million young people are infected annually.13 Preventing HIV among young people is particularly urgent in sub-Saharan Africa, where in many countries young people comprise over 30 percent of the population and general HIV prevalence rates often exceed 10 percent.14 In the United States, AIDS is the leading cause of death in African-American young people aged 15-24.15

In most countries, HIV sentinel surveillance is carried out among women attending antenatal clinics and among other groups who are having blood taken for other purposes (such as STI clinic attendees, IDUs attending drug treatment programs). Although disaggregation by age can give indications of HIV prevalence rates among young people, samples from these populations will often not be representative. If seroprevalences from such surveys are extrapolated to general populations of young people, an overestimation of HIV prevalence rates may result.16

There have, however, been several community HIV prevalence surveys. For example, in Zambia 12.3 percent of young women and 4.5 percent of young men aged 15-19 were found to be seropositive in a three-site community survey. Seroprevalence rates among the 20-24 year-olds were even higher, with 35.4 percent of women and 10.7 percent of men being infected in this age group.17 This illustrates the potential for HIV prevention in young people and the urgency of providing young women in particular with HIV-prevention services (including VCT). In this survey, as in others from sub-Saharan Africa, HIV rates are high among young people and HIV-infected females are disproportionately affected, with a ratio to infected males in excess of 4:1 in some populations.18,19

In Nigeria, the first populous country to have an average national HIV prevalence rate of >5 percent (Nigeria’s overall national HIV prevalence rate was 5.4 percent in 1999), “youth” (defined by the Nigerian National Action Committee on AIDS [NACA] as being aged 20-24 years) show the highest seroprevalence rates (4.2-9.7 percent). Since 1995, the HIV prevalence rates among youth in the worst-affected state have increased by more than 700 percent. The high HIV prevalence rates among the 20-24 age group in Nigeria demonstrate that young people are particularly vulnerable. As most young people were infected in the last few years, this gives an indication of the rapidity of transmission. VCT for young people has been recognized as a major priority within the Nigerian HIV-prevention program.20

In industrialized countries, HIV prevention among young people is also important. In the United States, at least 25 percent of all new HIV infections are occurring in young people before the age of 21 years.21 In Russia and the Newly Independent States, although prevalence in the general population remains low, young people are becoming increasingly vulnerable to HIV.22
Table 1: HIV Prevalence Rates among Young People (15-24 years), End 1999

<table>
<thead>
<tr>
<th>Country</th>
<th>Estimated HIV prevalence rates</th>
<th>Young Women</th>
<th>Young Men</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>West Africa</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Côte d'Ivoire</td>
<td>6.7-12.3</td>
<td>2.1-5.47</td>
<td></td>
</tr>
<tr>
<td>Nigeria</td>
<td>4.35-5.89</td>
<td>1.68-3.35</td>
<td></td>
</tr>
<tr>
<td>Senegal</td>
<td>1.12-2.07</td>
<td>0.39-1.02</td>
<td></td>
</tr>
<tr>
<td><strong>East Africa</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kenya</td>
<td>11.07-14.98</td>
<td>4.26-8.52</td>
<td></td>
</tr>
<tr>
<td>Tanzania</td>
<td>6.85-9.27</td>
<td>2.64-5.28</td>
<td></td>
</tr>
<tr>
<td>Uganda</td>
<td>6.65-8.99</td>
<td>2.56-5.12</td>
<td></td>
</tr>
<tr>
<td><strong>Southern Africa</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Botswana</td>
<td>32.55-36.07</td>
<td>13.68-18.00</td>
<td></td>
</tr>
<tr>
<td>South Africa</td>
<td>22.51-27.13</td>
<td>7.56-15.11</td>
<td></td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>23.25-25.76</td>
<td>9.77-12.85</td>
<td></td>
</tr>
<tr>
<td>Zambia</td>
<td>16.86-18.68</td>
<td>7.08-9.32</td>
<td></td>
</tr>
<tr>
<td>Mozambique</td>
<td>13.36-16.11</td>
<td>4.49-8.97</td>
<td></td>
</tr>
<tr>
<td><strong>Asia</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thailand</td>
<td>1.53-3.11</td>
<td>0.47-1.89</td>
<td></td>
</tr>
<tr>
<td>India</td>
<td>0.4-0.82</td>
<td>0.14-0.58</td>
<td></td>
</tr>
<tr>
<td><strong>Eastern Europe</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Russian Federation</td>
<td>0.09-0.15</td>
<td>0.19-0.32</td>
<td></td>
</tr>
<tr>
<td>Ukraine</td>
<td>0.6-0.98</td>
<td>0.95-1.63</td>
<td></td>
</tr>
<tr>
<td>United States</td>
<td>0.16-0.3</td>
<td>0.15-0.44</td>
<td></td>
</tr>
</tbody>
</table>


1.1 HIV Risk Factors Specific for Young People

Several cultural, biological and environmental factors place young people, especially adolescents (10-19) at increased risk of HIV infection. In addition, many normative behaviors of adolescents intersect with risk-taking behaviors.23

Early Sexual Debut

Whether voluntarily or not, young people often begin their sexual lives at early ages. In Uganda, 30 percent of women report having had sexual intercourse by the age of 15 and 72 percent by the age of 18.24 In Kenya25 and Tanzania26, the average age of sexual initiation is reported to be 16 years for females and 17 years for males. In Zambia, the median age for first sexual intercourse for men and women is reported as being 16 years.27 However, qualitative research suggests that the age of sexual debut is probably often much lower. In Lusaka, Zambia, for example, sexual debut has been reported as an average age of 12 years for boys and 10-11 years for girls28 and in Livingstone, Zambia, at 10 years and 9 years for boys and girls, respectively.29
Emotional and Developmental Factors

For many young people, adolescence is a development stage in which experimental and potentially risk-taking behaviors occur as part of marking their transition into adulthood.

Low Level of Condom Use

Despite relatively high levels of knowledge about HIV/STIs among young people being cited in most countries, many young people engage in risky behaviors, with fewer than 10 percent of the sexually active adolescent females from most countries in sub-Saharan Africa reporting condom use (various Demographic and Health Surveys). This also reflects the patterns of condom use among some adult populations. Adults may therefore compound attitudes toward condom use. Young people do not live in isolation. Continuing education of adults and policymakers is crucial.

Biological and Social Vulnerabilities

The immature genital tract of female adolescents makes them biologically more susceptible to HIV, a risk compounded by a variety of social and environmental factors such as young girls engaging in sex with older men. HIV prevalence rates among young women reflect the realities of these risks. From formative research in Southern and Eastern Africa the following pattern of sexual activity was found to be driving the epidemic:

- Young girls are becoming infected before marriage by partnerships with older infected men;
- These young women in turn infect their spouses;
- Their spouses in turn infect younger women.

Sexually Transmitted Infections

The presence of STIs is known to facilitate HIV transmission. In many industrialized and developing countries, STI rates among young people are rising and knowledge about symptoms and where to seek effective or youth-friendly treatment is often poor. Prevalence of STIs has also risen, particularly among young people, in the Newly Independent States.

Alcohol/Substance Use

Experimentation with alcohol and other drugs is common during youth and may impede the development of psychosocial skills. Substance use is also associated with increased risk-taking activities, including sexual activity and violence. In addition, alcohol and substance abuse may act as a disinhibitor, facilitating risky sexual practices. There are few programs addressing this issue, particularly in developing countries.

Practice of Heterosexual Anal Sex

In some countries, as well as within some subgroups, heterosexual anal sex is practiced as an alternative to penetrative vaginal intercourse and as a strategy to preserve virginity or prevent pregnancy. There is a scarcity of literature on this topic as it relates to heterosexual populations due in part to taboo surrounding the practice, and potential underreporting where research has been carried out. A recent study of South African sex workers at truck stop locations in South Africa reports that almost half of the 145 respondents had practiced anal intercourse.
1.2 Health-seeking Behavior

Patterns of use of health care facilities may differ greatly for young people in different settings and among different groups of young people. Young people often do not attend formal health services for their preventive health needs. Young people may seek sexual and reproductive health (SRH) services through a variety of settings (e.g., government health facilities, private clinics, chemists, friends and, in some countries, traditional healers). In Zambia, when young people were asked where they went for SRH services outside of formal health centers, the top three responses were traditional healers (44.0 percent), private clinics (32.0 percent) and friends (8.0 percent). Issues that concern young people and influence their choice of SRH support are:

- Privacy/confidentiality;
- Waiting time;
- Availability of medications;
- Costs and pressure by health staff to notify partners.  

In industrialized countries, young people also have different patterns of health services use, particularly for reproductive health and STI/HIV health services.

Fertility, Pregnancy and Abortion Care

In surveys of SRH needs, the major self-reported health concerns of young women are often pregnancy and abortion. In an 11-country survey in sub-Saharan Africa, at least 10 percent of 16-year-old girls in eight countries had started childbearing.

The Zambia DHS reports that of young women aged 10-25 attending ANCs, presentation during the second trimester ranged from 45.9 percent in Kitwe to 82.6 percent in Livingstone. Young women are reported as being significantly more likely to present late in pregnancy for antenatal care and less likely to deliver in a health facility or be attended at delivery by a skilled birth attendant. This contributes to higher infant and maternal mortality among young mothers and is also an important factor when considering the provision of VCT/PMTCT interventions for young pregnant women.

There is urgent need to address access constraints to ANC/MCH facilities for young women across the globe.
Table 2: Adolescent Pregnancy in Zambia

<table>
<thead>
<tr>
<th>Background Characteristic</th>
<th>% either pregnant or have given birth (excludes TOP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>4.5</td>
</tr>
<tr>
<td>16</td>
<td>15.3</td>
</tr>
<tr>
<td>17</td>
<td>28.3</td>
</tr>
<tr>
<td>18</td>
<td>46.1</td>
</tr>
<tr>
<td>19</td>
<td>59.4</td>
</tr>
<tr>
<td>Residence</td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>26.6</td>
</tr>
<tr>
<td>Rural</td>
<td>34.4</td>
</tr>
<tr>
<td>Education</td>
<td></td>
</tr>
<tr>
<td>No education</td>
<td>48.1</td>
</tr>
<tr>
<td>Primary</td>
<td>33.1</td>
</tr>
<tr>
<td>Secondary</td>
<td>21.1</td>
</tr>
</tbody>
</table>


2. VCT AND SUBGROUPS OF YOUNG PEOPLE

2.1 Vulnerable and “At-risk” Young People

In industrialized countries, certain groups of young people are at greater risk of HIV infection. Counseling and VCT interventions have been developed specifically to reach these groups. In a study targeting “high-risk adolescents” attending an adolescent clinic in Boston, United States, condom use increased and the sharing of needles decreased following both the “standard care” and the specific HIV counseling intervention. This demonstrates that if services can be developed that are acceptable to young vulnerable people, they can be effective in promoting safer behavior.

Reaching vulnerable young people, including street kids, young people who have experienced sexual abuse, young people with drug and alcohol abuse issues and young people engaging in sex work, is an important challenge. These young people may be at increased risk of HIV infection. In addition, few services have been developed to help young people in developing countries who have been raped or abused. In Uganda, the NGO “Hope after Rape” provides support to young people. Development of this type of service is a high priority.

2.2 Injecting Drug Users

In many settings, young people are at risk of HIV infection through injecting drug use. This is a significant problem in many industrialized countries and in parts of Asia and Eastern Europe. Providing VCT and counseling services for young IDUs provides particular challenges and requires innovative, targeted interventions such as those used for harm reduction in parts of Thailand, India and Australia. There are no specific VCT models to date targeting young IDUs. VCT for this group needs to be explored as part of a more comprehensive approach to basic health service delivery such as those that might be offered through mobile clinics, needle exchanges or integrated via drug and alcohol facilities, including detoxification units.

2.3 Uniformed Services
HIV poses a significant threat to uniformed service populations, including military, peacekeepers and police. This is particularly true during complex humanitarian emergencies, including the descent into and emergence from crises involving armed confrontations. A large number of uniformed service personnel are young males. UNAIDS, the World Bank and FHI are currently providing funding and/or technical support to target uniformed services and VCT-related activities in Eritrea, Ethiopia, Ghana and Rwanda. Constraints to providing VCT for some of these groups (including the military and especially new recruits) include the mandatory testing requirement in place by some governments. Desirable interventions could focus on lobbying for policy reform of mandatory testing and/or encouraging governments to ensure that pre- and post-test counseling, sharing of results with the individual who has been tested, and adequate referral to care and support services as required take place during the mandatory testing intervention. In addition, VCT services need to be made available to uniformed service personnel even during the time of their service given the high degree of risk practices that often occur in the field.

2.4 Young Men Who Have Sex with Men (MSM)

In many developing countries, homosexual sex is illegal between men who are less than 18 years of age. In some developing countries, particularly in sub-Saharan Africa, all homosexual sex is illegal. Despite this, many young men have sexual relationships with men and are vulnerable to HIV infection. Young men who are involved in non-consensual sex or sex work are at particular risk of HIV infection and may be reluctant to access formal medical or preventive services. Young men who engage in homosexual sexual practices may not identify themselves as homosexual or MSM or may have transient homosexual experiences. This is particularly noted for young men in prison and other institutions.

2.5 Young People with Learning Difficulties

The need for sex education counseling and HIV awareness and prevention is often overlooked for this group of people (young people with special educational needs, low levels of literacy, etc.) Successful approaches have been developed and can be adapted for young people with particular learning problems.
2.6 Hemophiliacs

In many industrialized countries a significant proportion of HIV infection, particularly early in the HIV epidemic, was attributable to transmission of infected blood products. Counseling young men with hemophilia involves counseling the family (more than one family member may be infected). There is considerable experience in counseling young men with hemophilia and their families. There are some parallels between early experiences of counseling young men with hemophilia in industrialized countries and young people who have been infected perinatally. These parallels relate to potential application of lessons learned regarding disclosure (who/how), parent’s experiences of “protecting children” through lack of disclosure and potential for exacerbating harm, and issues related to grief and loss.

Ongoing HIV/AIDS-related Needs of Young People

A broad range of HIV/AIDS-related needs exists for young people. Services must be developed in country to respond to these needs, and where not housed in a one-stop shop (ideal and desirable for some youth subgroups), strong linkages to such must be fostered. Some of these needs may be best met by counseling, although other needs are adequately met for some young people through access to comprehensive health education and opportunities for quality life skills training.

These needs include individual and group support (including peer models) to address:

- Peer pressure;
- Assertiveness and negotiation skills;
- Self-esteem;
- Risk-taking and experimentation as related to development of safer behaviors, limit and boundary setting;
- Alcohol and other drug use and abuse;
- STIs, including HIV;
- Contraception;
- Condoms and overcoming barriers to ensure safe and effective use;
- Sexual and intimate relationships;
- Familial relationships;
- Abuse (sexual/physical/emotional);
- Domestic violence;
- Rape;
- Pregnancy and fertility issues;
- Safe abortion;
- Sexual identify issues;
- HIV/STI disclosure issues;
- HIV treatment-related issues (adherence to ARV therapy, coping with adverse effects, treatment failure, etc.).

It is clear that young people value opportunities for counseling, and that to be efficacious, more than one session is required to adequately explore most of the above-mentioned needs.
Support that MAY be required for young people during pre-test counseling:

- Exploration of reason for presenting and provision of unconditional support;
- Affirmation for young person (courage to present to service, encouragement where the young person is attempting to implement healthy practices);
- Exploration of risk assessment, perceptions and factors relating to vulnerability;
- Testing of decision-making support (including outlining test procedures and practice, what a positive or negative result would mean to them, to whom they would disclose their status);
- Exploration of existing support systems;
- Opportunity for health education and/or information as required (including modes of transmission and prevention, condom demonstration and distribution);
- Brief exploration of personal risk reduction as appropriate (including opportunity for role play);
- Opportunity for young person to ask questions and communicate their concerns;
- Referral as appropriate (including for generic or specialized counseling, drug and alcohol services, abuse and domestic violence services, medical services, support groups, peer support person, legal and financial services, religious organizations, etc.);
- Distribution of IEC materials as appropriate;
- Opportunity to facilitate or mediate for familial and spousal support as desired and appropriate.

Support that MAY be required for young people during post-test counseling:

- Exploration of readiness to receive test results;
- If not on the same day as the pre-test: exploration of how things have been/what has changed since last meeting;
- Re-visitation of risk assessment and risk-reduction planning as required;
- Opportunities to role play/practice behavior modification;
- Opportunity for additional health education and/or information as required (including modes of transmission and prevention, condom demonstration and distribution);
- Opportunity for young person(s) to ask questions and communicate their concerns;
- Re-visitation of support systems, disclosure and coping capacity (especially where the result is positive);
- Referral as appropriate (including for generic or specialized counseling, drug and alcohol services, abuse and domestic violence services, medical services, support groups, peer support person, legal and financial services, religious organizations, etc.);
- Distribution of additional IEC materials as appropriate;
- Opportunity to facilitate or mediate for familial and spousal support as desired and appropriate;
- Planning for additional or ongoing support as possible and desired.
3. APPROACHES FOR COUNSELING AND VCT FOR YOUNG PEOPLE

The following points should be noted:

- There is no “ideal” model of VCT for young people.
- Further documentation and evaluation of successful VCT approaches with young people is required.

3.1 Integrated VCT: A Challenge to Develop a Youth-friendly Model for VCT

- Integrated into primary health care, including “youth-friendly VCT” (e.g., youth-friendly corners within primary health care settings).

What we know:

- Young people are often reluctant to attend formal health services.
- Reproductive health services reach few adolescents and there does not appear to be a “magic bullet” to increasing the use of clinic-based services by unmarried adolescents.
- This has led to support for youth-friendly health services (YFHS).
- “Youth-friendly” services initiatives appear to be better when combined with other “outreach” strategies in order to attract youth to clinic-based services.

In Zambia, nurses and clinical officers have been trained to provide more effective health care for young people and “youth-friendly corners” have been established in some primary health clinics. Young people have also been trained as “peer educators” to provide health information to young people and act as a bridge between young people and formal health providers. As part of this program, adult peer educators are also trained and mobilized to work with parents, guardians and other elder figures. It is essential that these individuals understand the SRH issues and needs of young people in order to reduce the stigma at the family and community level that young people currently face in protecting their rights to health.

A national multi-center, randomized, controlled study conducted in five publicly funded STD sites across the United States over a six-year period compared two counseling interventions and an informal messages intervention: Enhanced Counseling (four interactive, behaviorally based sessions), Brief Counseling (two short sessions based on CDC’s HIV-prevention counseling model) and an informal messages intervention (Didactic Messages, two information-only sessions).

Participants in the Enhanced Counseling and Brief Counseling interventions reported significantly more condom use at three and six months post-intervention compared with participants in Didactic Messages.

Significantly fewer participants in both the Enhanced Counseling and Brief Counseling interventions had new STDs.

The counseling interventions were more efficacious for adolescents (45 percent fewer had new STDs) than those who received the Didactic Messages intervention.
What we suspect:

- VCT and counseling services could be integrated into YFHS. This would be easy and low cost to implement, if VCT is already available in primary health care settings.
- Adolescent reproductive health services may be more effective at influencing knowledge and attitudes than behavior.

There is no hard evidence to suggest:

- That YFHS are efficacious.
- That YFHS are successful in increasing uptake of health services by young people.

In industrialized countries, the importance of reaching young people by integration and adaptation of services into primary health care settings has been recognized, but many of these services focus solely on young women.

In the United States, a program to provide HIV education and counseling services within a primary health care setting for vulnerable young women was developed. Two approaches were explored: peer educators were trained to provide HIV-prevention information (both sexual and IDU prevention); and health workers were trained to use counseling to convey the same information. Follow-up revealed that both approaches significantly affected knowledge, attitudes and sexual behaviors of young people.

The counseling by health workers achieved a greater effect on sexual behavior and the peer education on safer drug use.

A program from Switzerland aimed at developing STI and other health prevention for young people was successful in reaching young women. From these studies it is noted that young men who have fewer contacts with health services are more difficult to reach.

Interventions just aimed at young women are unlikely to be as successful as those that address the needs, roles and responsibilities of both young men and young women.

<table>
<thead>
<tr>
<th>Key Features of Youth-friendly Health Services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Community mobilization</strong> to increase understanding of the health needs of young people;</td>
</tr>
<tr>
<td><strong>Peer education</strong> (for young people and their elders) in the form of community outreach and clinic-based educators; compensation packages to ensure participation and motivation;</td>
</tr>
<tr>
<td><strong>Designated “youth-friendly corners”</strong> at clinics and free-standing VCT sites (need alternatives to MCH clinics, which discourage attendance by young men);</td>
</tr>
<tr>
<td><strong>Health providers trained</strong> in youth-friendly approaches to communication and counseling;</td>
</tr>
<tr>
<td><strong>Suitable accommodation</strong> for issues of consent and disclosure;</td>
</tr>
<tr>
<td><strong>Integration</strong> with other health and psychosocial support services for young people after testing;</td>
</tr>
<tr>
<td><strong>Confidentiality</strong>;</td>
</tr>
<tr>
<td><strong>Adequate supplies of condoms, IEC materials and drugs</strong>;</td>
</tr>
<tr>
<td><strong>Full participation of young people</strong> in decision-making, planning and delivery of services.</td>
</tr>
</tbody>
</table>
VCT Integrated into School and College Health Care Services

In many countries, programs to provide HIV-prevention interventions in schools and colleges have been developed.\textsuperscript{51} Where school or college health services exist, these could provide sites for integrating VCT services. In one study from the United States, it was proposed that school-based clinics provided easier and more acceptable access to VCT services than other formal health settings.\textsuperscript{52} Single-session educational classes have been shown to be ineffective whereas multi-session small-group activities, which involve young people in their design and development and provide access to counseling and VCT, are more successful in promoting safer sexual behavior.\textsuperscript{53}

No VCT models within schools were identified that could be replicated or adapted, although a mobile service in Uganda run by the Kitovu Mission Hospital has successfully provided mobile VCT to school settings.

<table>
<thead>
<tr>
<th>Peer Education via Schools and Community Centers to Promote VCT for Young People</th>
</tr>
</thead>
<tbody>
<tr>
<td>The adolescent AIDS program of Montefiore Medical Centre in the Bronx, United States, developed a one-day training program for peer educators.</td>
</tr>
<tr>
<td>- Teenagers were recruited through existing peer education programs at schools and community centers.</td>
</tr>
<tr>
<td>- They signed pledges and were paid US$100 for their 25 hours of work, during which they were assigned to work in neighborhoods where teenagers are at high risk of contracting HIV.</td>
</tr>
<tr>
<td>- They visited schools, community centers, ice-skating rinks and parks. Their work involved informing other young people about the risk of infection and encouraging them to get tested.</td>
</tr>
</tbody>
</table>
VCT Integrated with Other Health Care Services (STI Services, Family Planning Clinics): An Unlikely VCT Model for Young People

HIV testing is offered in STI clinics and in association with some family planning services. Unless these are developed to ensure that they are also “youth-friendly” it is unlikely that they will be a key model for VCT delivery for young people.

Currently uptake in many sites is low, as many young people do not favor services within hospitals/clinic settings. Much of this is due to attitudes and responses by service providers within such facilities, e.g., regarding access (parental consent for VCT as well as associated services such as condom provision) and judgmental approaches.

However, there are some successful examples of this approach in industrialized countries. The Archway Centre in a derelict area of North London has been successful in attracting large numbers of young people for a range of sexual health services.

Lessons Learned from a School-based Sexuality Education and Integrated Health Service Program in Chile

CEMERA implemented a school-based educational and service linked programme in 1994/5 in two public schools in Santiago for students in grades 7-12.

- Teachers were trained to teach sexual and reproductive health in the classroom;
- Students were referred to the CEMERA clinic, which was open daily for all adolescents and provided free counseling and medical services.

Project outcomes reported:

- Increased knowledge and more responsible and mature attitudes toward sexuality by young people who completed the program;
- Males in the program became sexually active at a later age than the norm. Female students in the program initiated sex at later ages than girls in the schools where the intervention did not occur;
- Use of contraception increased among sexually active boys and girls in the program schools;
- The number of unwanted pregnancies decreased.

Factors attributed to the success:

- Engaging students in the design of the curriculum;
- Involving parents in a parallel course;
- Availability of linked clinic services that are easily accessible and close to the school to address health needs and provide contraception;
- Course sustainability was increased by teacher training;
- Lobbying public officials led to program implementation.

Website: www.cemera.uchile.cl  E:mail: cemera@uchile.cl
The National Adolescent Friendly Clinic Initiative (NACFI) in South Africa

NACFI is a countrywide program developed to improve the quality of adolescent health care in South Africa at the clinic level. NACFI aims to make clinics more “adolescent friendly.” NACFI provides:

- Services at times convenient to adolescents;
- Acceptable waiting times;
- Adolescent-sensitive information, education and communication materials on sexual and reproductive health;
- Information, counseling and appropriate referral for violence/abuse and mental health problems;
- Contraceptive information and counseling, oral contraceptive pills, emergency contraception, injectables and condoms;
- Pregnancy testing and counseling, antenatal and postnatal care;
- Pre- and post-TOP counseling and referral;
- Pre- and post-HIV test counseling and referrals for HIV testing.

NACFI is still in its early stages of implementation. Personal communication with staff revealed that when a VCT intervention started at one site, the numbers of clinic attendees fell. This was reported to be due to clients’ fears surrounding coercion to be tested. This feedback demonstrates the importance of adequate community sensitization and promotion when integrating VCT within services.

For more information: Telephone: (011) 933 1228  Fax: (011) 933 1227.

---

VCT for Young People Integrated into an STI Clinic


“The ARCH” offers free and confidential services for young people; walk-in services with no referral required; flexible hours (open until 19:00); and a wide range of services in addition to VCT:

- Family planning;
- Pregnancy testing and termination of pregnancy (TOP);
- Screening and treatment of STIs;
- Sexual health information;
- Free condoms;
- Advice about relationships;
- Advice for people who are not sexually active;
- Hepatitis B screening and vaccination;
- Advice and support following rape;
- Drug and alcohol advice;
- Website for information.
3.2 Tuberculosis and Antiretroviral (ARV) Service Access: A Model with Potential for Young People

Tuberculosis (TB) is commonly associated with HIV. In sub-Saharan Africa, the majority of people with TB are also infected with HIV and TB is a major cause of death in people with HIV. WHO and collaborators have developed the ProTEST initiative, which promotes VCT as a key to a more coherent response to TB in high HIV prevalence settings, through links between HIV and TB programs and general health services. VCT can be offered to people attending TB services, or TB and other medical services can be provided for people living with HIV or AIDS (PLHA) following VCT. Pro-TEST advocates an integrated approach to VCT and HIV care services (including TB, STI, family planning, etc). In Brazil, TB and HIV were found to be closely associated in young people and services are being developed to provide VCT for young people who present with TB.

Access to ARV therapy is being planned or expanded in many developing countries. It is envisaged that when ARVs for treatment of HIV disease are more easily available that demand for VCT may increase. The ongoing counseling needs of young people who are able to access ARVs following VCT should not be overlooked. Adherence to therapy and coping with adverse effects may require ongoing support. Furthermore, young people may benefit from counseling to help them maintain safer sexual behavior. Although ARVs usually result in a significant improvement in health for those with symptomatic HIV, a minority of people will not benefit or treatment may fail with time. These individuals in particular may need counseling support.

3.3 Free-standing VCT Services: A Beneficial Model for Young People

Many VCT services in developing and industrialized countries are delivered at free-standing VCT sites. Most free-standing services rely on self-referrals and young people are attending in increasing numbers. Where sites develop outreach programs for young people or special promotional activities are held, attendance has been shown to increase. When Kara Counseling outreach workers invited young people to attend for VCT this resulted in a large increase in attendees — particularly young men. At the New Start VCT service in Harare, Zimbabwe, a two-week promotion for youth (before the schools opened for the September term) resulted in a huge increase in young people attending for VCT. An average of 160 youth clients per day were seen at the at Union Avenue site in central Harare and about 120 clients per day at the Bulawayo site. Free-standing sites also provide an ideal setting for pre-marital or pre-relationship counseling where young people can attend either as couples or individuals. The New Start free-standing site also ran a highly successful “Valentines Day promotion” as an incentive for couples to attend for VCT.

A major consideration in the development and scaling up of such services is the need for long-term investment by governments and/or international donors. There are no models to date of free-standing VCT sites that are currently self-sustaining, and most in fact rely on considerable donor funding for survival.

---

iii Several terms are used to describe VCT services that are not attached or integrated with medical services. "Stand alone" and "direct" VCT services are also commonly used to describe such services.
Kara Counseling and Training Trust, Lusaka, Zambia

Kara Counseling and Training Trust has been a pioneer in the development of VCT services. Hope House, its free-standing site, opened in 1992 and is still widely active to date. Services offered on site include:

- Free pre- and post-test counseling;
- Minimal or no-cost same- or next-day HIV antibody testing;
- Supportive counseling;
- Support groups;
- Condoms free (WHO) or at low cost (Maximum/Reality);
- Entry for PLHA to onsite skills training including batik, tailoring and other income-generating activities;
- Family counseling.

Value-added services also offered by Kara offsite to which young people may be directly referred include:

- Skills training for adolescent girls who are orphans;
- Post-test clubs for all individuals irrespective of the outcome of their HIV serostatus (the majority of club members are youth);
- Hospice care;
- TB prophylaxis (as appropriate);
- Positive speaking/outreach to schools and other organizations.

Additional services offered by partner organizations to which Kara refers:

- PMTCT projects;
- Home care;
- STI screening and treatment.

AIDS information Centre (AIC), Kampala, Uganda

Since 1990, AIC has grown from one site to 51 sites (2001), with a cumulative total of over 500,000 clients. Breakdown of ages of clients receiving VCT in the year 2000:

- 15-19, 10 percent
- 20-29, 46 percent
- 30-39, 29 percent
- 40+ years, 15 percent

Services offered include:

- Rapid testing with same day results;
- Syndromic management of STDs;
- TB information and preventive therapy;
- Family planning;
- Linkages to support services including TASO;
- Positive speaking in schools and other institutions via members of the Philly Lutaaya Initiative.

The most common reasons for clients seeking testing include marriage (25 percent) and those worried about their status (22 percent).

The proportion of clients testing as couples is increasing over time.
3.4 Youth Clubs and Centers: Scope for Counseling Services . . . Some Scope for VCT

Recent advances in rapid HIV testing are increasing options for providing VCT at sites such as youth clubs. Although there are cautions with using such sites for VCT (ensuring confidentiality, quality of testing, adequate referral networks for seropositive young people, etc.) there is scope for increasing the delivery of counseling through such sites. Innovative approaches for integrating HIV counseling with youth culture, such as music and drama, have been developed in the United States and are being demonstrated in some African settings (e.g., Botswana, Uganda, Zambia and Nigeria).

Centre Dushishoze

Opened in January 2001, Centre Dushishoze is a youth center in Butare, Rwanda, managed by Population Services International (PSI). Between January 9-September 9, 2001, 23,016 youth visited the center; more than 77 percent are young men; 83.6 percent of clients visit the counseling service for VCT; 16.4 percent were counseled for other reproductive health reasons. All clients presenting for VCT between March and August opted to be tested; 93.12 percent were negative; 2.94 percent were positive; 3.94 percent were indeterminate. Of those 1,599 tested to date, 112 (approximately 7 percent) were repeat visits for confirmation/control after three months.

Additional activities include:

- Peer education sessions (sketches/videos on behavior-change communication themes, discussion of activity and theme, condom demonstration and IEC messages to complement BCC messages). Peer educators are also visited by youth in their homes;
- Counseling on STIs, family planning and pregnancy;
- Activities targeted to parents to increase support for behavior change among youth;
- Promotional competitions and prizes (pens and t-shirts);
- Publicity campaign including posters, billboard and media spot;
- Youth newspaper entitled Indatwa Z’ego (Heroes of the Future);
- Basketball and volleyball courts (located next to the center).

Lessons learned: Attempts to increase attendance of girls have resulted in offering free skills-building sessions to girls in hairstyling, embroidery, English and basic literacy. Hair styling is the most popular. Each course is three months in duration. Since commencing these activities, girls’ attendance at the center has risen from 14 percent to 38 percent. Day class days have become unofficial “girls days” when girls now come to “hang out.”

“A behavior change project can not be successful without the support of parents including their approval of the center and conducting BCC with parents to get them to talk to their children and to support preventive behaviors, such as condom use among their children.”
The Adolescent Counseling and Recreation Centre (AcRC)

AcRC was launched by the Kenya Association of Professional Counselors (KAPC) on February 1, 2001 in response to youth VCT needs. KAPC felt youth needed a center that is non-medicalized, youth friendly, affordable, accessible and confidential, and manned by trained counselors who are sensitive and non-judgmental to youth issues. Services are open to youth between 15-30 and provide VCT in a youth-friendly environment. The center offers:

- “Same hour” HIV testing using simple/rapid tests;
- Ongoing preventive and supportive counseling;
- AcRC Club;
- Creating awareness and mobilization for VCT;
- Recreation activities to facilitate further interaction and relaxation;
- Correspondence to youth issues through mail;
- Referral for other services not available at the center;
- Networking with other organization dealing with youth, HIV/AIDS, etc.

More than 1,000 clients have received services since the center was launched in February 2001, and the infection rate is around 7 percent. The center attracts youth from all walks of life and from a vast geographical region.

There are more male than female clients and the reason for this disparity needs further investigation. The main reasons for seeking VCT are: unprotected sexual intercourse; wanting to get intimate with boy/girlfriend; premarital; belief that they are already infected; STI infections and pre-university or employment, etc.

Counselors find it less challenging to counsel self-referred youths than those who are referred.

Youth couple counseling is a big challenge for counselors.

Most of the youth seem to disclose more information regarding personal risks after the test results are out during post-test counseling. The level of knowledge about HIV/AIDS is very high among the youths but the internalization or conceptualization of potential risk is very low.

Clients expect a negative HIV result despite exposure, and a positive result is usually devastating. Thus, the counseling offered should help clients to identify personal risk status for HIV, develop a personally tailored HIV safe life plan, and establish healthy values regarding relationships, self-esteem and future decision-making.

The same-hour results are preferred to the many days of waiting offered elsewhere; if clients are given appointments to come back another day chances are that they do not come back.

Youths are more informed and more open to information regarding HIV/AIDS than their parents and more prepared for the results. Most youths prefer not to disclose their HIV status to their parent(s) because of fear of rejection, discrimination, isolation and what it would do to their parents who have sacrificed so much to educate them. Some claim that their parents are already stressed with life; thus, it would not be fair to stress them further with positive HIV results.

Restrictive, unclear public policies concerning this age group are a challenge.

The centers that AcRC clients are referred to are very unaccepting of adolescents’ sexual behaviour and disapprove of condom distribution to young clients.

Many of the youth that frequent VCT centres are stigmatized and it is not uncommon for people to refer to the AcRC as an “HIV center.”

Youth appreciate being involved in the planning of their services, as evidenced by the formation of the AcRC club, where youth (both tested and untested) meet regularly.

Regular counseling supervision can rejuvenate counselors to be more supportive in counseling the adolescents.
3.5 Mobile VCT Services

In order to make VCT more widely available to people who do not routinely attend health facilities, mobile VCT services have been developed in some settings. The “mobile unit” can be a van/caravan that offers VCT in situ and has a schedule of places it visits at particular pre-advertised times. This approach has been used for serving “hard-to-reach” populations who do not visit formal health settings, such as homeless people, sex workers or IDUs. It may also be appropriate for increasing access to remote or rural areas. The majority of established mobile services are in industrialized countries. Feedback provided through personal communication with U.S.-based service providers, including those at the UJIMA Project, suggest that uptake and access by young people has been limited to date.

Kitovu Hospital Mobile Home Care Program in Uganda offers an innovative mobile service. The program, which is under the mandate of the mission hospital, has a van that visits a range of rural outposts, one of which has included parking on the premises of a local school in order to offer same-day VCT services to young people.

Countries such as Malawi and Zambia are also exploring capacity and models for delivering mobile services, though these may be less targeted to youth and more focused on accessing rural locations.

---

The Whitman-Walker Clinic offers mobile VCT in various parts of Washington, DC.

Anonymous testing for HIV is offered to the general public each week by appointment. The service uses OraSure, an oral HIV antibody test. Individual morning (10-12 a.m.) or evening pre-test sessions (6-7:30 p.m.) are available on Mondays, evening sessions on Fridays (5:45-7 p.m.) as well as group pre-test sessions on Wednesday afternoons (5:45 p.m.).
3.6 Outreach

A variation on the mobile VCT service is a mobile outreach “team” that travels between sites providing services at fixed times at a variety of sites such as community centers, religious centers or schools. Pre-advertising via fliers and public announcements can provide potential clients with information, maps and schedules for the mobile service. Using rapid tests can make it possible for results to be given to clients on the same day. However, in some settings it has been more feasible to ask clients to return the following day for their result.

In Zimbabwe, the New Start team has been piloting a range of such services. Their approach includes training of outreach staff, community mobilization, education and VCT with a time allocated during which the team returns with results and post-test counseling. To date, outreach has occurred at farms, two NGOs, one clinic, one private hospital and in areas where PACT is establishing Post-Test Clubs so as to link clients to post-test support services.

---

**Outreach VCT in Zimbabwe: Lessons Learned to Date**

[A strategy of the Ministry of Health and Child Welfare coordinated by the HIV and TB Program with funding from the U.S. Agency for International Development (USAID). PSI provides program management.]

Around 250 clients per week are seen when outreach is conducted.

Once an outreach activity is started, monthly outreach is scheduled in order to address the window period issue, and to sustain demand and interest.

Assessment of the proposed site is essential to avoid sensitive locations such as churches and schools to ensure that the location is acceptable to the local community.

Assessing the potential for adequate and effective community mobilization well in advance of the proposed dates for service provision, and level of assistance needed from PSI in terms of mobilization and implementation, is crucial. Community mobilization should ensure that the employed and unemployed are catered to; thus, the actual dates for service provision last for at least six days, including a Saturday. The hours are usually 09.00-15.00 hrs. Once dates are agreed upon, intensive community mobilization and advertising in the local media (if possible) is arranged.

The staff at the location to be used for VCT outreach are oriented to the program, the need for high-quality service provision and the importance of anonymity and confidentiality. Orientation is for ALL staff, including the security guards at the gates.

Mobile services are offered for free—when charged a fee, people do not come. To date, there has been higher HIV seroprevalence among clients reached through outreach services than the fixed site. It is also noted that the outreach services have accessed more marginalized clientele than the fixed site.
In the United States, Teen Outreach and Primary Services (TOPS) provide HIV outreach services including HIV education, counseling, support and case management for seropositive young people. Peer educators were recruited from the target population and were trained and paired with staff to provide peer counseling and education. Another outreach program in the United States successfully provides outreach VCT and care for homeless/vulnerable young people.

### 3.7 Social Marketing: Attractive to Young People

Social marketing is a research-driven, consumer-centered process based on commercial marketing techniques. In social marketing campaigns, “social products” (such as condoms, or in this case, VCT services) are promoted using the same principles as applied to the commercial sector. With consistent long-term commitment and funding there have been many effective social marketing programs in industrialized countries. This approach has been used for HIV prevention and care interventions in developing countries. New Start in Zimbabwe involves replicating services through a franchising approach. The guiding principles for this program are the development of high-quality, professional, confidential, affordable and client-oriented VCT services in partnership with local communities. To promote VCT in at-risk young people in New York a social marketing VCT program aimed at young people was developed. Although to date socially marketed VCT has demonstrated attractive uptake figures (including access by young people), one of the major drawbacks is cost-effectiveness and replicability in settings or institutions that are not heavily subsidized by donors. In addition, some VCT social marketing approaches in Africa have so far focused their programming on individuals who test negative, who comprise the vast majority of clientele at New Start in Zimbabwe and Dushishoze in Rwanda. If social marketing is used as a service delivery model, it is crucial that support services and mechanisms are also in place for those individuals who test positive. New Start has taken firm measures to enhance support services for all who test. Strategies have included the establishment of onsite post-test clubs as well as strengthened linkages with care and support establishments within the communities.
Getting busy? HIV. Live with it. Get tested.

Developed and piloted in New York, this social marketing campaign promoting counseling and testing focused on urban at-risk youth aged 13-24.66

In 1999, the campaign was implemented in six cities: New York, Baltimore, Philadelphia, Washington DC, Los Angeles and Miami.

Each city built a coalition offering free YFHS offering confidential or anonymous HIV counseling and testing using an oral fluid antibody test (although blood tests were also available), and a phone line for referrals and data collection. Youths who tested positive were provided with HIV care. At least 2,000 youth peer educators were trained and worked to promote the campaign in high seroprevalence neighborhoods.

Paid advertising, dynamic IEC, youth-targeted materials and media coverage (leading daily newspapers, national and local television, radio and websites) were also used as marketing strategies. A 60-second television spot was created with Miami-based rapper Midnite.

A conference targeting more than 500 health care providers, young people and physicians was held to kick off the campaign.

The campaign was successful in: strengthening coalitions among service providers; creating youth participation as outreach workers (through training and small stipends); distributing more than 600,000 palm cards, fliers and magazines; accessing 2,774 hotline calls over six months in six cities; and creating regional sensitization of VCT for young people.

The campaign was less successful in: Uptake of testing by young people (462 young people tested during Get Tested Week).

Access to newly HIV-infected young people (who could then be linked to care and support programs): Nineteen (19) out of the 462 young people tested were newly HIV infected.

Calls that translated into referrals were minimal.

For more information log onto www.HIVGetTested.com.

VCT Communication Messages: Promoting hope for the future is appealing to young people:

Communication messages must be designed with particular target audiences in mind. Given that young people are not a heterogeneous group, messages must be developed that relate to the particular group/subgroup in question. This will be of particular importance in countries with localized epidemics that need to target “hard-to-reach” populations.

There is widespread recognition that fear tactics do not work, and that in fact they may perpetuate stigma and discrimination of PLHAs.

VCT communication messages that have been directly related to the theme of hope and incorporate notions of future, healthy attitude (positive thinking/living) and safety are generally well received.
In addition, though no examples were found, “Get Tested” campaigns using youth icons (sports figures, musicians) to promote VCT could be explored within focus group testing of BCC material development for young people.

The following are examples from existing VCT services:

### 3.8 Home Testing: Some Cautions

Given the concerns about confidentiality associated with clinic-based or free-standing delivery of VCT services, some individuals have expressed a preference for home test kits.

Most health professionals remain concerned about the promotion of home testing as a viable option:

- Results may be inaccurate or misinterpreted;
- It reduces the uptake of appropriate pre- and post-test counseling and does not facilitate referrals for the individual;
- It may appear to be an easy way out for governments that should be compelled to protect basic rights to privacy and freedom from discrimination;
- There is no data demonstrating the potential positive impact of home testing in comparison to VCT;
- At this point in time the potential harms outweigh the few advantages for wider global use.
3.9 Private Sector: VCT Service Delivery Needs Strengthening

In many countries in West Africa and Asia, private health practitioners deliver much of the primary care, including care for young people. HIV testing is carried out in these settings, often without adequate pre-test counseling or informed consent and with insufficient quality control of HIV testing procedures. VCT (or more often, HIV testing alone) in this setting is usually carried out as part of clinical care, often to confirm clinical suspicion of HIV disease. There is great potential for improving VCT in the private setting. There have been some small-scale efforts to train private practitioners to offer a better VCT service, for example in Nigeria, but as yet little emphasis on improving VCT services for young people in this context.

4. FACTORS AFFECTING DEMAND AND UPTAKE OF VCT AMONG YOUNG PEOPLE

4.1 Attitude toward and Demand for VCT

VCT is currently not available for the majority of people in high-prevalence, low-income countries and most young people are unaware of their HIV status. Although VCT is available in at least one site in most countries, these services are generally in large (often capital) cities and have rarely been designed specifically to be acceptable and accessible for young people. However, when young people are asked whether they would like to be tested, they are often in favor of VCT being more widely available and say that they would like to be tested.

Information from Kenya and Zimbabwe reveals that more than 60 percent of both male and female young people (15-19) who have not undergone VCT say that they would like to be tested (Kenya DHS, 1998; Zimbabwe DHS 1999).

In the pilot phase of a study among young couples in rural Western Kenya, 95 percent of participants said that they would accept a free HIV test. If they had to pay for the service (a US$4 subsidized fee), potential demand remained relatively high with 31-40 percent saying they would pay for the test.

In a study on knowledge and attitudes toward HIV among university students in Zambia and the United Kingdom, 10 percent of Zambian students and 7 percent of UK students said that they had received an HIV test. A further 35 percent of Zambian and 15 percent of UK students said that they would like to be tested.

In a KAPB study from Rakai Province in Uganda, 84 percent of young people questioned (18-25 years) said that they would like to see an HIV counselor in the future.

In a participatory study from Uganda with young people (12-19 years) in Mpigi District, males (17-19 years) and females (14-16 years) showed the greatest interest in HIV testing. However, many young people expressed concerns about issues of confidentiality, cost and location of services, as well as a lack of trust in their sexual partners to remain faithful after having the test.

Similar findings were encountered in focus group discussions and in-depth interviews among young people from three provinces in Zambia. Four hundred sixty-five (465) young people (m=217, f=248) aged 12-21 (mean age 17) took part in the study. Young people proposed several theoretical reasons for HIV testing. Fifty-seven (57) percent of boys and 53 percent of girls
said that they would like the opportunity for an HIV test. However, the majority of them were not keen to have an HIV test at the present time, as they were worried that they would be positive (despite HIV prevalence being relatively low in this age group). Some young people said that they would consider having an HIV test in the future. The small number who had been tested thought it was better to know, even if the result was positive. There was a wide interest in pre-marital testing, which was promoted by several churches. Respondents saw this as an opportunity for a “clean slate,” although some said they would still be too scared of the results to have a test, or felt there was nothing that could be done for them if they were found to be positive. Some said they would like pre-marital testing to prove their partner has been as careful as they have, while others wanted to check before exposing their marriage partner to risks they have taken themselves.

What we know:

- There is demand for VCT among young people and youth populations (e.g., Uganda, Rwanda, Tanzania, Kenya, Zambia).

- Reported demand does not always translate into actual demand if VCT is made available.

- Demand can also be successfully created through communication mediums and active service promotion.

- Capacity to supply should be addressed in parallel or prior to creating demand (e.g., Kenya and Rwanda, where demand is now outweighing supply).

What we suspect:

- Availability of support services (including clinical care, ARVs, etc.) for those who test positive may be increasing demand for VCT.

- Normalization of VCT (knowing one’s serostatus) increases demand.

There is no evidence/data regarding:

- Specific variables that lead to “natural” demand outside of demand-creation campaigns.

- Under what conditions it is necessary to generate demand as compared to strengthening infrastructure that may result in natural demand.

4.2 Uptake of VCT

Young people actively seek and receive VCT even where VCT services have not been designed specifically for them.

The AIDS Information Centre (AIC) in Uganda has reported an increase in the numbers of youth seeking VCT, especially for pre-marital testing. About 15 percent of AIC clients are between the ages of 15 and 19 years. By the end of 1995, 39,000 adolescents had visited the center. Of these adolescents, 78 percent were females and 40 percent came to the center with their sexual partners. In Zambia, 14.6 percent of attendees at the Hope Humana VCT site in Ndola were aged 10-19
years. In Brazil, uptake of VCT by young people (13-19 years) is reported to be increasing. In Thailand, 40 percent of those attending the ATC site in Bangkok described themselves as "students." In the United States, 900,000 records of people who had undergone HIV testing were reviewed. Thirteen (13) percent of HIV tests were found to be carried out among those aged 13-19 years.

4.3 Motivation for VCT

Young people have a range of motivations for seeking VCT. These include:

- Pre-marital;
- Wanting to know their serostatus;
- Worried well;
- Exposure to risk practice (either own or partner’s);
- Suspicion of infection and/or feeling ill;
- Partner or child ill/died;
- Planning pregnancy;
- Currently pregnant;
- Entering a new sexual relationship;
- Study requirement;
- Immigration requirement;
- Employment requirement.

In addition, a recent report from Horizons based on a small sample of young people aged 14-21 years in Uganda and Kenya found that 20 percent of the young people who undertook VCT reported that they were not sexually active. Personal communication with the research investigator revealed that the perceived motivator for VCT among some of this subpopulation was access to information in its own right. This finding begs many questions, including the need to further explore the derived value of VCT for young people, and youth motivations for testing in order to tailor services more effectively to their needs. It may also suggest that other services such as counseling, life skills, health education and hotline services may more appropriately meet the needs of some young people and/or be mutually reinforcing.

4.4 Return Rates (for HIV Test Result): Same-day services yield better return rates.

Rate of return appears to be largely correlated with capacity to provide same-day services (or at the very least reduced waiting times for test results). In some industrialized and developing countries, individuals may still require a waiting time of between 2-14 days for test results. For example, in the United States (where same-day services are not available) only 63 percent of people who undergo HIV testing at publicly funded HIV testing centers returned for post-test counseling. Young people and people from ethnic minorities were less likely to return for their HIV test results. People who attend free-standing VCT sites are more likely to return for post-test counseling than people who undergo VCT at STI or family planning clinics. Some pilot outreach services also report problems with rates of return. This can be wasteful both financially and in staff time and means that some people who test positive may not benefit from treatment options as well as post-test and follow-up counseling. With simple/rapid testing, much higher proportions of people who are tested will end up receiving their HIV test result. Some VCT sites now receive 100 percent return rates for test results (usually where quality counseling services and simple/rapid same-day services are offered).

4.5 Barriers to VCT
In the United States, sexually active young people under 18 are less likely to attend VCT than their adult counterparts aged 18-44, although half of new HIV infections in the United States are in men and women under 25. In order to learn about young people’s attitudes and experiences regarding HIV testing, 73 “high-risk” youth (sexually active and economically or socially marginalized youth, living in urban areas with relatively high rates of HIV infection) were interviewed in depth. Factors detected as deterrents to HIV testing among adolescents included:

- Availability and acceptability of VCT services;
- Worries about confidentiality and fear that results would be shared with parent(s) or partner(s) without their consent;
- Internalized beliefs that they are outside the specter of risk (risk perception);
- Fear of being labeled and stigmatized by their families, friends and communities;
- Perceptions of the consequences of living with HIV.

These factors apply equally to young people’s deterrents to using VCT services in Africa as well as reproductive health services in Asia (including India and Bangladesh).

In developing countries, although young people are attending VCT in increasing numbers, there is still often great reluctance to attend VCT sites. Experiences of barriers to attending VCT as reported by various populations include:

**Method of Reporting/Confidentiality**

VCT services have different methods of reporting HIV results, and this may influence uptake of the service, especially where people are worried about confidentiality or belong to groups that are already unsupported or marginalized.

**Confidential versus Anonymous Testing**

Most VCT services offer a *confidential service* where the individual and his/her counselor share the test result. Test results and records are generally kept within a locked facility on site to ensure confidentiality and to limit access to records to only the necessary service provider/s. Within confidential services, identifying information may be recorded (e.g., name and/or contact details within records). In addition, some countries may have a policy of reporting seropositive results to a referral center (named reporting) or a policy of partner notification. Named reporting is also important for sentinel surveillance of HIV within communities/countries. Reporting of some contact details can also allow ease of access by a health care provider to offer follow-up and continuity of services. Other VCT sites offer an *anonymous service* where someone wanting a test can attend without giving his/her name. Anonymous services use only code names or numbers to ensure anonymity. Such services are more desirable among marginalized groups. Experience in industrialized countries such as the United States and Australia suggests that anonymous services may be more desirable to young people, including vulnerable and “at risk” young people and young MSM.

The main disadvantage of such is lack of potential follow-up of clients to facilitate referral and support services.

A study from the United States examined the effect of named reporting on the uptake of VCT services in publicly funded VCT programs, where approximately 2.5 million people are tested for HIV each year. It was feared that the introduction of named reporting to aid surveillance
would cause some individuals to avoid testing. However, there was no significant effect on the use of testing facilities following the introduction of named reporting, though in some states there was a statistically non-significant reduction in testing among African-Americans and IDUs.

Other studies suggest, however, that the introduction of anonymous testing increases testing in higher-risk populations, such as IDUs.\(^\text{85,86,87}\) Studies from the United States have also reported that ending anonymous services results in a decline in testing of vulnerable populations.\(^\text{88,89}\)

### Stigma/Societal Factors

Stigma and discrimination are important factors in the uptake of VCT in different communities. It has been postulated that political commitment to HIV prevention and care has led to less discrimination and hence higher demand for VCT (for example, in Uganda when compared to neighboring countries). It has also been argued that the large number of people who have been tested is a major factor in promoting normalization and reducing stigma and discrimination.

It has been shown that a role model or valued member of the community declaring that he/she has been tested is important in reducing stigma and increasing the uptake of HIV testing. When the celebrity athlete Magic Johnson announced that he had been tested and was seropositive there was a significant rise in people requesting VCT in the United States.\(^\text{90}\)

### Availability of Treatment, ARVs and Support Services for Those Who Test Positive

In countries where ARVs and other effective medical interventions (e.g., PMTCT) are available, there are considerable advantages to people with HIV to be diagnosed early. This has changed attitudes toward VCT among health workers as well as people who are at risk of HIV infection in industrialized countries, resulting in a greater uptake. In developing countries, the lack of ARVs and medical and social support services available for people with HIV are reported as a reason for the poor uptake of VCT.\(^\text{91}\)

### Capacity to Promote Hope

Although little documentation exists regarding the capacity to promote hope and its relationship to testing, there is substantial personal communication and anecdotal evidence to support the tenet that “in order to support VCT, there must be a perceived benefit to testing. For those who test positive, there must be a package of services to offer. Otherwise, why test?” A qualitative evaluation conducted with young people in Rwanda revealed that some young people referred to an HIV-positive result as receiving a "red card that is designed with a hoe and pick-axe" and that death is near.\(^\text{92}\) In addition, some health service providers in Eritrea refer to counselors as “angels of death.”\(^\text{93}\) These sentiments are illustrative of the impact of prevention interventions that have utilized fear tactics to promote behavior change rather than messages that advocate hope.

The most successful VCT and care and support initiatives have marketed notions of hope within their organizational names, logos and value-added services: Hope House (VCT center) and Fountain of Hope (orphan project) in Lusaka Zambia; New Start (VCT center) in Zimbabwe; Hope Humana (VCT center) in Ndola, Zambia; Hope Worldwide; Heroes of the Future (Indatwa Z’èjo, a youth magazine) in Rwanda; and Winning through Caring (BCC strategy) in Eritrea. In addition, two key publications are the Strategies of Hope series and Rays of Hope (Salvation Army). “Hope” has also been successfully packaged by religious organizations, and in many countries church groups have provided outreach to AIDS patients during the terminal stage of their illness, a
time when feelings of hopelessness may prevail. Hope must also be packaged and promoted by health providers, who continue to hold great power to help or hinder the test decision-making process. Service providers who themselves do not have hope create further barriers to VCT for their potential clients.

Additional barriers to young people accessing VCT include:

Health Provider Responses and Attitudes

Because adolescence is a time when habits, behavioral patterns, cognitive skills, decision-making ability and attitudes toward self and health care are established and reinforced, the experiences that adolescents have with health care providers form the basis of future provider-patient relationships, communication patterns and help-seeking behaviors. Health provider attitudes and their comfort levels play a crucial role in effectively addressing sexual issues with young people. Service providers who themselves are inhibited may inhibit young clients who present to them, which creates additional access barriers for young people. Unmarried but sexually active adolescents in Bangladesh reported that they did not feel comfortable seeking family planning or STI services from nearby clinics and pharmacies and perceived providers to be judgmental and unfriendly.95

In a qualitative follow-up of 100 counselors trained by Kara Counselling and Training Trust, 27 counselors stated that they felt uncomfortable counseling about sexually related issues. Of these, 19 specifically mentioned age as a barrier to their comfort level. This was true both for older counselors working with young people, and young counselors working with their elders:

- “I feel youth should not engage in sexual issues”;
- “I cannot counsel my own daughter if she has a problem with her husband”;
- “I cannot counsel people who are like my daughter”;
- “I don’t approve condoms to people who are not married. The young people should use condoms but we shouldn’t influence them to use them.”
- “Those under 15, 14 years . . . I don’t test.”96

In a U.S.-based study by the Kaiser Family Foundation, young people noted that medical professionals did not discuss, offer or suggest testing when according to teens themselves, they would have been open to that recommendation. Deterrents to youth seeking health care and HIV testing included the sense that medical officers and clinic workers do not “respect” youth or are “judging” them for being sexually active.

According to a study in the July 1999 issue of Paediatrics, only half of all physicians reported that they provided any counseling or education in their encounters with adolescents; fewer than 3 percent reported providing counseling or education on STDs or HIV.97

Many counselors at VCT sites in sub-Saharan Africa (e.g., AIC and Kara Counselling) have themselves not been tested for HIV. Counselors are still a reflection of their communities at large. The lack of testing among this cadre also demonstrates the degree of stigma still evident. It is also unclear as to whether this impacts upon their approach in promoting VCT within their communities as well as to clients.
Possible incentives for service providers to deliver high-quality VCT services:

- Involvement in the design and planning of services from the onset/interim;
- Defined job descriptions, including individuals who are employed as full-time counselors and/or who are designated to provide counseling services X percent within their existing role at X times. (VCT should not be designated as an additional duty, nor should it be expected to be performed outside or regular work hours, e.g., after hours or during lunch breaks);
- Salaries that reflect the role and experience of the provider;
- Transport costs accommodated within salary or addressed separately (this is especially important in hard-to-access locations, or where providers travel across sites/services);
- Acknowledgement and respect of the service provider's role by management and senior staff, including the Sister/Matron in charge, doctors, hospital administrators, etc. Support provided in writing as a letter of commendation for services is particularly effective;
- Professional development (supportive supervision, training, attendance at national, regional and international fora; peer support, including staff support groups; formalized meetings on site; flexi-day systems; role diversification such as opportunities to undertake supervision of junior staff, or to deliver training as part of the designated role);
- Office spaces that are conducive to deliver VCT;
- Exchange visits to other sites/centers;
- Annual "retreats" and/or other stress management mechanisms.

Cost Factors: VCT for young people must be free to be accessible to the majority of young people.

Services in Zimbabwe, Zambia, the United States and Kenya suggest that cost factors significantly affect uptake and acceptability of VCT services by young people. Therefore, any attempt to introduce or scale up VCT for young people must take cost analysis into consideration.

Operating Hours: Flexible hours are more likely to provide accessibility.

Uptake is also significantly affected by service operating hours. Many VCT sites have piloted operating hours in order to determine how best to cater to the needs of target groups. Approaches known to be effective with young people include:

- Offering services available after hours (e.g., until 8 p.m.) as well as on weekends (Saturdays have been preferable in some countries with large Christian majorities);
- Offering youth or subgroup “clinics” on a particular afternoon or evening which then becomes known by its time slot (e.g., “Tuesdays Clinic”);
- Remaining open through lunch hour or lunch breaks in countries where business ceases between 12 p.m. and 2 p.m. (When this occurs, services must ensure that staffing is addressed in order to prevent burnout).
5. **OUTCOMES FOR YOUNG PEOPLE FOLLOWING VCT**

<table>
<thead>
<tr>
<th>Outcomes for Young People Following VCT</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Sexual behaviour change;</td>
</tr>
<tr>
<td>- Uptake of services:</td>
</tr>
<tr>
<td>- HIV-prevention services (including male and female condom supplies);</td>
</tr>
<tr>
<td>- Emotional support;</td>
</tr>
<tr>
<td>- Health education and capacity for increased dialogue regarding negotiation and life skills, etc.;</td>
</tr>
<tr>
<td>- Medical care (including treatment of STIs, preventive therapies and ARV interventions, PMTCT interventions, family planning services);</td>
</tr>
<tr>
<td>- Increased capacity to cope — inclusion of family and/or peer support — where helpful and appropriate;</td>
</tr>
<tr>
<td>- Adverse consequences following VCT and disclosure.</td>
</tr>
</tbody>
</table>

For VCT services to be promoted and developed it is important to demonstrate that they are effective as part of HIV prevention and as an entry point for care and that young people are not disadvantaged following VCT. Although many studies have been designed to evaluate outcomes following VCT, very few look specifically at young people.

For example:

- Does VCT help young people make therapeutic changes in their sexual behavior?
- How do young people who test seropositive cope? With whom do they share their test result? Who provides emotional support?
- Are they able to access support services following VCT?
- What is the incidence of HIV over time among young people who initially test negative?
- What are the long-term outcomes for young people who undergo VCT?
- Is a VCT package more effective in addressing behavior change when compared with good quality counseling alone? What do young people value?

### 5.1 Sexual Behavior Change among Young People following VCT

There have been several studies demonstrating VCT to be effective in promoting sexual behavior change in people attending VCT centers but there are few studies that specifically look at young people. A small descriptive study from Nigeria stated that the VCT service for young people increased uptake of condoms and decreased incidence of STIs.100

Three studies from the United States have examined behavior change following VCT with mixed results. One small study showed that VCT promoted a reduction in sexual partners among the majority of males, but none of the females reported increasing safe sex practices.101

A study from New Orleans, United States, among 4,031 economically disadvantaged black young people aged 15-25 showed mixed results following VCT.102 The incidence of STIs following VCT did not change for those young people who tested seropositive; although incidence of STIs...
decreased for those testing seronegative, it did not decrease for those young people who had repeat HIV tests. In this study, HIV testing with individual pre- and post-test counseling was offered at a public STI clinic and quality of counseling and ongoing care may not have been as consistent as at VCT sites.

Another study from the United States looked at behavior in the two years following VCT among “high-risk” young people attending an adolescent medicine clinic in Washington DC. “Single-dose” VCT as offered in this setting did not result in any significant decrease in STIs or reduce risk behavior.

From these studies, offering VCT as part of medical care for young people at high risk of HIV infection in an industrialized country does not demonstrate consistent, successful behavioral outcomes.

5.2 Access to Care for Young People

Increasing access to VCT can ensure that people with HIV can obtain earlier and more appropriate medical care. However, there is no information describing if VCT enables young people in developing countries to benefit from better medical care.

Approaches to care for young people still require considerable improvement, even in industrialized countries.

It is estimated that only 11 percent of youth living with HIV in the United States receive adequate medical care.

Says Dr. Donna Futterman of the Adolescent AIDS Program/Montifiore Medical Centre in New York, Unites States: “What we would ultimately like to see here is that the offering of HIV testing be more routine in adolescent care among teens who are sexually active. There are a lot of ways of making testing more accessible to young people. We bring them out of the clinical setting into the community setting, using oral testing and urine-based testing in addition to standard blood testing.”

More information is also needed on the most appropriate models of care for young people. Lessons from industrialized countries suggest that a one-stop shopping model of multi-disciplinary care with integrated services including primary care, gynecological, HIV-specific, mental health and case management is desirable to some groups of young people. However, this may not be realistic or achievable in many contexts. Availability of flexible appointments, attention to payment barriers and walk-in capacity may facilitate participation in health services.

5.3 Coping

VCT has been shown to help people cope with their HIV infection and make plans for themselves and their family. However, as previously mentioned, operational research is required for a more in-depth understanding of coping capacity of young people following VCT. Research into coping should take account of issues relating to emotional capacity and psychological well being, medical care, financial planning, social support, disclosure, familial and sexual relationships and spirituality.
5.4 Adverse Consequences following VCT and Disclosure

There is little published data that monitors adverse consequences for young people following VCT in various country contexts and issues relating to disclosure. However, it is evident that adverse consequences may follow VCT, and these consequences are inextricably linked to stigma, discrimination and gender-based power relations (refer to 7.9).

6. LEGAL ISSUES

Age of Consent for Young People

In most countries there are legal requirements necessitating parental or guardian consent before medical procedures can be carried out. HIV testing may be subject to such legislation. VCT sites vary widely in their policies and or practices for testing young people depending on local and country polices. Many sites have not drawn up a formal policy regarding age of consent for testing, and in practice, procedures may be implemented at the discretion of the particular counselor on duty at the time.

In Kenya the legal age of consent is 18 years.

Anyone 18 years of age and over requesting VCT is deemed able to give full, informed consent.

For young people between the ages of 15 and 18 years, VCT may be provided if the counselor determines that the young person has sufficient maturity to understand the testing procedures and results.

Young people between 15 and 18 years who are married and/or pregnant are considered "mature minors" who can give consent for VCT, though the counselor makes an independent assessment of the minor’s maturity to receive VCT services. Children 14 years and under are given counseling if requested but should not be tested unless testing is done for medical reasons and the counselor determines that VCT services have potential benefit to the minor, and this is clearly explained to the minor.

When children are brought to a VCT site for testing in Kenya, the counselor meets with the parents or guardians to determine the reasons for testing. VCT services are provided only if there is a clear potential benefit for the child, and the counselor determines that there is no potential for neglect or abuse of a seropositive child. Rwanda has formulated similar policy guidelines regarding age of consent for VCT.

What we know:

- Some young people are being denied access to VCT as well as clinical care on the basis of ageism (either based on provider judgment or policy restriction).

- In the absence of conducive policy, some service providers refer to generic policy guidance that endorses services for all (irrespective of gender, socio-economic status, age, etc.) as a way of ensuring service provision to young people.
Jamaica: Conducive Policy Reform

The Jamaican Ministry of Health amended its Reproductive Health Service Delivery Guidelines in 1999 to provide legal protection to health professionals wanting to provide information or services to youth below the legal age of consent (16 years), many of whom are already sexually active.107

- Parental consent is a barrier to uptake of VCT by some young people (including those who could benefit from the intervention).
- Service providers currently employ “judgment” to determine who may or may not receive services.

What we suspect:

- Some service providers withhold VCT from young people who request it through fear of parental retribution (in the absence of protective policy guidelines).

What is needed:

- Capacity for young people and some adolescents (above 12) to provide consent (without parental consent) for VCT. Disclosure to parents should still be discussed within counseling and encouraged where young people have supportive relationships with parent/s. In addition, where young people are deemed to be at high risk, pre-test counseling will need to ensure adequate coverage of potential support systems if the test result is positive to ensure sufficient test decision-making outcomes.
- Capacity for service providers to undertake VCT for young people who request it, without fear of retribution.
- National policy frameworks that support access to VCT by young people without parental consent (though parental support is encouraged where conducive, and support by a trusted relative or friend is encouraged in the absence of a supportive parent).
- Reduction of “judgment-making ability,” especially in countries with poor quality of counseling and counselors with limited training.

(See also Section Two on consent and children.)

Coercion

HIV testing should take place within an ethical framework, which ensures that testing is voluntary with informed consent. When testing young people (particularly children, see Section Two), they may be unable to give informed consent. In other circumstances, an adolescent may be ambivalent about HIV testing but be brought by a parent or guardian for testing. HIV testing in these circumstances should be carried out only if it is deemed by the counselor to be of benefit to the young person (after thorough assessment with the young person in the absence of the guardian/parent). Consent to meet with the young person privately will require endorsement by the parent/guardian (in the case of “minors”).
Disclosure of HIV Test Results

As with consent to testing, in some circumstances there may be a legal obligation to inform a parent or guardian of an HIV test result. The consequences of this should be explored during pre-test counseling. There are great benefits of sharing HIV test results with someone. However, some young people have dysfunctional relationships with their parent/s or guardian/s and may suffer physical, sexual or emotional abuse as a result of such disclosure/informing. In these circumstances, another trusted adult family member or close friend could be identified to provide post-test support.

Legal and Social Barriers

In some countries there are social and legal barriers to the provision of HIV education and counseling programs for young people. For example, in the United States, although recommendations have been made to provide age-appropriate HIV education and counseling for all school children, there have been legal actions to prevent this. Barriers include lack of access to condoms and STI services for young people. Provision of such warrants acceptance of the fact that young people of varying ages are sexually active. Even in industrialized countries, widespread acceptance of this reality has not been endorsed by policymakers, including politicians.

7. CHALLENGES

7.1 Summary of Issues to Consider for Acceptable and Ethical VCT for Young People

Disclosure (to parent, guardian, family members, sexual partner/s):

- Are staff adequately trained and competent to explore such issues within counseling? What are the service and or national policies in place in relation to disclosure? Are staff aware of the guiding policies?

Consent (legal and ethical considerations):

- Who can provide consent? Under what conditions? Are staff consistent in addressing consent issues within a given service? Are staff aware of the legal and ethical framework in which they operate? Are they adequately trained to facilitate procedures relating to informed consent?

Confidentiality (anonymous vs. confidential VCT):

- Does the service offer anonymous or confidential services? What is its experience in terms of young people accessing the service? Is it feasible to consider modifying services to increase access and uptake by youth, which may include re-visitation of practices pertaining to confidentiality?

7.2 Approaches for Involving Young People in Design, Development and Promotion of VCT Services
The rhetoric: Experience from other health interventions has demonstrated the importance of involving young people in the design and development of services to ensure that they are relevant and acceptable. Young people should also be involved in the ongoing monitoring and evaluation to ensure that services respond to their needs.

The reality: Documented examples of standardized regular youth participation in planning and development of VCT services were not located. Although various national policies advocate youth involvement and representation on various committees, including National AIDS Committees, tangible evidence of such practices was not found.

Leading by example: Encouraging and appropriate examples of the involvement of young people in four pivotal areas can be highlighted:

1. Youth as active members and leaders of Post-test Clubs, especially those that employ drama as an educative medium (Zambia, Uganda and Zimbabwe);
2. Youth, especially young men and young couples, as community mobilizes for promotion of VCT within their respective communities (Zambia and Uganda);
3. Youth as Anti-AIDS Club leaders within schools and universities (Zambia and Uganda);
4. Youth as positive speakers (Zambia, Uganda, South Africa, Australia, United States).

7.3 Availability of Ongoing Emotional and Support Services

Provision of VCT for young people should be linked with the development of support services following testing. These may include:

- Linkages with youth support groups;
- Involvement of and support from religious groups that advocate for a holistic approach to AIDS prevention and care;
- Ongoing support for vulnerable young people, which may include IDUs;
- Adequate support for orphans, street kids and children-headed households.

In addition, the potential role of schools to provide support must be fostered and enhanced. Where participatory teaching methodologies are encouraged and experiential learning is promoted and modeled by teachers, young people may have opportunities to learn how to reduce their vulnerability to HIV.

7.4 Access to Medical and HIV Preventative Care

For VCT to be acceptable, linkage with ongoing medical care should be considered, including:

- ARVs;
- Preventive therapies (TBPT and cotrimoxazole);
- PMTCT interventions;
- STI screening and treatment;
- Family planning/contraception;
- Access to condoms (male and female).
7.5 Different Needs for Young Men and Young Women

Most epidemiological studies reveal much higher HIV prevalence among young women compared with young men. There are many biological and social factors that contribute to this difference. Young men and women may also have very different health beliefs, vulnerabilities and abilities (real and perceived) to make decisions about their sexual lives following VCT.

A study from South Africa found that young people, especially young women, are at high risk due to an apparent gap between awareness and practice. In peer group discussions with girls aged 14-15 and boys aged 16-19, separate male and female safe sex paradigms emerged, with boys less likely to perceive themselves as “at risk” and more likely to use condoms. Girls had not used condoms, would have preferred to delay sexual relationships and feared pregnancy as well as HIV. Both sexes deemed it difficult for girls to initiate condom use, although both sexes viewed condoms favorably. Girls saw condoms as a sign of love and protection, whereas boys tended to use them with casual partners. A lack of decision-making autonomy within relationships further constrained girls’ ability to practice safer sex.

These findings suggest the need for research into sexual socialization patterns (especially in high-prevalence countries in Africa). In addition, programs to address gender inequalities and emphasize behavioral skills in the years before sexual activity begins must be developed and thoroughly evaluated in terms of their efficacy (refer to 7.9).

7.6 Pre-marital Counseling (Legal and Religious Requirements)

What we know:

- Pre-marital testing has potential to help or hinder couples.

- Couple counseling for VCT is a valuable intervention when truly voluntary and when adequate undertaking of informed consent by both parties is carried out.

- Pre-marital VCT is being widely promoted, particularly by churches and religious groups in sub-Saharan Africa.

- Some groups (including Evangelical church groups) demand to cite test results that are used as grounds for denying the conduct of a marriage ceremony (where results are discordant or positive). Test result certification or documentation is not provided by most VCT sites because of the numerous grounds for potential misuse or negative consequences that may arise, including stigma and discrimination, and false hopes of “safety.”

- The Anglican Church and Catholic Dioceses both met recently in Africa to reaffirm their commitment to the fight against AIDS. However, neither symposium resulted in detailed positions related to counseling and testing.

- Although there are clear advantages in couples knowing their status before marriage there are cautions, particularly in communities that have a high prevalence of HIV in young women.
What is needed:

- For VCT to remain voluntary and for couples to discuss in pre-test counseling the implications of discordant results. If young women are at risk of discrimination, isolation, abandonment and abuse if found to be seropositive (as can occur with VCT associated with PMTCT interventions), safeguards and support systems for seropositive women must be ensured.

- Supportive policies on pre-marital testing (especially by religious bodies) to prevent stigma and discrimination on the basis of results.

Pre-marital Testing in Malaysia: A New Policy for the State of Jahor

The State Religious Affairs Department (JAIJ) has introduced compulsory pre-nuptial HIV testing for Muslim couples in Johor, Malaysia.

Johor launched the new policy on November 13, 2001, and is the first state in the country, and one of the few places in the world, to implement compulsory HIV testing on a segment of its population. Under the policy, Muslim couples applying to marry in the state will have to undergo HIV testing. In the event one partner is found to be HIV-positive, that person will undergo counseling sessions by JAIJ. If he or she intends to go ahead with the marriage, the future partner will be informed by a JAIJ case worker, and the couple will then be counseled together to ensure that the uninfected partner understands the future consequences of proceeding with the union. Workers handling these caseloads will be required to take an oath of confidentiality. JAIJ claims that compulsory testing is a “compassionate move” that will ensure that a person knows that his or her future partner is HIV-positive, and that this will empower the person to make an informed decision. A feature of the policy is that the affected couple is not actually prevented from marrying if they decide to do so.

The Malaysian AIDS Council (MAC) has stated that certain technical aspects of the policy, such as the problem of the “window period” in testing, the implications of what would happen if the couple decided to marry in another state instead, and the issue of confidentiality still need to be addressed.110

7.7 Mandatory Testing

Although not VCT, it is necessary to highlight categories of mandatory testing that occur in some countries and that relate to a sizeable number of young people globally. These include young people and adolescents who:
- Are planning to marry (pre-marital);
- Plan to work, study or live abroad (temporarily or permanently);
- Plan to attend university (e.g., in Ecuador, mandatory HIV testing is a requirement for any prospective student attempting to gain entry to university within the country. Those who test positive will be denied entry into university);
- Are refugees;
- Are new military recruits;
- Wish to enter the seminary or convent (commonly practiced in high-prevalence parts of Africa though this may not be global protocol);
- Are institutionalized, including orphanages, foster care, detention centers, prisons, etc.

For young people in the above-mentioned categories, a common feature is the lack of supportive services offered after testing. The implication for these young people is particularly concerning, given that a positive result for most will mean denial of access to their chosen life path. Therefore, it is particularly important that support services be created, or at the very least, linkages to such for young people in these situations. In addition, there may be a role for the international community to lobby for amendment to some of these legal or guiding frameworks.

### 7.8 Outcomes for Young People following VCT: Limited Data Available

There is currently very little published data on the outcomes for young people following testing. There is data to suggest that most adults who test seropositive can cope if they are supported with ongoing counseling when needed.

In Zambia, many people who tested seropositive expressed sadness, anger or anxiety following testing, although this was relatively short-lived and no cases of attempted suicide occurred. Some people who had suspected they were positive said that they felt at ease on receiving their result, as they were now able to understand symptoms and make plans for treatment or for their dependants. People who tested seronegative expressed relief, but some also expressed guilt or sadness as partners or family members had tested positive.111

In a multi-center trial, 81 people were interviewed in depth about their emotional feelings following VCT.112 Seronegative clients reported feelings of relief, decreased anxiety, improved hope and increased confidence in themselves. Seropositive people reported better coping skills to deal with their situation, increased hope, disappearance of suicidal thoughts and help in decreasing isolation and normalizing their situation. Among seropositive people, most distress was described as transient. However, some participants reported persistent feelings of sadness, desperation and a sense of loss as they felt they may have to give up having children and abstain from sex due to worries about infecting others.

---

China's People's Liberation Army will begin testing all new recruits for HIV. Tests will begin this year in three districts in Beijing and will expand to eventually encompass all new recruits. Men between the ages of 18 and 20 with at least a junior school education are eligible to join the 2.5 million-member army.

*Shanghai Morning Post, Oct. 25, 2001*
Some young people may not have the emotional maturity to cope as well as adults following VCT. They may also be less likely to have a stable sexual partner with whom to share their status. **There is an urgent need to explore the long-term outcomes for young people following VCT.**

### 7.9 Young Women and Violence

Studies have found that a serious barrier to disclosure for women is fear of violent reaction by male partners and that HIV-infected women are at increased risk of partner violence.113

In a qualitative study carried out in Dar es Salaam, Tanzania, young HIV-positive women (18-29 years) were 10 times more likely to report partner violence than young HIV-negative women.114

In some countries, partner notification is required by law. Though limited data are available, it is likely that such legislation would affect uptake of VCT services by some young women who may be at risk of abuse, isolation or abandonment following an HIV-positive result. A survey of 136 health care providers in Baltimore, United States, revealed that 24 percent of providers had at least one female patient who experienced physical violence following disclosure to a partner. More than one-third of all providers (38 percent and 37 percent) had at least one female patient who experienced emotional abuse and abandonment following disclosure.115

**What is required:**

- Continued community-based efforts to address harmful attitudes and norms about sexuality and violence in parallel with any attempts to develop, expand or scale up VCT services for young people.
- Ensuring that partner notification strategies and legislation do not threaten the safety of HIV-positive women.

### 7.10 Counselors for Young People

Counselors who feel comfortable counseling adults do not necessarily feel comfortable providing counseling for young people (refer to Section 4.5). Most counselors have not had specific training in counseling young people and may feel uncomfortable or lack experience in helping young people make decisions about sexual behavior. Experience from many services illustrates that health workers are often authoritarian and judgmental when dealing with young people and have difficulties engaging and listening to their needs.

Counter-transference often features during observation of counseling and counseling role-play. Counselors may identify with young clients as their own children, grandchildren or younger siblings. This can pose significant challenges in their counseling roles as they may take on a role of advisor (which often includes instructing the young person to return to their parent for consent/advice, etc.) or guide, rather than actively listening, supporting and suspending judgment. This has been cited among counselors in sub-Saharan and North Eastern Africa.
What is required:

- Training for counselors involved in providing VCT services for young people to help them work successfully with young people and to understand transference and counter-transference, which has cross-cultural relevance to VCT.

7.11 Peer Counselors versus Peer Educators: They are not the same!

What we know:

- There are clear and significant roles for young people in designing and developing VCT services, providing community mobilization, advocacy, HIV and health education and providing ongoing support through post-test clubs and individual “buddy” schemes.

- The terms “peer educator” and “peer counselor” have been loosely and inappropriately used in an interchangeable manner.

- The roles and skills bases of peer counselors as opposed to peer educators may vary considerably.

- At many sites, young people have been successfully trained in basic counseling skills, which can be successfully applied to the provision of emotional support and group work with peers, as well as in application to their own lives and surroundings.

What we suspect:

- While peer education has a documented role, it will usually not be appropriate for youth peer educators to provide pre- and post-test counseling.

What is required:

- That service providers enter into dialogue with young people to seek their views about whom they would find most appropriate as counselors.

In Eastern Europe, outreach peers (young former IDUs) were found to be effective in providing outreach education services for young drug users, but specially trained counselors were more acceptable in providing counseling around testing.\textsuperscript{116}

Research from Kenya and Uganda suggests that young people would prefer to be counseled by young adults, and not their peers (i.e., “not their friend, and not their mother”). Most importantly, young people wish to feel confident that confidentiality will be ensured, but that the counselor is “on their level/close to young people.” Some of the qualities young people look for in a counselor include “knowledge, trained, kind and a good communicator.”\textsuperscript{117}
Issues to consider for peer educators:

- Payment/allowances for “volunteers”;
- Training for peer educators;
- Support and supervision of peer educator activities;
- Support and counseling for peer educators themselves;
- Prevention of burnout;
- Expanding the role of peer educators who have undergone VCT to play a role in community mobilization, post-test clubs and positive speaking (where the peer educator is HIV-positive and able to “go public” without suffering adverse consequences);
- Creation of job training or mentoring opportunities for young peer educators to encourage them to take on alternative roles such as group facilitators or to provide emotional support to other young people.

7.12 Access to Health Education/Information/Skills Building Outside of VCT

Young people benefit from mutually reinforcing messages that are delivered by a diverse range of providers within a diverse range of contexts and settings.

**LIFE SKILLS CONTINUUM**

<table>
<thead>
<tr>
<th>Away from . . .</th>
<th>Toward . . .</th>
</tr>
</thead>
<tbody>
<tr>
<td>Only school and health-setting based settings</td>
<td>A range of settings, including clinical and non-clinical, public and private, home and community-based</td>
</tr>
<tr>
<td>Only teachers and clinicians as providers</td>
<td>Parents, guardians, peers, older peers, guidance counselors, elders and traditional helpers (e.g., “aunties,” wise people, “sahwiras”) as providers</td>
</tr>
<tr>
<td>Only school-based youth as recipients</td>
<td>In- and out-of-school young people and children including adolescent mothers as recipients; older school-based youth as providers to younger recipients in and out of school</td>
</tr>
<tr>
<td>Programs that only give information and advice and do not lead to behavior change</td>
<td>Programs that address a balance of knowledge, attitudes and skills such as communication, negotiation and refusal skills that can lead to behavior change</td>
</tr>
<tr>
<td>Didactic teaching</td>
<td>Participatory modeling and experiential learning</td>
</tr>
<tr>
<td>Interventions based on adults views of what young people need and from adult-based service centers</td>
<td>Starting with what young people want and what they are doing already to obtain sexual and reproductive health information and services</td>
</tr>
<tr>
<td>Integration of life skills into each subject</td>
<td>Curricula that is adequately housed</td>
</tr>
</tbody>
</table>
Life skills as they relate to VCT would include:

- Exploring accurate individual risk assessment (to address the fact that many young people have inaccurate risk perception);
- Risk-reduction strategies including opportunities to model effective behaviors;
- Referral and linkages to VCT and care and support services as appropriate;
- Health education related to VCT, modes of transmission, relationship between HIV and other STIs, prevention strategies;
- Access to condoms, condom demonstrations and practice and distribution.

A “community of services” could coexist with linkages to VCT (via referral mechanisms) such as:

- Internet/web-based programs (e.g., CDC in Honduras);
- Hotlines (e.g., New Start in Zimbabwe, Get Tested in the United States, Childline in Namibia);
- Use of traditional “aunties” as an entry point to undertake sex education/prevention/VCT promotion during rites of passage (including initiation ceremonies);
- Intergenerational education for parents and guardians (e.g., Family Life Movement and UNICEF Caring for Us in Zambia (see also Section Two);
- Peer education via “older peers” (e.g., young people before they commence university, as in Zimbabwe);
- Post-test clubs that undertake advocacy and edutainment;
- Anti-AIDS Clubs.

---

**A Parent-centered Approach in Kenya**

The Family Planning Association of Kenya implemented a parent-centered model for expanding information and services to young people living in Nyeri and surrounding farm areas. The emphasis was on meeting the needs of young people who are not yet sexually active, although those who are active may also benefit.

Parents are trained to be friends to their children and to provide adolescents and other parents with information, basic counseling and referrals.

In addition, a diverse group of public and private providers is trained to receive referrals from those adolescents who require further information, counseling or clinical care.
In Mwanza Region, guardians were selected from among female teachers whose task it is to assist girls (and boys if needed) on issues relating to sexual health. The guardians are trained in counseling and problem-solving skills. Apart from maturation issues, girls may also report unwanted sexual harassment by teachers, other adult men or boys.

The guardian reports directly to the district and regional authorities who can take action. Guardians have also formed a support committee of representatives at the district level that negotiates with district authorities concerning action and support for guardians, who may face threats from males engaging in sexual relations with schoolgirls.

Girls are encouraged to solve their own problems by discussing and sharing problems among themselves. Exchanges between girls and boys are also organized with the aim of exchanging views about the obstacles that both groups experience when trying to postpone sex or to negotiate protected sex.

A radio program and newsletter have been developed to give guardians ongoing support and information about how to develop gender-based responses to the sexual health problems faced by pupils of both sexes.

What is required:

- Advocacy for mutually reinforcing approaches linking VCT with ongoing access to health education, information and life skills. This could be done via existing mechanisms developed to support FRESH (Focusing Resources on Effective School Health is an agreement initiated by key United Nations agencies to improve school health through policies, clean water and sanitation as a first step in creating a healthy environment, skills-based health education and related health services with the support of school, family and community partnerships).

- Going national with life skills in high-prevalence countries in Africa. Ensuring that life skills curricula in these countries address VCT, risk assessment, risk reduction and referral of young people to VCT, as well as counseling. This will require considerable government and donor support. Examples include support by the ministries of education in Vietnam (setting up focal points) and Senegal (establishing support from inspectors in each province), and support by the World Bank in West Africa to integrate life-skills training within generic teacher training.

- Support for capacity building of teachers and guidance counselors (and other providers) to deliver the programs. “Teachers must be the overt target group for their own personal needs as well as the vehicle for working with youth.”

- Strengthening and resurrecting indigenous structures as entry points to undertake sex education/prevention/VCT promotion, including during rites of passage (e.g., initiation ceremonies).
- Engaging adults, including parents and guardians, in creating a safer and more supportive environment in which young people can learn to manage their lives more effectively through training and support for intergenerational communication.

- Evaluations of the impact of parent education programs on parent-child communication. Note: Horizons has written a concept paper on this topic and is exploring avenues and programs that might be feasible to evaluate.

**Incentives for young people to participate in non-client-centered activities:**

- Involvement from onset in design and planning;
- Training opportunities;
- Opportunities to address a range of audiences (e.g., a post-test club that creates drama skits requires opportunities to present at public fora to receive validation, affirmation and to give meaning to its efforts);
- Edutainment, including prize giveaways and IEC materials;
- Sessional financial incentives;
- Income-generating opportunities (these may also relate to skills-building activities);
- Skills-building activities are also highly valued by young people who are unemployed and/or out of school, and PLHAs;
- Involvement and appearances by youth icons (e.g., football players, rap musicians);
- Music;
- Transport reimbursement;
- Pens/notebooks/t-shirts;
- Food/soft drinks.

**VCT-related training manuals/materials have been developed by:**

- FHI;
- CDC;
- Kara Counselling and Training Trust;
- Kenya Association of Professional Counsellors;
- TASO;
- AIC;
- Muhimbili Health Information Centre;
- Whitman-Walker Clinic.
Suggested VCT reading materials:

UNAIDS. Caring for Carers: Managing Stress in Those Who Care for People with HIV and AIDS. UNAIDS Case Study. 2000.
Summary: VCT and Counseling Issues for Children (15 years and under)

What needs to be done: Advocate for rights-based frameworks as they apply to access to health care and psychosocial support for children.

How to do it: Lobby, advocate and support agencies and governments in developing supportive policy guidelines that relate to:

- Counseling and testing of children (when benefits outweigh harms) and parental/guardian involvement;
- Consent for testing, medical and psychological care and support;
- Psychosocial support interventions for children who test positive;
- Use and application of testing for infant (0-2 years) diagnosis (including provision of ongoing support to parents to decide if testing the infant is beneficial/appropriate).

What needs to be done: Guidance documentation relating to disclosure issues.

How to do it: Support and disseminate guidance information relating to:

- When and how to disclose to a child their HIV serostatus;
- When and how to share HIV serostatus with school, family members, friends, etc.
- When and how a parent can disclose to a child the parent’s serostatus;
- Develop and disseminate lessons learned and case studies from organizations and institutions dealing with disclosure.

What needs to be done: Support intergenerational communication initiatives and skills building for children and guardians to increase coping capacity.

How to do it: The impact of HIV/AIDS on children begins from the time a parent is diagnosed as positive, not when the child becomes orphaned. Parents, families and children must be assisted to cope more effectively through support for programs that help parents in communicating and facilitating disclosure with children and programs that assist children (and carers, such as grandparents, etc.) with managing the household, caring for the ill parent, planning for death and parenting siblings.

What needs to be done: Capacity building of service providers that work directly with vulnerable children.

How to do it:

- Support organizations (including regional institutions) involved in streamlining child counseling training especially in relation to:
  - Grief and bereavement (pending loss and loss of a parent/s and/or family member);
  - Illness affecting children (including children with HIV/AIDS);
  - Abuse, including sexual abuse and incest;
- Support service providers to attend experiential participatory training;
- Disseminate generic training materials for broader application;
- Support training of trainers (TOT) and subsequent training plans to ensure increased coverage of training.
What needs to be done: Promote and invest in initiatives led by and involving HIV-positive and -negative children and adolescents.

How to do it: Foster support to Anti-AIDS Clubs, youth ambassador programs, post-test clubs, drama clubs and edutainment initiatives that involve HIV-positive and -negative children and adolescents in fighting stigma and discrimination.
SECTION TWO. INFANTS, CHILDREN AND VCT

There are an estimated 1.4 million children under the age of 15 living with HIV worldwide.

UNICEF has recognized the urgent need to prioritize care and support interventions alongside existing prevention strategies. As part of UNICEF’s current strategy for the period 2002-2005, two major focal areas have emerged that warrant discussion. These are:

- To increase care and support for children and parents living with HIV;
- To ensure care and protection for orphans and vulnerable children (OVC).

The majority of interventions have focused on the second level of programming. However, the impact of HIV/AIDS on children begins from the time a parent is diagnosed as positive and thus more investment is required to assist parents, families and children to cope more effectively by encouraging open and supportive communication regarding emerging needs and planning for the future through:

- Assistance to parents in communicating and facilitating disclosure with children;
- Assistance to children (and carers) with managing the household, caring for the ill parent, preparing for death and parenting siblings.

Section Two focuses on counseling and testing issues in relation to children and HIV/AIDS. Issues relating to pediatric clinical care are beyond the scope of this document.

In order to best address the care and support needs of children as they relate to knowledge of one's serostatus, the follow critical areas must be considered:

1. Motivation for Testing a Child

Who has requested/suggested testing? What is the rationale for testing a child? What are the perceived benefits and/or possible harms that could come to children if they were to be tested?

Testing of a child could be considered if:

- A child is sexually active;
- A child has been sexually abused;
- A child is symptomatic;
- A child has been exposed to other risks such as through contaminated blood or perinatally.

2. Consent

What are the age restrictions/limitations regarding testing children for HIV? Who is able to give informed consent and under what conditions? Who can consent in circumstances where there
is no parent (e.g., frameworks relating to the “guardian” who would like to have his/her “ward” tested)?

In California, United States, anyone aged 12 or older can give consent to test for HIV or other STDs.\textsuperscript{122}

In Brazil, adolescents over the age of 12 have the same rights to health services as adults, and do not require parental consent to access services.

3. Policy Frameworks

What policy frameworks exist in relation to testing and psychosocial support to children? Are national policies and/or site-based protocol in place to respond to the issue of testing of children?

Policy frameworks in some countries do not include national strategies that relate to testing of children, although rapid progress is being made to develop such guidance. National guidelines are required, but in the interim, so too are protocol within sites that are currently faced with such situations on a daily basis.

<table>
<thead>
<tr>
<th>National HIV/AIDS Policy Zimbabwe 1999</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under the legal age of consent, a child is considered a minor and consent (for testing) is obtained from parents or a legal guardian (Guiding Principle 17).</td>
</tr>
<tr>
<td>Section 6.5 of the policy: If children have HIV/AIDS, these rights must extend to freedom from discrimination in all spheres of life and the right to full access to health care, education and welfare support.</td>
</tr>
<tr>
<td>Support and counsel children and young people to help them cope with HIV infection and/or living in a family with someone infected with HIV.</td>
</tr>
<tr>
<td>Provide support to parents and guardians to inform and educate their children about HIV/AIDS/STI and unwanted pregnancy.</td>
</tr>
<tr>
<td>Promote youth-friendly health services.</td>
</tr>
<tr>
<td>Children and young people below the age of 16 years who have concerns about and/or have an STI have the right to appropriate counseling and care services and advice on means to prevent HIV/STI. The counseling and professional advice given should depend on each young person’s circumstances and potential risk of HIV/STI.</td>
</tr>
</tbody>
</table>

This policy is an admirable attempt by the Government of Zimbabwe to respond proactively to the needs of children and young people in relation to HIV/AIDS. Although on the one hand access to services is promoted, access to HIV testing still requires parental consent for those under the “age of consent.” This practice is likely to impact uptake of VCT by adolescents who seek services.

“Age of consent” is a contentious issue that confounds the ability to provide access to VCT as well as care and support in numerous circumstances.
Legal Ages of Consent in Six African Countries

<table>
<thead>
<tr>
<th>Country</th>
<th>Marriage</th>
<th>Identification Registration</th>
<th>Medical Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tanzania</td>
<td>15/16 female</td>
<td>18 drivers license</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td>19/20 male</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Malawi</td>
<td>18-20</td>
<td>18 drivers license</td>
<td>18</td>
</tr>
<tr>
<td>South Africa</td>
<td>16 for sex 21</td>
<td>16 ID registration 18 to vote and license</td>
<td>14</td>
</tr>
<tr>
<td>Zambia</td>
<td>18 16 customary law</td>
<td>16 ID registration 18 to vote</td>
<td>18</td>
</tr>
<tr>
<td>Mozambique</td>
<td>15/16 male 18 female</td>
<td>16 for passport 18 to vote</td>
<td>18</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>16, also for consent for sex</td>
<td>16 drivers license 18 to vote</td>
<td>18</td>
</tr>
</tbody>
</table>

The Kara Counselling Experience

The Kara VCT sites were reporting an increase in the numbers of children and adolescents being brought by parents and guardians to their centers for HIV testing. Counselors were concerned and realized that Kara did not have a policy relating to the testing of children and adolescents. Upon this revelation, members of the management team drafted a Kara Policy relating to VCT for adolescents and minors.

Section 10, Special Groups

Section 10.2, Young People: KCTT is committed to offering youth-friendly health services and counseling will be offered to all young people who attend VCT centers. Testing of young people will be carried out in line with current legal requirements.

Section 10.4, Children: In some circumstances, HIV testing for children will be provided with parental consent as defined by the prevailing legal requirements. However when there are other testing agencies available that deal specifically with testing of children then the counselor will refer.

In addition, KCTT played a role in the development of child counseling guidelines currently in publication by the Southern African AIDS Training (SAT) Program.

4. Infant and Child Diagnosis (role and options regarding testing)

In most parts of sub-Saharan Africa, testing of infants is largely not practiced given the limited accuracy of antibody tests for a minor under 18 months of age. For infants under 18 months, testing is restricted to circumstances where polymerase chain reaction (PCR) testing technology is available, and in most instances is still mostly used for serological surveillance purposes and for clinical confirmation by medical professionals. PCR testing is conducted mostly through major referral hospitals or through private health facilities, in both circumstances usually at a cost prohibitive to most clients.
Questions to be asked in the context of testing infants and children include:

- Under what circumstances is testing of infants and children conducive, and to whom?
- What is the role of health care providers in supporting parents/guardians through decision-making processes regarding whether or not to test an infant or child?
- Once results are known, how and in what manner is such information shared and with whom?
- How will knowledge of HIV-positive serostatus be used to ensure access to care and support for the infant or child?

**HIV Testing of Infants in Belarus: An Anecdotal Insight**

In Belarus, a relatively small number of infants are born to mothers with HIV. HIV transmission in the adult population is most commonly thorough IDU, so infected women are IDUs or, more commonly, partners of IDUs. They often are young, unsupported and have other psychosocial problems. Approximately 50 percent of mothers will abandon their babies following delivery. The rest will look after them, often with help from the maternal grandmother. The practice for diagnosis of HIV infection in infants was HIV testing at 18 months (this was not carried out earlier, largely due to technical difficulties with PCR). Interestingly, many families did not return with their children for diagnosis. When asked why, a common response was that they would rather not know; if the baby seemed healthy they would rather carry on than have "the terrible anxiety of finding out he/she was infected." They would consider HIV testing if and when the child became persistently or seriously unwell.

**Disclosure: Should the Child Know His/Her HIV Serostatus?**

There are no guidelines that can direct health care providers on the best age, the best person or the most appropriate method to tell a child about his/her diagnosis of HIV. And limited documented experiences exist in relation to such disclosure issues. However, several disclosure studies have been published in the United States.123

<table>
<thead>
<tr>
<th>Author</th>
<th>No. in sample</th>
<th>Age</th>
<th>% knowing diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bor (1997)</td>
<td>503</td>
<td>&lt;10</td>
<td>37</td>
</tr>
<tr>
<td></td>
<td></td>
<td>10</td>
<td>48</td>
</tr>
<tr>
<td></td>
<td></td>
<td>16</td>
<td>100</td>
</tr>
<tr>
<td>Cohen et al (1997)</td>
<td>92</td>
<td>5-10</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td></td>
<td>&gt;10</td>
<td>95</td>
</tr>
<tr>
<td>Funck-Brentano et al (1997)</td>
<td>35</td>
<td>5-10</td>
<td>17</td>
</tr>
<tr>
<td>Grubman et al</td>
<td>42</td>
<td>9-16</td>
<td>57</td>
</tr>
<tr>
<td>Lewis, Haiken, &amp; Hoyt (1994)</td>
<td>42</td>
<td>9-15</td>
<td>57</td>
</tr>
<tr>
<td>Lipson (1993)</td>
<td>30</td>
<td>&gt;6</td>
<td>10</td>
</tr>
<tr>
<td>Wiener, Battles &amp; Heilman (1998)</td>
<td>17</td>
<td>5-18</td>
<td>41</td>
</tr>
</tbody>
</table>
In a small U.S. survey of caretakers of children aged five and older consisting of both biological and non-biological (foster, kinship or adoptive) parents, all caregivers stated that the best time to tell a child their HIV serostatus is around 10-11 years, especially if the child was asking questions about medicines and clinic visits. Sixty-five (65) percent of caretakers expressed that the best place to disclose to the child was the home. More than 90 percent of all caregivers wanted to be primarily involved in making the decision to disclose, although one in three of the non-biological caretakers felt that the decision should be made by the clinic providers. Seventy (70) percent of biological parents wanted to be the one to tell the child about the diagnosis by themselves, while only 40 percent of non-biological caretakers wanted that responsibility alone. The most common reason for not disclosing was if they felt the child was “not ready.”

The American Academy of Pediatrics recommends encouraging disclosure of HIV infection to school-age children. However, health care providers vary widely in their actual disclosure practices. Concrete guidance for accomplishing disclosure is not currently available.

Of particular need is guidance and training relating to the role of service providers in supporting families (including parents and guardians) to determine how to address disclosure issues in relation to their HIV-positive child/ward.

### Potential Advantages of Disclosing a Child's Serostatus to a Child

- To help children cope with their illness (to address fear, concerns and suspicions in an honest and supportive manner);
- Nondisclosure may result in a variety of problems: anxiety, depression, phobias and exclusion from peer support groups and medical camps;
- To facilitate involvement in planning their care, including medical (preventive therapies and ARVs where accessible), educational and psychosocial needs.

### Potential Disadvantages of Disclosing a Child's Serostatus to a Child

- Potential for discrimination and harm by others if further disclosure occurs.

N.B. There is no evidence to suggest that long-term psychological harm is caused by a supportive parent/guardian and/or care provider disclosing a child’s HIV serostatus to the child. In fact, there is more evidence to suggest that associated psychological harms relate to non-disclosure (see Endnote 74).

### Disclosure: Should the child know if their parent/s are HIV positive?

Dr. Hores Isaac Msaky, a pediatrician in Dar es Salaam, Tanzania, and head of ANNEA, says that children around the age of seven are mature enough to understand the finality of death and they have heard about HIV/AIDS in the community or at school.

Research from Zambia and Uganda among other countries demonstrates that older children want parents to tell them the truth about being HIV positive.
In a study of 393 HIV-positive women in Bangkok, Thailand, interviewed at 18 months post-partum (all of whom were enrolled in a clinical trial of short-course AZT), 98 percent of the mothers had considered the future care of their children, but only 37 percent had disclosed their HIV status to the potential future caretaker.\textsuperscript{128}

In most instances, it is beneficial for older children to learn about their parent’s HIV serostatus directly \textit{from the parent/s} before illness has occurred. In reality, at present many children learn of their parent’s status much later in life through a caregiver/guardian or other individual, or even remain unclear as to the cause of their parent’s death. It is also evident that this has a significant psychological impact on children. Assisting parents to facilitate effective disclosure to their children (as well as to potential guardians of their children) is a priority for programs addressing the psychosocial needs of children. Few programs are successfully tacking this to date, although the Memory Book Project implemented by NACWOLA in Uganda is one successful example. In addition, many guardians in high-prevalence countries are also infected with HIV/AIDS. This factor compounds the potential for increasing the multiple losses to be suffered by children.

\begin{center}
\textbf{The Psychosocial Well-being of Children in Relation to Disclosure and Coping Capacity}
\end{center}

FHI is completing an assessment of the psychosocial well being of OVC in four districts of Zambia (Kitwe, Mongu, Lusaka and Livingstone). The assessment was conducted with a sample of 800 children aged 6-18 who were identified as orphaned or vulnerable and living within households. In addition, a survey was completed by each guardian eliciting their views as guardians caring for OVC.

The assessment will include insights relating to children and guardians’ experiences of grief and loss, if and how disclosure of parents’ HIV serostatus is revealed to children, frequency of HIV testing occurring within the child-based sample and factors that help or hinder both children and guardians to cope with their circumstances.

A detailed report of the findings will be available from FHI by March 2002.

\begin{center}
\textbf{5. Stigma}
\end{center}

More information is required on how HIV-positive children experience stigma. The way in which stigma manifests has direct bearing on issues relating to disclosure.

Further promotion and investment in initiatives led by and involving HIV-positive children and adolescents in fighting stigma and discrimination must be supported.
Role Models among Children

South Africa’s Nkosi Johnson died of AIDS in June 2001, aged 12, defying his prognosis of nine months to live by a decade. Nkosi lobbied the South African Parliament for equal education rights for children with AIDS, resulting in the passage of an anti-discrimination law for children affected with AIDS who want to attend school.\(^{129}\)

Ryan White of Indiana, United States, became an international name in the 1980s when he fought discrimination in the school system by pursuing a court case against the school board. In August 1990, the U.S. Congress signed the Ryan White CARE Act, creating a system of services to improve the quality and availability of health care service for people living with and affected by HIV and AIDS in the United States.

NetCom SA has been funded by USAID to implement the National Youth Commission’s Young Positive Living Ambassadors activity, aimed at enabling young people who have tested HIV-positive to serve as role models for other young people by promoting the concept of positive living.

6. Training of Health Care Providers and Counselors

Evidence suggests that both providers themselves, as well as clients (e.g., adolescents), feel that many health care providers and counselors are not well versed in communicating effectively with young people, adolescents and children, especially in relation to:

- Sexual practices;
- Grief and bereavement (pending loss and loss of a parent/s and/or family member);
- Illness affecting children (including children with HIV/AIDS);
- Abuse, including sexual abuse and incest.

A range of short courses has emerged in some countries to assist in building staff capacity in these areas. However, their adequacy in increasing the comfort levels and competency of trainees to work with young people, adolescents and children remains unclear. This is due to the fact that the most active institutions that offer training are already stretched in their service provision, and thus time and resources often do not allow for adequate follow-up and evaluation of course impact within the field.

Examples of short courses available to date:

Many of the following institutions are members of the Regional AIDS Training Network (RATN), whose secretariat is based in Nairobi, Kenya.

- MildMay, Uganda (short courses tailored to individual needs);
- Child counseling: Connect Zimbabwe (RATN member);
- Child counseling: Kara Counseling and Training Trust, Zambia (RATN member);
- Working with adolescents: KAPC, Kenya (RATN member);
- Child counseling/working with OVC: Chikankata, Zambia (RATN member);
- Child counseling/working with OVC: Humuliza;
- Psycho-social support for OVC: Salvation Army Masiye Camp, Zimbabwe;
- Child counseling: TASO (RATN member).
7. Challenges in Implementing Child Counseling Training

Most of these courses are two to four weeks in duration. Many do not include actual counseling practicum with children, although some include substantial classroom role-play and experiential learning methodologies (with or without children). As with other counseling skills training, there is no standardized curriculum across countries or regions.

Trainers skilled in facilitating such courses are limited. Some of these courses are reliant upon use and availability of external trainers, which limits the frequency in which they may be offered as well as consistency in quality. Most training institutions report ongoing community demand for these courses, demand often outside of the capacity to provide.

Most trainees who would benefit from undertaking such courses do not have the capacity to pay for such training. And government health services often will not or do not have the capacity to pay.

Government health services often insist on selecting the trainees (many of whom are inappropriate for the training). This was observed in relation to some trainees from large referral hospitals in Kenya and Zambia.

8. Linkages across Service Providers

There is urgent need to strengthen linkages at two levels:

- Training institutions must further collaborate and develop generic materials for adaptation and use across continents. Training institutions should also explore ways of organizing exchanges and “attachments” or “secondments of trainers” to assist in meeting global training needs. Donors could play a role in investing funds or lobbying other agencies to invest in such practices. In addition, investing in strengthening of training networks (e.g., RATN in Nairobi and the regional Center for Quality of Health Care in Uganda) to undertake this role is also encouraged.

- Service providers within VCT services as well as other services that cater to children must expand their professional networks to ensure familiarity with organizations and individuals versed in working with children. This should include psychologists and social workers, community-based organizations (CBOs) and NGOs such as the YWCA, Save the Children, World Vision, the Salvation Army, etc. In addition, staff must have linkages with bodies that provide support for families, legal organizations, financial/loan-granting agencies, religious organizations and leaders, traditional healers and clinicians that can provide assistance in relation to medical care, nutrition, palliation, etc.

9. Service Provider Supervision and Support

For many service providers, working with children and families in relation to VCT is highly stressful. Few facilities in developing countries offer adequate support and supervision for their staff. Lack of supervision and support leads to burnout and low staff morale, and results in poor quality of service provision to clients. Therefore, it is crucial that services be supported to attempt to offer some or all of the following:

- Individual supervision;
- Peer support (may be individual or group);
• Exchange visits to other agencies for learning opportunities;
• Regular formalized meetings, including opportunities for case presentation, theme-based dialogue and guest speakers;
• Opportunity for higher-level training where a staff member has demonstrated proficiency and motivation;
• Opportunities to attend national, regional and international fora as possible;
• Support to document and disseminate innovative practices and lessons learned;
• Stress management in-service training and/or one-/two-day retreats.

Some service providers have begun addressing the above, including New Start in Zimbabwe, Kara Counseling in Zambia and many clinical practices in South Africa, including PMTCT settings and advocacy for such at the national level and via the University of Natal.

10. Inadequate Cadres of Higher-level Providers Versed in Addressing the Psychosocial Needs of Children

How many higher-level providers are available in a given country who are specialized in responding to the psychosocial needs of children (e.g., psychologists or child psychologists, child psychiatrists, social workers trained to work with children, pediatricians with counseling training)? Where these are limited, as is the case in many countries, donors should invest in direct support to build larger cadres of higher-level providers.

11. (V)CT for Symptomatic Children and Their Parents or Guardians to Help with Clinical Management and Psychosocial Development of the Child

There is a paucity of information relating to the condition of children living with HIV/AIDS in developing countries. More understanding of disease progression and its impact on childhood development is necessary to inform programming priorities.

VCT sites in high-prevalence countries require major investment in the creation of guidelines, capacity building and infrastructure development in this area. No ideal sites have been observed that are addressing these needs in a comprehensive manner (although Mildmay/Uganda offers a promising package of quality services). Issues to be addressed include:

• National and site-based policies that relate to the necessary conditions under which to provide (V)CT for children. Policies must ensure that coercion does not take place, and that if and when testing does occur, it is deemed by the health care provider and consenting adult/child to be in the best interest of the child. Where testing is determined to be appropriate, it must be ensured that access and facilities relating to care and support are available for the child and family.

• Training of counselors to support parents and guardians to make informed decisions whether or not to test their child.

• Guideline development on consent and disclosure of serostatus to children. This should include assistance for counselors to support family members to disclose the child’s serostatus to the child (with or without direct involvement from the counselor).

• Training of service providers to undertake (V)CT with children in a way that is understood and supportive of the child’s needs and concerns.
- Training of service providers to support parents and guardians in relation to clinical management of symptomatic children irrespective of whether or not the child is tested (e.g., access to palliation, treatment of OIs). This includes facilitating referral to clinicians versed in working with HIV-positive children as well as hospices that have pediatric and respite facilities.

- Fostering supportive systems of “shared confidentiality” as it relates to knowledge of the child’s serostatus within the familial and community structure.

**Jajja’s Home: A Day Centre for Children**

Jajja’s Home is separately owned and managed by Mildmay International. This day center was established as a result of the overwhelming unmet needs of sick children for whom a clinic visit was simply not enough.

In allowing the children to retain their roots within their individual community, as opposed to entering institutionalized care, the day center is consistent with Ugandan government policy.

The children are brought in by minibus each weekday. They benefit from clinical care and treatment (including symptom monitoring and control), emotional and social support, a feeding program, educational play and development. There are three separate age-related homes: 0-5s*, 6-13s and adolescents.*

The overall focus is on improving their quality of life and, wherever possible, promoting independence. Older children are taught approaches to income-generation to help ease the financial burden on themselves and others, which may include younger children in their care. The adolescent unit will house an existing adolescent support group in which they learn about healthy living and develop their life skills within a friendly, social setting.


12. **Intergenerational Communication Initiatives and Skills Building for Children and Guardians to Increase Coping Capacity**

As described earlier, the impact of HIV/AIDS on children begins from the time a parent is diagnosed as positive, not when the child becomes orphaned. Parents, families and children must be assisted to cope more effectively though support for programs that assist parents in communicating and facilitating disclosure with children and programs that assist children (and carers, etc.) with managing the household, caring for the ill parent, preparing for the death of a parent and skills in parenting siblings.

**What we know:**

- Parent-child communication patterns require enhancement.
Many parents in many cultures feel uncomfortable discussing issues relating to illness, grief and loss.

Parental involvement in educating adolescents about sex has taken on a new sense of purpose in the era of AIDS.  

Effective communication can be achieved through other means without counseling.

What we suspect:

The rapid interest in and increasing demand for counseling services and skills building across non-industrialized countries may relate to unmet individual needs that could be served within familial and community-based communication mechanisms without counseling.

Though some traditional community-based mechanisms for providing help and addressing coping capacities of adolescents and young people may have diminished over time, urgent investment could potentially strengthen such bodies to play some of the role that has been advocated to be played by counseling.

What is required:

Training and skills building of parents to communicate with their children, such as programs that have been implemented by religious organizations (Family Life Movement), NGOs and UNICEF (Caring for Us).

Training of “aunties” and other figures who play traditional respected “helping roles” in communities to provide emotional support and to encourage open communication with children and to facilitate health education, skills building and problem solving. Though “aunties” still play a role in traditional rituals, including initiation ceremonies, their role often suffers from lack of dynamism and current relevance. Information giving tends to be directive and prohibitive, and health information may be dated or inaccurate. Also, delivery may not encourage opportunity for dialogue and problem solving.

13. Counseling and Support for Orphans and Vulnerable Children (OVC)

There are increasing numbers of orphans and children living in families affected by HIV, particularly in sub-Saharan Africa. In South Africa, there are an estimated 1 million children under the age of 15 who have lost their mother or both parents to AIDS. The South African Department of Health has stated that “care of orphans will become one of the greatest challenges facing the country.”

In many developing countries, orphans have been looked after by their extended family. However, because of the overwhelming number of orphans and the burden of HIV on other household members, many end up in already-strained households. Other orphans will seek to survive on the streets of the towns and cities or find marginal shelter in child-headed households. Orphans are less likely to receive adequate nutrition or education. They may be taken out of school while their parents are alive to provide household labor, to help care for sick family members, to generate income or because the household no longer has the resources to send them to school. When parents die, children may often have little incentive and limited capacity to return to school.
Orphans face not only the trauma of losing parents, but also the stigma of losing them as a result of AIDS. Without the protective role of parents, orphans are also more likely to face sexual abuse and exploitation (and hence HIV infection themselves). Girls are particularly vulnerable to this. One of the key determinants of infant and child survival and health is the education of the mother. Counseling and emotional support services for orphans and children living in families affected by HIV have been poorly developed in most high-prevalence developing countries. Providing for the psychological and material needs of orphans and children living in HIV-affected households remains an important challenge.

For children who have lost or may lose a parent(s) to AIDS, in addition to the emotional devastation of this loss, there may be increased vulnerability to HIV and risk behaviour as a result of changes in circumstances, including family and household dynamics.

There are an estimated 72,000-125,000 children and adolescents in the United States who have lost their mother to HIV. The most urgent unmet needs for children, their families and new guardians are for mental health services, including bereavement counseling; transitional services to help overcome the loss of AIDS-related benefits following the parent's death; legal services; housing supports; and appropriate evaluations and referrals by juvenile justice and school staff to community-based services.

Numerous services are being rapidly established (mostly in Africa) to respond to the psychosocial needs of OVC. However, rhetoric that relates to responding to psychosocial needs of OVC has become common, with few programs adequately defining what they mean by “psychosocial needs,” and fewer programs to date demonstrating innovation in programming in this area. More programs are required that build upon indigenous structures and existing models of care that nurture the ability of families and guardians to address the psychosocial needs of children that include:

- Talking with children about illness and pending death (for ill parents and ill children);
- Talking with children about plans for their future and involving them as much as possible in the decision-making process. Addressing the range of questions, concerns and fears a child may have in an open and supportive manner (e.g., regarding future schooling, housing, who might become their guardian, etc);
- Talking about HIV/AIDS in clear, simple language as it relates to the individual circumstances;
- Talking with children about their involvement in funerals and helpful ways for them to grieve;
- Affirming children’s emotions and providing opportunities for children to express these emotions in therapeutic ways.

Examples of innovative programming could include:

- Application of experiential mediums using music, art, drama and play as therapeutic tools. Such mediums are well recognized for their cross-cultural applicability, although cadres of providers will require training and piloting of such techniques in many countries. Use of the memory book or memory box are examples of how such tools have assisted families to address pending loss and planning for the future of children with a sick parent or parents. Such mechanisms can also involve extended family and community structures to assist children to cope with illness, including understanding the way the virus works, developing practical positive-living strategies, adherence to ARVs, loss and a range of emotions, including depression, guilt and anxiety. Examples of such
can be found in the United States, Europe, Australia and Brazil mostly in relation to work with children with HIV/AIDS and cancer, as well as work with children with a terminally ill parent. In addition, numerous examples that could be adapted to this context can be found in work with torture and trauma survivors worldwide (including Central and South America, Asia and the Middle East).

- Training cadres of teachers and guidance counselors to recognize, identify and assess vulnerable children, and to develop rapport with such children in order to provide emotional support and to facilitate access for referrals as appropriate. Teachers and guidance counselors have a role to play in working with family and community members, especially in community schools and rural settings (though substantial capacity building and incentives may be required).

- Training for adolescent orphans and child heads in parenting and household management.

- Training the groups of “traditional advisers” (e.g., aunties, elders to provide emotional support and access to accurate information in relation to sexual practices, negotiating safety, risk practices and how to reduce vulnerability).

### Childline Namibia

Provides a counseling hotline and additional services, including outreach counseling facilities (volunteer-based) that provide face-to-face counseling. The Childline Schools Program started in 1998 and is reaching at least 12,000 children per annum. The program entails interactive educational drama on such topics as domestic violence and HIV/AIDS. The focus is on children aged 8-12/13 years.

Referral is also provided as required and a small fund is available to help children who require intensive therapy to overcome trauma.

Childline does not differentiate issues sexual abuse, HIV/AIDS, domestic violence or other issues, as they believe they are interrelated.

### 14. Counseling and/or VCT for Children Who Have Experienced Sexual Abuse

Sexual abuse must be addressed within the broader context of counseling and (V)CT needs of children. **Attempts to create services and service providers that are responsive to these needs will include:**

- Training of service providers in working with children, identifying and assessing abuse and referring children who have been abused for clinical and supportive services, including family support as appropriate;

- Continued advocacy for policies that ensure that perpetrating sexual abuse constitutes criminal behavior and that perpetrators of abuse are prosecuted and convicted of such crimes;
- Continued national policy development and ensuring that protocol is developed and widely disseminated and known by all bodies in relation to steps to follow when a child had been abused;

- Ensuring that hospital staff who undertake such medical examinations are versed in VCT options on or off site;

- Ensuring that VCT staff are versed in protocol following abuse and knowledgeable of when and how to refer, including liaisons with hospitals, police and other key agencies (e.g., YMCA) that may have trained staff to respond to children and families affected, and shelters that cater to children as well as their mothers (in the case of incest and/or domestic violence);

- Ensuring wide distribution of written information to service providers (nurses, counselors, those working with young people and children, religious leaders) that will assist them in counseling sexually abused children. The first edition of a document entitled “Counselling Guidelines on Child Sexual Abuse” was produced in April 2001 by SAT with funding from the Canadian International Development Agency. This simple, brief yet practical guide warrants wide dissemination given its potential value to many workers in a variety of countries and regions.

---

The YWCA has played a leading role in combating sexual abuse in Zambia by:

Advocating for progressive policy development, including increasing penalties against perpetrators of abuse and undertaking national community sensitization campaigns;

Training nominated representatives of the Zambian Police Force to serve as leaders in Victim Support Units (VSUs). Each precinct has a trained VSU leader who responds to abuse cases. Training includes basic child counseling skills, support to families, identifying and assessing abuse and how to provide emotional support to children who have been abused;

Training service providers to work with abused children (including a training module within VCT courses run by Kara Counselling), developing a high calibre of staff trained to work with abused children (including psychologists and social workers) and promoting linkages and referral across sites (including for VCT);

Creating a shelter for women who have been abused (and their children) and creating a day center for abused children that offers play therapy as part of its services.
15. Counseling for Parents as Part of HIV Diagnosis for Infants Born to Mothers with HIV, including following PMTCT Interventions

Most children with HIV 1 infection acquired from the mother will display clinical features within six months of life.\textsuperscript{134} It will be necessary to ensure that the following issues are covered for parents with infants born to HIV-positive mothers. Some may be covered during post-test counseling and others will be more appropriate to cover during follow-up counseling sessions. It will depend on the individual client’s circumstances as to when and how topics are covered:

- Information on ARVs and access as available and appropriate;
- Information on infant-feeding options and the benefits and risks of breastfeeding;
- Exploration of the parent/s coping capacity, concerns and fears;
- Exploration of the parent’s support system and potential for shared confidentiality within the extended family and/or friendship circle;
- Information on family planning;
- Information about treatment, care and support services available and referral for the mother, baby and partner (where present);
- Information about and exploration of infant diagnostics for HIV and how to ensure the infant’s well being, including nutritional advice and seeking early treatment for illnesses;
- Disclosure issues for the mother, including disclosure to spouse and/or potential support persons;
- Exploring the potential for couple counseling (if not already occurring in a couple context);
- Information about safer sex, including condom use to prevent transmission of HIV and STIs;
- Discussion of sero-discordance and HIV testing for the partner/s as appropriate;
- Planning for the future (including emotional, spiritual and legal support);
- Assessment of coping capacity and provision of options for referral as required.

N.B. Many of these are complex issues that may require significant investment. They will not be adequately addressed in one session and some of these needs can also be met through referral to peer support groups or “peer buddy systems” where available.

Service providers and clients should also be trained to assist in establishing such groups or buddy systems where they do not already exist (as appropriate).

They may also require referral by some service providers to colleagues with higher proficiency levels. Ideally, these issues should be explored with both members of a couple present in order to foster support, facilitate disclosure, encourage reduction of further HIV/STI transmission and help the couple or mother to plan for the future of the family and infant, including their own care and support needs.

These topics will need to be covered in all relevant evolving training curricula. This is not the case to date. In particular, there is still no training body offering an HIV/AIDS-focused couple counseling course in Africa. (Though some institutions have had long-standing plans to do so.)

Organizations that have developed child counseling and related training materials include:

- Connect in Zimbabwe;
- Kara Counselling and Training Trust in Zambia;
- CHIN in Zambia;
- Chikankata Health Services in Zambia;
- Humuliza in Tanzania;
- Salvation Army Masiye Camp in Zimbabwe;
- Sinosizo in South Africa;
- Save the Children (handbook for health workers on Communicating with AIDS Infected Children).

“Starting from Strengths Community Care for Orphaned Children” is a training manual that contains information relating to grief and loss as well as care and support for OVC. It was developed by the University of Victoria, Malawi, in collaboration with a range of Malawi-based government bodies and NGOs. It provides practical materials and exercises that are easily adapted to a range of African settings. Funding was obtained by the International Development Research Centre, UNICEF Malawi and World Vision Malawi.

Suggested Resources


SECTION THREE. VCT SERVICES FOR PREGNANT WOMEN AND THEIR PARTNERS

This section will discuss VCT services for pregnant women and their partners.

1. BACKGROUND

Approximately 1.8 million seropositive women become pregnant each year. Without PTMCT interventions, approximately 35 percent of their infants will become infected, leading to 600-700,000 children being infected annually. One of the most important advances in PMTCT in developing countries has been the trial of short-course zidovudine (ZDV). This has been shown to prevent MTCT by 50 percent. Nervirapine (administered as a single dose intrapartum to the mother and a single post-natal dose to the infant) has also been shown to be effective in preventing MTCT. If ARV interventions for PMTCT were widely available, up to 300-350,000 infections among infants could be prevented each year. This revelation has led to an increasing number of pilot PMTCT program being developed and promoted, particularly in developing countries. Currently, there are 19 countries with 79 implementing sites and two national programs in the United Nations-sponsored PMTCT program. In addition, the Call to Action Project implemented by the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) has also grown to 70 locations through 18 projects in 10 African countries, as well as projects in Thailand.

All PMTCT ARV interventions rely on identifying pregnant women with HIV so that they and their infants can benefit. VCT is therefore an essential component of PMTCT projects, and it is important for VCT to be provided in an ethical and acceptable manner to clients if PMTCT interventions are to be fully effective.

MTCT occurs during pregnancy, labor and delivery, and breastfeeding. A range of interventions exists that can be implemented across three levels.

Level 1: Prevention of HIV among Women of Childbearing Age;
Level 2: Prevention of Unwanted Pregnancy among HIV-infected Women;
Level 3: Prevention of Perinatal HIV Infection and Caring for Mothers and Infants.

Some of this section is based on work carried out by Rachel Baggaley for the joint UN PMTCT working group. For further information, refer to Baggaley, R (2001) VCT for PMTCT.
It is important to ensure that preventive interventions focused on women at levels one and two continue to be strengthened in conjunction with those that may occur at level three. Some stakeholders argue that the Third Conference on Global Strategies for the Prevention of HIV Transmission from Mothers, held in September 2001, focused heavily on level-three interventions with minimal attention to practices that prevent HIV and/or unwanted pregnancy from the onset.

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Potential Roles</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level 1: Prevention of HIV among Women of Childbearing Age</strong></td>
<td>✓ Promote VCT and other HIV/AIDS prevention communication initiatives targeting young people and highlighting PMTCT (focus on non-health sector contexts); ✓ Promoting linkages across service delivery sites via advocacy messages; ✓ Supporting interventions related to family planning and continued investment in services that support STI prevention (including condom access and use) and care (including diagnostics and treatment for young people including partners); ✓ Lobbying for continued government and donor investment in MCH service strengthening (including capacity building of TBAs); ✓ Supporting investment in NGO/CBO-based organizations that empower young women and men (including those targeted to SW/IDU, etc.); ✓ Ensuring coverage of PMTCT and VCT within life skills curricula.</td>
</tr>
<tr>
<td>Behavior-change interventions targeting young men and women; Better STI management in men and women; Family planning options; Reduction of unsafe transfusion; Improving MCH services; Addressing contextual factors that increase women’s vulnerability to HIV (e.g., economic dependency, schooling);</td>
<td></td>
</tr>
<tr>
<td><strong>Level 2: Prevention of Unwanted Pregnancy among HIV-infected Women</strong></td>
<td>✓ Investing in counseling skills training that addresses the psycho-social needs of HIV-positive women, including PMTCT. ✓ Dissemination of training manuals/materials/job aides relating to care and support for HIV-positive women.</td>
</tr>
<tr>
<td>Family planning options; Health education and counseling to assist in decision-making; Comprehensive care and support;</td>
<td></td>
</tr>
<tr>
<td><strong>Level 3: Prevention of Perinatal HIV Infection and Caring for Mothers and Infants</strong></td>
<td>✓ Advocacy for all level-three interventions; ✓ National campaigns within a comprehensive communication strategy on all level-three activities aimed at community sensitization and acceptance of factual prevention and care messages; ✓ Contributing to technical guidance (including stances on formula/replacement feeding through policy formulation); ✓ Lobbying and direct support to governments regarding national policy guidance and development (including access to care and support for mothers/partners and children); ✓ Supporting governments to bulk purchase the necessary supplies (infant feeding alternatives, EIAs, rapid tests, STI drugs and laboratory supplies).</td>
</tr>
<tr>
<td>Interventions to reduce transmission during pregnancy, labor and delivery; Interventions to reduce transmission through breastfeeding; Optimal services for children under age five; Comprehensive care and support for mothers and children.</td>
<td></td>
</tr>
</tbody>
</table>

2. APPROACHES TO VCT IN THE ANTENATAL SETTING
There are several approaches to VCT delivery in antenatal settings. WHO is undertaking technical leadership in this area, and guidance documents on scaling up VCT in ANC are in progress. Some of these models are based on work being undertaken by WHO in this area.

VCT Models for the ANC Setting

**Model 1.** Individual pre- and post-test counseling and testing ("classic" model);

**Model 2.** Group information, optional shortened individual pre-test counseling, individual post-test counseling (e.g., PMTCT in the United Kingdom until recently, Botswana);

**Model 2b.** Group information, simplified individual pre-test counseling, routine individual testing (with right of refusal), individual post-test counseling (e.g., EGPAF site in Cameroon);

**Model 3.** Group information,* routine individual testing (with right of refusal), individual post-test counseling for seropositives, seronegatives informed of their negative status (e.g., PMTCT in Thailand and recent UK/United States model);

**Model 3b.** Group information,* routine individual testing (with right of refusal), individual post-test counseling for seropositive women, seronegative women not informed of their negative status (operational model for some MTCT sites);

**Model 4.** Group information, couple/family pre-test counseling, individual/couple/family post-test counseling (shared confidentiality model);

**Model 5.** No pre-test information, screening/testing (with right of refusal), individual post-test counseling for those found to be seropositive (PMTCT in Russia, some sites in the United States).

* May include distribution of written information.

**Additional practices occurring in ANC that exclude VCT:**

- Mandatory screening of all pregnant women with post-test counseling and ARV interventions for those found to be seropositive (some sites in the United States);
- ARV PMTCT interventions without VCT.

The major variations in models of delivery relate to:

- Handling of pre-test contents, including:
  - Information giving and/or provision of counseling;
  - Group and/or individual sessions;
- Testing and consensual practices.

The major challenge in determining appropriate VCT models for ANC/MCH relates to:
- How to create a time efficient, non-labor-intensive, simplified package that increases uptake without compromising quality or individual rights, including provision of informed consent or right of refusal.

### MODELS OF VCT DELIVERY IN ANTENATAL SETTINGS

<table>
<thead>
<tr>
<th>Model 1: Classic VCT model (individual pre- and post-test counseling with follow-up counseling as required).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Advantages:</strong></td>
</tr>
<tr>
<td>Quality one-on-one service;</td>
</tr>
<tr>
<td>Client-centered;</td>
</tr>
<tr>
<td>Test decision-making addressed;</td>
</tr>
<tr>
<td>Personal risk assessment and risk-reduction planning addressed;</td>
</tr>
<tr>
<td>Follow-up support provided;</td>
</tr>
<tr>
<td><strong>Disadvantages:</strong></td>
</tr>
<tr>
<td>Time consuming;</td>
</tr>
<tr>
<td>Labor intensive.</td>
</tr>
</tbody>
</table>

**Comments:**

* Unsuitable for most PMTCT settings where health workers are expected to include VCT within routine antenatal care.*

<table>
<thead>
<tr>
<th>Model 2: Group information, <em>optional</em> shortened individual pre-test counseling, individual post-test counseling. Health information is provided by group information via a talk/with or without a video or providing written information, and encouraging women to discuss issues around VCT/PMTCT. Following pre-test information, women can opt for pre-test counseling and receive a shortened individual counseling session.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Advantages:</strong></td>
</tr>
<tr>
<td>* Acceptable in many antenatal settings;</td>
</tr>
<tr>
<td>More time- and human-resource efficient than Model 1.</td>
</tr>
<tr>
<td><strong>Disadvantages:</strong></td>
</tr>
<tr>
<td>* Uptake may be low;</td>
</tr>
<tr>
<td>* Vocal group members may persuade/dissuade other members to be tested;</td>
</tr>
<tr>
<td>* Less comprehensive individualized package;</td>
</tr>
<tr>
<td>* Is not client-centred.</td>
</tr>
<tr>
<td><strong>Comments:</strong></td>
</tr>
<tr>
<td>* More successful if women already have knowledge of HIV and PMTCT. Advocacy and community awareness are important in ensuring this.</td>
</tr>
<tr>
<td>Ongoing support must be available for seropositive AND seronegative women. This may be provided by referral to services off-site or from post-test support groups or peer support groups.</td>
</tr>
<tr>
<td>The health educator/counselor must be trained in group education and handling group dynamics.</td>
</tr>
</tbody>
</table>

Model 2b: Group information, simplified individual pre-test counseling, routine individual testing (with right of refusal), individual post-test counseling (e.g., EGPAF site in Cameroon). All women access group information followed by simplified individual pre-test counseling.
Banso Batist Hospital, Cameroon

Supported by EGPAF. Figures from February to November 2000:

Pregnant women presenting for first antenatal visit and group pre-test counseled, 720.

Percent of those pre-test counseled who consented to HIV testing, 695 (96.5 percent).

Pregnant women testing HIV-positive, 65 (9.4 percent).

HIV-positive pregnant women eligible to have received NVP (delivered or post due date) on December 12, 2000, 46.

HIV-positive women who have received NVP (percent of those eligible), 28 (61 percent).

Babies who have received NVP, 27.

Site offers:

Group information session followed by an individual session (women are given the opportunity to ask questions and have information clarified).

Informed consent is contained at this stage and the blood draw is conducted.

Comments:

A promising model for VCT in ANC.

Model 3: HIV testing incorporated as part of routine ANC screening, but women informed of range of tests included in the screening (including HIV); informed consent provided and women free to choose to decline the HIV test; referral and linkages to care and support services strengthened in parallel; streamlining pre-test counseling content and services within ANC/MCH services (particularly important for busy sites where services are provided by nurse/midwives, not full-time site-specific counselors); Strengthening post-test services to respond to mother/family needs, including care and support options in relation to the pending pregnancy.

Women are given a leaflet explaining that they will be tested for HIV (as part of routine antenatal screening). The benefits and rationale of HIV testing are discussed in the leaflet, as is the right to refuse testing; otherwise HIV testing will be carried out. Seropositive women are offered ARVs for PMTCT and following delivery are provided with comprehensive medical care (including ARV therapy where indicated for themselves). Their infants are tested for HIV by PCR at four weeks post-delivery and also receive comprehensive medical care and follow-up.

Advantages:  

Comments:
* High efficacy and acceptability in low-prevalence settings with established support services for seropositive women;
* In low-prevalence countries, counseling can be focused on the small minority of women who test seropositive;
* Human-resource efficient.

**Disadvantages:**

* Models 3/3b depend on availability of treatment and support for seropositive women and their infants;
* When no or inadequate services are available for seropositive women they may be vulnerable/disadvantaged following testing. Unlikely to be suitable for rural sites at onset;
* Limited intervention for seronegative women (including opportunity to address prevention);

* Women with limited understanding may not use the right of refusal;
* Some women may fear exclusion from other medical services if they refuse;
* Refugees/immigrant women with language barriers/low literacy may be disadvantaged.

* Adopted in some low-prevalence countries (UK and United States). Also adopted for PMTCT in Thailand;
A similar model is recommended for VCT/PMTCT in the United States.137
**Model 3b:** Group information/written information, routine individual testing (with right of refusal), individual post-test counseling for seropositive women. Seronegative women are not informed of their negative serostatus.

**Disadvantages:**
Practiced in some VCT/PMTCT services due to poor levels of staffing; Negative women are not informed of their status, negating any VCT benefits.

**Comments:**
UNAIDS/WHO does not support this practice.

**Model 4:** Group information, couple/family pre-test counseling, individual/couple/family post-test counseling (shared confidentiality model). Antenatal women are encouraged to attend with their husbands/partners, a supportive friend or trusted family member.

**Advantages:**
* Enhanced ideal version of Model 2;  
* Enhanced coping capacity: women dependent on families/husbands/partners may be more able to obtain nutrition, medication, etc. if family members are involved. Blame can be avoided/sexual behaviour change facilitated if couples test together;  
* Provides a comprehensive quality package for the pregnant woman with her identified support person present.

**Disadvantages:**
* Labor-intensive;  
* Human-resource intensive;  
* Few existing field examples.

**Comments:**
“Shared confidentiality” must always be voluntary and women who decide after shared pre-test counseling that they wish to be tested alone must be allowed to do this.
**Model 5:** No pre-test information, screening/testing (with right of refusal), individual post-test counseling for those found to be seropositive (used in some parts of Eastern Europe and other countries of low prevalence).

**Disadvantages:**

Women may have little understanding of HIV and testing. Women with high levels of “compliance” with medical demands may not employ their refusal right, and testing may not be truly voluntary.

Because pre-test counseling is not a feature of this model, women who test seropositive (or fear that they will test seropositive) may be reluctant to continue with antenatal care in the center where they were tested. This has led to some vulnerable women declining antenatal care (and hence limiting access to PMTCT interventions) as was noted in the Ukraine.

Because pre-test counseling is absent there is little benefit for women who test seronegative. This can be a particular loss for women who are at higher risk of HIV infection (such as IDUs or partners of IDUs who would benefit from HIV-prevention information and guidance during the antenatal period).

An untargeted approach is costly for low-prevalence countries. Millions of tests are currently performed in Eastern European on pregnant women with small numbers of seropositive pregnant women identified who could benefit from PMTCT interventions.

**Mandatory Screening of All Pregnant Women with Provision of Post-test Counseling and ARV Interventions for All Those Found to Be Seropositive**

In some U.S. states pregnant women are screened for HIV and those who are seropositive are provided with ARV interventions for PMTCT.

**Dilemma:** It may be claimed that the rights of the unborn child to PMTCT interventions override the rights of the mother to decline testing.

**ARV PMTCT Interventions without VCT**

Nevirapine regimens for PMTCT offer a single dose to the mother and a single dose to the child (HIVNET 012).

Cost-effectiveness models have shown that providing all women with this regimen without offering them VCT would reduce costs significantly.138

A trial carried out by Sinkala in Lusaka, Zambia, compared uptake and adherence to (mass) universal NVP administration (women of unknown status) and targeted administration of NVP (to known HIV-positive women).139 Findings indicated that:

NVP uptake was similar in both arms except where the clinics were not functioning well (i.e., the targeted approach has the same uptake as mass treatment if quality counseling was available). UNAIDS/WHO does not support this.

Non-compliance of treatment was twice as high with the mass group (i.e., drug adherence was greater in the mothers who knew their HIV status).
Two possible models have been observed at EGPAF sites that warrant further address:

**Model A (Applied in Kenya and Cameroon)**

Explain to the woman that the center provides VCT services for women to learn their HIV serostatus. However, in this instance VCT has not been provided. Explain to the woman that NVP is an intervention that helps to reduce MTCT in women who are HIV-positive.

Explain that NVP can be provided to this client (of unknown status) if she wishes and consents, and VCT services could be offered after delivery as appropriate. Request consent to administer NVP. NVP is then provided and:

- After delivery, counseling and testing are undertaken;
- For those testing positive, the NVP baby dose is administered.

**OR**

**Model B (Applied in Rwanda)**

- If women are less than 6cm dilated, VCT is undertaken;
- Upon receipt of a positive result, NVP is administered;
- The baby dose is given within 72 hours of birth.

**Disadvantages of Model B:**

Delay in onset of delivering NVP while VCT occurs may affect NVP efficacy.

Many organizations consider it inappropriate to undertake VCT during labor. There is anecdotal feedback from service providers at the Rwanda site suggesting that even in labor some women appreciate the opportunity for VCT. This lends support to the tenet that *if all other efforts fail, women should not simply be denied access to VCT when they may benefit from the service.*
Additional Issues Informing the UNIVERSAL NVP Debate

- Universal NVP without VCT prevents women from making informed infant-feeding choices and long-term sexual behavior changes that are facilitated by knowledge of HIV status.

- Universal NVP mostly involves the majority of recipients receiving the drug unnecessarily.

- Resistance development to a single dose of NVP has been documented in Uganda.

- NVP efficacy is dependent on when the drug is administered. NVP treatment failure was noted to be significantly higher when mothers took the drug less than one hour before delivery.

- It is important to administer the maternal NVP dose as soon as labor begins in order to allow time for the level of the drug to circulate in the system. If the maternal dose is given two hours or less before delivery, an extra NVP dose to the baby immediately (or as soon as possible) after delivery should be considered. This post-delivery baby dose is in addition to the infant NVP that should be given between 48-72 hours after delivery (Milochnik, United States).

- Some women are mistrustful of NVP (e.g., in one community there was a widespread myth “that NVP would make your babies’ skin fall off.” Therefore, it is crucial that post-test messages are improved alongside communication messages (which are scarce in many settings) within communities.

Summary

It is ideal that we continue to strive to reach all women at early stages of their pregnancy. Universal NVP is generally not supported, though further address of interventions for women of unknown serostatus, especially in high-prevalence settings, is urgently required.

Programmatic guidance is required to respond to situations where the mother and service provider believe there are perceived benefits to administering “blind NVP.” NVP and exclusive breastfeeding could be advocated while ensuring encouragement during discharge for a VCT appointment in the postpartum period.
3. CHALLENGES TO THE PROVISION OF VCT IN ANTENATAL SETTINGS

Despite the large number of PMTCT projects and programs being developed there remain substantial challenges in the provision of acceptable and effective VCT in antenatal settings.

Broadening the Scope of VCT in ANC

Although the primary aim of VCT in antenatal settings is to identify seropositive women and to enable them to benefit from ARVs for PMTCT, a range of potential secondary benefits exists. In addition, PMTCT could be more cost-effective if the wider benefits of the VCT component could be fully realized. It is crucial that donors, governments and service providers also consider these pivotal secondary benefits rather than focusing on the drug intervention itself.

Improving Uptake of VCT in ANC

If PMTCT interventions are to be successful, VCT must be endorsed by the majority of women attending antenatal clinics where these services are offered. Women must return for their test results and understand the implications of their result. The acceptance and uptake of VCT in ANC settings has varied between settings. Research and small pilot sites tend to have higher uptake of VCT than larger-scale operational sites. In many countries there are barriers to people accepting VCT, and uptake of VCT settings outside antenatal clinics has often been low from the onset.

Low uptake of VCT, especially at the start of PMTCT interventions, should not be viewed as project “failure.” It demonstrates that women are able to make choices on testing without coercion from counselors.

As the program develops and the benefits of VCT associated with PMTCT interventions (for both mothers and children) are more widely known and understood, it would be expected that uptake should increase.
To move from the current framework to a reality-based utopian ideal there is need to:

- Increase access to and use of MCH/ANC services by pregnant women;
- Increase access to (including physical set-up of services) and acceptability of VCT in ANC settings. At a site in Kenya, women were told at the end of the group session that those interested in undertaking an individual session should “go over there.” Women were directed to a room down the hallway. This practice is not client-friendly as it ostracizes women who desire individual counseling. Such barriers to uptake must be removed from the onset (this must include reducing stigma);
- Ensure that confidential services are promoted and maintained (thereby increasing women’s trust in the services);
- Ensure that losses through the cascade are minimized through efficient health system organization, training and maintaining motivated staff;
- Ensure women’s infant-feeding options and decisions are supported;
- Provide appropriate follow-up care and support to the woman and her child;
- Ensure that PMTCT is integrated with other services, including psychosocial counseling, nutritional guidance, treatment of opportunistic infections, etc.;
- Move toward comprehensive care and support at the household level (including reaching women who deliver at home by a TBA or without support);
- Encourage men’s and/or family participation and support for their spouses.
### Factors Influencing Uptake of VCT in PMTCT settings

<table>
<thead>
<tr>
<th>Category</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Geographical variation</strong></td>
<td></td>
</tr>
<tr>
<td>Seroprevalence rates within ANC/MCH</td>
<td></td>
</tr>
<tr>
<td>Economy</td>
<td></td>
</tr>
<tr>
<td><strong>Testing method</strong></td>
<td>Zambia PMTCT pilot site</td>
</tr>
<tr>
<td>Higher uptake seen when rapid same-day testing replaces ELISA.</td>
<td><strong>UK antenatal HIV screening policy, EGPAF Cameroon PMTCT site</strong></td>
</tr>
<tr>
<td><strong>VCT model</strong></td>
<td></td>
</tr>
<tr>
<td>Higher uptake when &quot;opting out&quot; replaces &quot;opting in.&quot;</td>
<td></td>
</tr>
<tr>
<td><strong>Attitudes of counselors</strong></td>
<td>Study from UK and program review Botswana</td>
</tr>
<tr>
<td>Where counselors understand and support the benefits of VCT/PMTCT interventions, uptake by women attending ANC is higher.</td>
<td></td>
</tr>
<tr>
<td><strong>Quality of counseling and quality of testing</strong></td>
<td>Study on attitudes toward VCT among pregnant women in Uganda</td>
</tr>
<tr>
<td>Where quality counseling is provided (including adequate time frames and skilled counselors).</td>
<td></td>
</tr>
<tr>
<td>Where women believe that undertaking VCT is useful and safe, that confidentiality is respected, that tests yield a &quot;true&quot; result.</td>
<td></td>
</tr>
<tr>
<td><strong>Ownership and input from the implementing team from onset</strong></td>
<td>South Africa Zambia, Tanzania PMTCT sites</td>
</tr>
<tr>
<td>Successful pilot sites attribute some degree of success to a bottom-up approach that is owned and implemented by the service (hospital administrators and medical staff, especially nurses).</td>
<td></td>
</tr>
<tr>
<td>Some less-successful sites report lack of service or government ownership/buy-in.</td>
<td></td>
</tr>
<tr>
<td>However, Botswana has demonstrated high-level political commitment, yet other impediments highlighted within the table may effect uptake.</td>
<td></td>
</tr>
<tr>
<td><strong>Medical care for women following delivery</strong></td>
<td>Botswana PMTCT program review Study on attitudes toward VCT among pregnant women in Uganda</td>
</tr>
<tr>
<td>Lack of medical care for women following PMTCT was cited as being a deterrent to testing as well as a perceived deterrent.</td>
<td></td>
</tr>
<tr>
<td><strong>Approach to infant-feeding options</strong></td>
<td>Botswana PMTCT program Uganda PMTCT site</td>
</tr>
<tr>
<td>Degree of support for a range of infant-feeding options and women’s choice.</td>
<td></td>
</tr>
<tr>
<td>Promotion of infant formula as policy may have a negative impact on uptake.</td>
<td></td>
</tr>
<tr>
<td>Lack of information regarding mixed feeding.</td>
<td></td>
</tr>
<tr>
<td><strong>Scaling up</strong></td>
<td>UNICEF PMTCT sites in sub-Saharan Africa</td>
</tr>
<tr>
<td>Initially lower rates of acceptance seen in operational sites cf. smaller research PMTCT sites. Some sites also report that the length of time the VCT within ANC/MCH has been operating affects uptake. Experience in Cote d’Ivoire and Zimbabwe suggests that over time counselors become more proficient with their practice, and the service becomes normalized within the community though increased coverage, thereby increasing acceptance and uptake.</td>
<td></td>
</tr>
<tr>
<td><strong>Individual barriers to testing</strong></td>
<td>Studies from Kenya, Uganda, Zambia and India UNICEF PMTCT sites in Zambia, Zimbabwe and Tanzania</td>
</tr>
<tr>
<td>Stigma in the community.</td>
<td></td>
</tr>
<tr>
<td>Fears of rejection, abandonment or abuse by husband/partner and/or family.</td>
<td></td>
</tr>
</tbody>
</table>
The uptake of VCT and return rates for HIV test results in PMTCT research sites has been studied in detail. Thirteen sites from West (Abidjan, Bobo-Dioulasso), East (Addis Ababa, Nairobi, Mombassa, Dar Es Salaam) and Southern Africa (Blantyre, Lusaka, Harare, Soweto, Durban), and one from Thailand were included in a cross-sectional mailing survey about the acceptability of VCT and various MTCT interventions in antenatal clinics. The median overall acceptability was 65 percent, ranging from 33-95 percent. Where several studies were conducted in the same country, pregnant women had similar attitudes toward HIV testing. The main reason cited for not wanting an HIV test was “wanting to discuss with partner.” Five studies had overall acceptability rates of >70 percent, with high return rates to collect test results.

In general, the uptake of VCT and return rates to collect HIV test results are lower in pilot and operational settings, compared with research sites. This may be because of more limited resources (financial and staff) to provide high-quality counseling and lack of incentives (such as transport money) that women may receive when attending research sites.

Results from the UNICEF PMTCT pilot projects reveal differing levels of uptake. Preliminary results from the large MTCT program in Botswana show relatively low uptake of VCT during the first 18 months of operation. However, it is important to look at the emerging trends over time, and to acknowledge the major challenges encountered in particular, by the larger pilot projects.

In the pilot site in Zimbabwe, early results revealed that 186 women attending an antenatal clinic in Zengeza, Chitungwiza, were offered VCT as part of their antenatal care. Although most women endorsed the multiple benefits of VCT, uptake was low with only 23 percent of women consenting to VCT. More recent results (March 2001) indicate that uptake rates are now much higher due to a change in pre-test counseling practices. Women are now screened for HIV with only pre-test information and the opportunity for opting out if women explicitly ask this.

PMTCT interventions have recently been introduced in antenatal clinics in Lusaka, Zambia, as part of routine antenatal care. Prior to this a survey among antenatal attendees showed that when VCT was offered to women at less than 28 weeks, 28-36 weeks and more than 36 weeks, 71 percent, 62 percent and 64 percent of women, respectively, said that they would agree to be tested. It is not known whether this proposed high acceptance will translate into uptake when services are active.

In South Africa, provisional results from the Khayelitsha Mother-to-Child Pilot Project, Western Cape, show a high rate (79 percent) of acceptance of HIV testing.

In Côte d'Ivoire, a recent study from Abidjan offered all pregnant women individual pre- and post-test counseling. All seropositive women were offered ARVs for PMTCT and emotional support was provided by women living with HIV/AIDS from NGOs. During the first year of activity 13,000 HIV pre-test sessions were given to pregnant women. 8,920 women accepted the HIV test (68.6 percent); 77.6 percent of them returned for the HIV test result. Prevalence of HIV among the pregnant women was 13.5 percent.

Uptake rates outside Africa tend to be higher. In the UK and United States, antenatal HIV testing is a routine part of antenatal screening and uptake rates are high. In Thailand, VCT/MTCT interventions in antenatal clinics are routine in some provinces. In a study of 24,465 women attending 27 hospital antenatal clinics, 99 percent of women accepted testing.
uptake is most likely related to differences in maturity of the epidemic, attitudes toward PLHA and stigma in the community, seroprevalence rates and medical infrastructure for and after VCT (high staff/client ratio, care and support services in place, etc.).

In the UNICEF PMTCT pilot sites, reports suggest variations in uptake depending on:

**Attitudes toward and availability of VCT in the community:** In Botswana, when PMTCT services were first introduced, VCT services had not been previously available in the community. This meant that pregnant women were not well informed about the benefits of VCT prior to the start of the program. In these contexts, it may be the first time that women learn about MTCT and/or VCT when they attend ANC.

**Stigma and discrimination in the community:** Willingness to go for VCT is related to societal openness about HIV, which in turn is closely related to societal acceptance and support for HIV-infected persons. VCT programs must therefore be accompanied by national campaigns to promote openness and reduce discrimination and prejudice toward persons with HIV.

**Support services for women and families following VCT:** The lack of effective treatment available for infected women following VCT/PMTCT interventions has been cited as a barrier to women accepting testing.

**Personal anxieties:** Women interviewed in antenatal clinics state fear of a seropositive result and worry about partners reactions as barriers to accepting VCT.

**Quality of counseling:** This may be a factor in some services. For example, the PMTCT pilot site in Rwanda offers a high-quality counseling service. Staff are motivated and have adequate time to provide in-depth counseling when needed. This may be an important factor for the high acceptance rate at this site.

**HIV testing method:** Higher acceptance of VCT is reported where same-day testing is employed or introduced.

**Motivation of counseling staff:** Where the nurse/counselors are highly motivated and understand the benefits of VCT for PMTCT, uptake is likely to be higher.

**“Opting out” of HIV testing rather than “opting in”:** In many industrialized countries where HIV prevalence is relatively low, women in antenatal clinics are screened for HIV without pre-test counseling with the option of opting out. This approach is also used in Russia and some of the Newly Independent States. In higher-prevalence countries, where a significant proportion of women will test seropositive, it is generally accepted that pregnant women should be given the option to receive individual pre-test counseling. However, from one site at Zengeza in Harare where uptake of VCT was very low, group pre-test information with opting-out has recently been introduced. This has led to a much higher proportion of women being tested but the longer-term consequences such as uptake of and adherence to ARV therapy for PMTCT is as yet unknown. WHO/UNAIDS policy on VCT states that everyone undergoing VCT should have access to pre-test counseling and should give informed consent prior to testing. Without access to counseling, both women who choose to test or not to be tested may not benefit from valuable information and skills building for risk reduction of HIV infection.
HIV Testing Method: Simple Rapid Testing May Increase Uptake for VCT

If women are able to obtain their HIV test result within a few hours they are much more likely to receive their test result than if they have to wait 1-2 weeks. Other PMTCT projects using rapid testing or changing to rapid testing have also shown high uptake rates.

In Zambia, when rapid testing was offered in a pilot research project at antenatal clinics the overall acceptance was very high (81 percent).149

In Côte d’Ivoire, although rapid testing increased the proportion of women receiving an HIV test result during the antenatal period (compared with ELISA testing), there was overall very poor adherence to ARV interventions for PMTCT.150 Although uptake rates of VCT can be improved using rapid testing, unless women receive adequate counseling so they understand the benefits of testing this may not be translated into higher uptake of ARVs and hence beneficial outcomes for the mother and child.

ARV Regime: NVP may be preferable to AZT for increasing uptake of treatment in high-prevalence countries with limited infrastructure and high levels of stigma.

Although to date there have not been any head-to-head comparisons of AZT versus NVP regimes, problems with uptake of treatment have been connected to the AZT regime at some PMTCT sites (mostly in settings with minimal infrastructure and resources). In one site, AZT was only taken by 50 percent of women for less than two weeks providing a sub-optimal dose.151 CDC plans to explore this issue in relation to uptake in Cote D’Ivoire. In addition, the Population Council plans to undertake comparative research. Other sites (e.g., the UNICEF site in Botswana) that initially commenced with AZT are adding NVP as a second-line drug in the hope of increasing acceptability and uptake of PMTCT interventions. The reported problems with uptake related to AZT in PMTCT include:

- High pill dosage versus single dose for NVP;
- Pills to be taken at home versus single client dose at site/home or under direct observation by health care worker;
- Multiple pill-taking may compromise privacy and disclosure and is therefore associated with increased stigmatization;
- Arguments against NVP, however, must also be considered. These include:
  - Only one published study demonstrating efficacy of NVP;
  - Drug resistance reported after one single dose.
Models of Pre-test Interventions: How do we maintain quality yet increase VCT uptake?

Attempts are being made to increase coverage of numbers of women being tested by diversifying approaches to pre-test practices (including and excluding counseling).

<table>
<thead>
<tr>
<th>Pre-test ANC/VCT Model</th>
<th>Advantages</th>
<th>Disadvantages</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mass pre-test information sessions (usually provided by nurse/midwives and more recently by “lay counselors”).</td>
<td>Able to provide basic facts/health information and conduct a question/answer session;</td>
<td>Used as a replacement to pre-test counseling;</td>
<td>Should not replace counseling in high-prevalence settings with high stigma;</td>
</tr>
<tr>
<td>Model 1</td>
<td>Useful at busy sites with large client load;</td>
<td>No opportunity to explore individual clients needs (including vulnerability to risk, support systems, etc.);</td>
<td>Is not counseling per se.</td>
</tr>
<tr>
<td></td>
<td>Time efficient;</td>
<td>Not client-centered;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Standardized client flow at the site.</td>
<td>May compromise quality;</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Test decision-making may not be adequately covered;</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>May lead to coercion.</td>
<td></td>
</tr>
<tr>
<td>Pre-test health education videos (e.g., maatla a go itse/ “The power of knowing,” Botswana).</td>
<td>Highlights essential issues covered within a traditional pre-test counseling session;</td>
<td>Tendency to show video with limited facilitation/dialogue;</td>
<td>Proven to be effective in low-prevalence settings;</td>
</tr>
<tr>
<td>Model 2</td>
<td>Used effectively in Thailand;</td>
<td>Lack of transferability across countries and settings (to date);</td>
<td>Efficacy in high-prevalence settings still to be determined;</td>
</tr>
<tr>
<td></td>
<td>Allows for mass coverage of basic information;</td>
<td>No opportunity to explore individual clients needs (including vulnerability to risk, support systems, etc.);</td>
<td>Best quality when followed by pre-test counseling session;</td>
</tr>
<tr>
<td></td>
<td>Reduces human resource burden;</td>
<td>Not client-centered;</td>
<td>Attention must be given to adequate scripting, piloting, pre-testing (as possible) so as to not compromise quality of content.</td>
</tr>
<tr>
<td></td>
<td>Standardized client flow at the site.</td>
<td>May compromise quality;</td>
<td>Videos must correspond to the language and educational level of clients presenting to the site.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Test decision may not be adequately covered;</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>May lead to coercion.</td>
<td></td>
</tr>
<tr>
<td>Mass pre-test information session/video followed by a reduced length individual/couple pre-test counseling session.</td>
<td>Provides best of both worlds;</td>
<td>Staff burden where nurse/midwives conduct individual session in addition to usual workload.</td>
<td>Potentially a golden package for pre-test VCT in ANC at high-density sites.</td>
</tr>
<tr>
<td>Model 3</td>
<td>Good quality of care combination allows for increased coverage at busy sites with reduced staff burden;</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Standardized basic facts coupled with opportunity to explore individual needs.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Model 4</td>
<td>Mass pre-test information session/video with individual/couple pre-test counseling offered optionally.</td>
<td>Less burdensome on staff time than M3; Well suited to clients who are already well informed with strong support structures in place, and limited vulnerability of risk.</td>
<td>Some women who would benefit from counseling may decline; Staff burden where nurse/midwives conduct individual session in addition to usual workload.</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Individual/couple full pre-test counseling session by MCH nurse/midwife.</td>
<td>Client-centered; Adequate coverage of decision-making may benefit from existing nurse/patient relationship; Uniform approach for all women. No need to go to a different room for counseling.</td>
<td>Quality of counseling may suffer where workload is high; Potential for coercion because of the care providers’ authority; Potential for increased staff burden at busy sites.</td>
<td>Best for centers with low provider/client ratio.</td>
</tr>
<tr>
<td>Model 5</td>
<td>(e.g., Rwanda EGPAF sites: Centre Hospitalier de Kigali, Centre de Sante Gitega)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual/couple full pre-test by dedicated counselors.</td>
<td>Client-centered; Adequate coverage of decision-making; Better chance of maintaining high quality (the counselor has no additional duties); Less risk of “obligation” by the client to consent to HIV testing.</td>
<td>May stigmatize clients who present for counseling; Women may choose not to share their test result with the care provider (nurse/midwife), which may result in decreased use or adherence to ARV intervention; Requires creation of counselor positions; Difficult to sustain without external funding.</td>
<td>Potential to provide high-quality counseling at centers with high provider/client ratios; Requires long-term commitment from government and/or external donors to be sustained.</td>
</tr>
<tr>
<td>Model 6</td>
<td>(e.g., Kenya EGPAF site: Kijabe Hospital)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual/couple pre-test decision-making discussion with the care provider.</td>
<td>Client-centered; Less time-consuming; Normalizes HIV testing as part of routine ANC profile; High likelihood of sustainability as human resource burden is minimized; Standardized client flow at center.</td>
<td>Women may be insufficiently prepared to deal with their results; May lead to coercion.</td>
<td>Potential approach; Requires careful exploration given levels of stigma in some countries; May be best used in combination with Models 1 or 2.</td>
</tr>
<tr>
<td>Model 7</td>
<td>Reality-based practice in some private facilities in industrialized countries.</td>
<td></td>
<td>Not counseling per se.</td>
</tr>
</tbody>
</table>
Some approaches (use of the information sessions/videos) may increase coverage (in comparison to traditional pre-/post-test counseling) although it remains unclear as to whether they will lead to more women testing, as such approaches when used alone do not address the numerous psychosocial and cultural barriers mentioned throughout the document.

Summary

There is need to redefine the objective of pre-test counseling in the context of PMTCT.

There is need to develop group pre-test model protocols in relation to the essential elements to be covered under the most conducive circumstances.

Practical lessons learned from models that result in increased coverage while maintaining high-quality service delivery should be rapidly documented and disseminated for potential adaptation or replication.

There is need to simplify pre-test sessions and streamline VCT within ANC/MCH while ensuring that women continue to make informed choices regarding their options relating to knowledge of serostatus as well as access to ARVs for PMTCT.
Couple Counseling: Benefits and Cautions

What we know:

✓ Couple counseling can facilitate disclosure of serostatus and contribute to behavior change through risk-reduction planning;
✓ Special communication promotions that target couples (e.g., Valentines Day promotions and couple “free days”) are effective mechanisms to increasing attendance by couples at a free-standing VCT site;
✓ A major barrier to uptake of VCT (as reported by women) is the capacity to obtain/seek consent from a partner/husband;
✓ Not all women (including pregnant women) are part of a couple; therefore, caution must be taken by service providers who suggest “bringing your partner” prior to assessing the individual client’s circumstances (this is particularly true for young pregnant women who may not have/want active involvement of the father of their unborn child);
✓ Couple counseling must uphold voluntary, consensual practice. Coercion by one partner and/or an organization (e.g., some forms of religious-based pre-marital testing) may result in adverse consequences for either party (in particular for women) that test positive;
✓ Couple-based VCT can be effective when offered on weekends (Rwanda and Zambia University of Alabama experience). This is also an incentive for service delivery staff if paid overtime or a supplement to work overtime.

What we suspect:

✓ Couple counseling when conducted in a skilled manner by a competent provider has the capacity to reduce further HIV transmission and PMTCT;
✓ Couple counseling may play a role in reducing gender-based violence, discrimination, isolation and abandonment experienced by women who test positive;
✓ Sero-discordant couples may be able to implement risk-reduction planning more effectively when VCT is targeted to the couple;
✓ Involving men in decision-making processes may increase ease of women’s adherence to PMTCT interventions, including ARVs, infant-feeding options and nutritional factors.

What is required:

✓ Protocols on couple counseling;
✓ Training of service providers to work with couples to adequately address consent, to facilitate disclosure and to negotiate areas of potential conflict and undertake conflict resolution as appropriate.

There is no documented evidence of:

✓ How to undertake VCT for couples in developing countries outside of research-based projects;
✓ Whether women want men to undertake VCT with them within ANC sites or whether alternative VCT service delivery models are more appropriate for couple VCT interventions.
Lay Counselors: A role in increasing uptake of VCT in SOME countries?

“Lay counselor” is a term that has been used to loosely describe individuals who are members of the general community and who are recruited and trained to undertake a counseling role. Lay counselors are more often than not non-clinical individuals, usually with limited experience in health care settings. To date, there does not appear to be a standard definition of who and what constitutes a “lay counselor.”

What we know:

- Lay counselors can play a role within VCT (including within PMTCT). It is crucial to clearly define their roles, boundaries and limitations.
- Lay counselors require systems and mechanisms to ensure quality monitoring and supervision that must be provided by counselors trained in supervision, including nurse/counselors, counselors within the clergy, social workers and psychologists.
- Some countries do not currently have adequate cadres of counselor supervisors, social workers or psychologists.
- Some countries in Africa are attempting to build cadres of counselor supervisors. Support for such measures must be addressed before consideration of further use of lay counselors for such contexts.

What we don’t know:

- The efficacy of using lay counselors to undertake VCT in developing countries and within PMTCT.
- How the use of lay counselors impacts the quality of the counseling intervention.
- Client satisfaction with the use of lay counselors in various VCT settings.
- The impact of using lay counselors on uptake and coverage of VCT.

What is required:

- Consistent use and definitions of the term “lay counselor.”
- Monitoring and evaluation of existing lay counselor programs.
- Documentation and sharing of lessons learned on the use of lay counselors for VCT, including within PMTCT
Use of Lay Counselors in South Africa

Experiences to Date from the Ministry of Health, Western Cape Province

Provincial Administration of the Western Cape (PAWC) controls all public hospitals and community health centers for the public sector within the province.

1. Lay counselors are invited to apply through newspaper advertisements or through NGOs. Interviews are conducted after screening all applications. Selection criteria are determined by each NGO employing the lay counselors. In most cases, the requirement has been completion of high school, but in some rural areas lower standards were set (e.g., Grade 9 or 10). Other attributes addressed during interview include level of confidence, ability to communicate, past social service work and at least literacy. Many NGOs set standards at grade 12 and past social experience. Selected candidates attend training for 20-25 days, which includes information on self-awareness, introspection, counseling skills, AIDS awareness, AIDS counseling, legal and ethical aspects, HIV and related diseases (TB, STIs), HIV and pregnancy, positive living, stress and burnout, bereavement counseling, abuse and trauma. After course completion, counselors are placed within health facilities to provide VCT and MTCT counseling.

2. Most counselors are female (about 3 percent are male). Unless previously employed by the NGO and exposed to such work, none of the counselors have formal health experience or educational background. Most apply because they were unemployed. A small salary is offered, which is incentive in itself.

3. From a three-year VCT grant from the national government, 80 lay counselors have been employed who are contracted to about 15 NGOs, each having their own contracts of employment with the counselors under them. All counselors are contracted to an NGO that oversees administrative duties (salaries, leave, etc.). There are also 10-15 NGOs providing counseling through lay counselors who are not part of the program.

4. The counselors do pre-test counseling for 30-40 minutes; the testing takes about 20 minutes and the post-test counseling 15 minutes. Each counselor sees about 5-6 clients per day. They work from 09h00 until about 16h00, depending on their mental state. They do not counsel on Fridays. This day is used for mentoring sessions and follow-up training at the various NGOs. They receive mentoring twice per month and have supervision and psychologists available if needed. No counseling is provided by lay counselors on weekends. Nurses at the clinics are also trained to do counseling and take over on weekends. In each of the districts, the counselor rotates to the clinics or may spend 2-3 days at one clinic, depending on the need and community response.

5. None of the counselors do testing. Testing is done by trained clinic sisters using rapid tests. Once 2-3 sisters have been trained at a site, they are responsible for training other staff at the clinic.

**Challenges to date:** Space for confidential counseling. Training in rape counseling, alcohol abuse, etc. is required and will be incorporated in follow-up training.

Increasing the Involvement of Husbands/Partners
There are numerous challenges to men accessing health care services in general. Substantial
gender differences have been noted and it is widely known that men often present late for
medical/curative treatments.

Substantial challenges have also existed to encourage men to present for syphilis screening.
Therefore, it is not surprising that systems are faced with the conundrum of how to increase the
involvement of husbands and partners in PMTCT, especially given the traditional and historical
context of MCH being primarily a woman’s domain.

In antenatal settings, women are usually tested alone, yet important decisions relating to their
status should ideally be shared with their partner.

Although in many PMTCT sites the involvement of husbands/partners is encouraged, many
women do not even discuss HIV testing or disclose their HIV test result to husbands/partners.
The proportion of husbands who attend VCT themselves is even lower.

Information from the 13 research sites in Africa offering VCT and MTCT interventions (see page
89) show low numbers (<10 percent) of men agreeing to test in all sites except in Thailand.\textsuperscript{152}

This high level of partner involvement in VCT associated with PMTCT in Thailand was con-
firmed in a review of the PMTCT program in two regions. Nearly sixty-nine (68.5) percent of
seropositive women said that they had discussed HIV testing with their partner/husband and 39
percent said that their husbands had also been tested. Eighty-eight (88) percent of sero-
negative women interviewed said that they had discussed HIV testing with their partner and 56
percent said that their partners had already had an HIV test.

In studies from sub-Saharan Africa, partner disclosure and testing have been found to be low.
In a small study from the Western Cape in South Africa, less than 50 percent of seropositive
women were able to disclose their HIV status to anyone and only a minority of these discussed
it with their partner.\textsuperscript{153} In the MTCT program in Botswana, disclosure to partners is reported as
being low and few men are either tested together with their partners/wives or agree to test at a
later date.\textsuperscript{154} In a recent report from Côte d’Ivoire, only 5 percent of the partners of the HIV-
tested women also accepted testing. In Rwanda, of the 1,223 women who were screened for
HIV at an antenatal clinic, 70 percent who had post-test counseling said that they wished their
partners to be tested for HIV. Despite the encouragement of the counseling staff and the
available infrastructure, only 8 percent of the partners were tested.\textsuperscript{155} EGPAF sites reveal
similar findings where women are encouraged during pre-test counseling to bring their partners,
yet counselors are not observed to offer assistance as to how women might approach such a
task. In addition, low uptake by partners is noted.

Women in industrialized countries may also have difficulties persuading their husbands/partners to
be tested. Results from a small qualitative study in the United States showed that following
antenatal VCT, although all women had disclosed their HIV status to their partners, only 56 percent
of seropositive and 44 percent of seronegative women knew their partner’s HIV status.\textsuperscript{156}
Adverse Consequences following Disclosure

In a study from Nairobi, Kenya, women offered VCT during antenatal care were advised to tell their sexual partner their HIV status and to bring their partners for further counseling and testing, if desired. Of the 324 women who were seropositive, only 66 (27.2 percent) communicated their test result to their partner, and only 21 partners (6.4 percent) subsequently tested. Five (23.8%) were seronegative. Even with this low rate of disclosure, 11 seropositive women were chased away from their house or replaced by another wife, seven were beaten and one committed suicide. Because of these adverse outcomes following partner disclosure, the policy of partner notification was changed and women were counseled to make their own choices about whether or not to involve their partner. Subsequently, only 109 of 311 (35 percent) women with a seropositive result returned for their test result and only nine (3 percent) partners came for VCT.

Studies from Rwanda have noted the burden of physical and emotional violence, as well as the financial difficulties that occur for women who test positive if they disclose their HIV status.

In a study from Tanzania, 340 women were followed up for three months following VCT to examine the relationship between HIV serostatus, domestic violence and disclosure. Both those who tested seropositive and seronegative experienced high levels of physical violence. Fifty-four (54.0) percent of seropositive women and 32.3 percent of seronegative women said that they had had at least one physically abusive partner in their lifetime, before attending VCT. Seropositive women were significantly more likely than seronegative women to report a physically violent episode with their current partner in the last three months (31 percent vs. 16.2 percent). It is not known whether the violence following VCT was related to disclosure of positive status or a reflection of the higher level of violence experienced by women who test seropositive.

In lower-prevalence countries, women identified to be seropositive in antenatal clinics may be more marginalized. In a study of 52 seropositive pregnant women from Mumbai, India, women reported serious adverse consequences after sharing their HIV status with their partner/family. Twelve were beaten or abused by their in-laws, 18 were no longer allowed to perform household tasks and six were left by their husbands (none of whom agreed to be tested). In industrialized countries, violence against women diagnosed as HIV-positive has also been described as a concern in relation to partner notification.

Summary

The final decision of whether to involve husbands/partners should rest with the woman. Men should be given the opportunity to be tested together with their partners/wives, and thus be able to share in decision-making around PMTCT and prevention of sexual transmission of HIV. Sharing responsibility may result in increased understanding of and involvement in PMTCT (e.g., by using condoms during pregnancy and being supportive of HIV-positive women’s infant-feeding choices).

If men are to participate in decisions about PMTCT and take responsibility in HIV prevention, their barriers to VCT (and their wives’/partners’ barriers to their involvement) should be addressed. The fact that so few men are willing to be tested together with their partners/wives adds to the discrimination and isolation of HIV-positive women.
It is clear that men often do not present with women, but it is less clear if and how they are invited. Women report the need to ask their husband before testing in some countries, but it remains unclear as to whether this results in active requests and/or the consequences of such requests.

It is also unclear as to whether service providers desire men to be involved in VCT within ANC and how service providers deal with the issue of partner involvement within counseling. There is need for operations research in all of these areas.

Interventions aimed at promoting involvement of partners and husbands should highlight involvement for the purpose of facilitating a therapeutic impact for the family (mother, husband/partner, baby and other household members). General VCT services for men and women outside the ANC setting need to be available and promoted to facilitate testing of partners.

**Approaches to Increasing Husband/Partner Involvement in VCT/PMTCT**

**Alternative VCT settings:** Men do not usually attend antenatal clinics and may be reluctant to do so or find clinic times inconvenient. Alternative VCT services where couples can attend together or men can attend alone should be developed in parallel.

**Making ANC settings more male accessible:** In addition to the above, efforts should still continue to encourage males to frequent sites that are traditionally perceived as “women’s business.” An example is the current construction of porto-cabins attached to the VCT sites in Botswana. Such endeavors may be more long term, as they involve a substantial paradigm shift in perception of services by men (such as the shift that has occurred in industrialized countries over generations for men to attend births on site).

**Accessible operating hours:** Research sites in Rwanda and Zambia found offering VCT services for couples on weekends (in addition to targeted VCT services for pregnant women during the week) to be a successful strategy. This is also desirable for staff if capable of being paid overtime for working on weekends. However, caution must be taken to extrapolate experience from research sites to operational sites.

**Communication materials:** PMTCT messages should address the roles and responsibilities of both parents.

**Community awareness:** In order for people to understand VCT/PMTCT interventions and the importance of involving men, community participation in planning services and raising awareness can be considered. **Communication campaigns targeting couples** could include both community mobilization by positive role models (e.g., couples who know their serostatus or men who have been tested), as well as media campaigns (materials/radio/print) targeted to couples.

**Safeguards to protect vulnerable women:** Although fathers should be given the opportunity to participate in VCT/PMTCT interventions, this must be with the consent of the pregnant women. There should be greater emphasis on providing ongoing support for vulnerable women.

**Increasing our knowledge and understanding about men’s attitudes and perceptions of testing:** For example, “Testing one’s wife is like testing one’s self.”
Potential Research Questions on VCT/PMTCT to Support

- A comparison study of different models of VCT within ANC (as presented in the models section);
- What can be learned from countries that had generic VCT coverage before introducing VCT for PMTCT versus countries where VCT for PMTCT precedes general VCT coverage?
- How is uptake affected when NVP versus other interventions (AZT) is used?
- How does the chosen regime affect issues such as compliance and adherence?
- Does involvement of men in PMTCT interventions have an actual impact on PMTCT in terms of uptake of testing, adherence to drug interventions and infant-feeding options?
- What can we learn from those who are given the ARV intervention and do not comply versus those who comply?

Resource Information on VCT/PMTCT

APPENDIX: COST FACTORS FOR VCT

The cost of rapid test kits is decreasing over time. The test kits alone cost around US$1.50-5 and the costs of VCT per client tested range from US$4-60 from published and unpublished studies and literature from developing countries.

Costs from industrialized countries are usually higher.

<table>
<thead>
<tr>
<th>Cost of VCT at New Start</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Start operates nine integrated and one free-standing center at an average annual total cost of US$1.2m. The nine sites account for 10 percent of this total cost, while the free-standing site accounts for 90 percent. Rapid testing is available at five of the 10 centers, including the free-standing site, which handles 55-60 percent of total monthly clients.</td>
</tr>
<tr>
<td>The New Start sites can be classified under three categories, based on number of clients per month:</td>
</tr>
<tr>
<td>Direct site (free-standing) averaging 1,383 clients/month;</td>
</tr>
<tr>
<td>Indirect (integrated) &gt;100 clients/month (five sites averaging 195 clients/month);</td>
</tr>
<tr>
<td>Indirect (integrated) &lt;100 clients/month (four sites averaging 35 clients/month).</td>
</tr>
<tr>
<td>Costs per client (excluding fully allocated management salaries and other consulting fees) range from US$16 to US$60. Cost recovery is at 2.4 percent on site costs, and 0.6 percent on total costs, with about 75 percent of clients paying an average US$0.80 fee.</td>
</tr>
<tr>
<td>The cost to the VCT client consists of the fee for service, transport to the site and time away from office, childcare, etc. New Start price policy only applies to those who can pay, and free promotions are run regularly. Transport costs are minimized because with the use of rapid tests clients have same-day testing and results.</td>
</tr>
</tbody>
</table>

Costs of providing VCT depend on:

**Start up costs:** Will usually be much higher in free-standing sites compared to integrated sites where infrastructure is available.

**Geographical location:** Unit costs of providing VCT to remote and smaller communities will be higher due to small client numbers and transport costs.

**Cost sharing/cost recovery:** If clients can contribute to the costs this may reduce the unit cost needed to provide the service. In high-prevalence developing countries this has not been a significant factor as many clients do not have the capacity to cost share at a substantial level for cost recovery. In industrialized countries and in the private sector, costs may be met fully by clients or covered by medical insurance. Workplace VCT allows much of the cost to be met by employees and may be a way of increasing access in some settings.

**Quality of services offered:** If in-depth individual counseling, ongoing counseling and support services are available, this will increase the cost of the service.

**Promotion and advertising:** A significant proportion of VCT costs at the New Start and Macro sites are due to promotional activities and radio advertising.
Data from the VCT efficacy study in Kenya and Tanzania found VCT to be feasible and cost effective compared to other health interventions in developing countries. The cost of VCT provisions, per DALY, was US$12.77 in Kenya and US$17.78 in Tanzania. This compares well to:

- US$10 - Enhanced STD services;
- US$5.25-$10.51 - NVP for all pregnant women in high-prevalence settings;
- US$12-$17 - Childhood measles vaccine;

The World Bank recommends support of health interventions when the cost per DALY is US$50 or less.

Provision of VCT in high-prevalence settings is more cost-effective as it has the potential to prevent more HIV infections. It is therefore most cost-effective to target high-prevalence countries and populations or high-prevalence populations with large numbers of sexual partners such as sex workers, where a multiplier effect makes VCT and condom promotion highly cost-effective. The cost to avert one HIV infection in emergency rooms with HIV prevalence of 1 percent is US$60,000 in the United States. In Tanzania and Kenya, US$60,000 would avert 173 and 241 HIV infections, respectively.

Lower costs per DALY saved can also be achieved by targeting more women than men, increasing the proportion of couples and targeting higher HIV prevalence settings and populations.

There may be significant costs to the client of receiving VCT, in terms of time, transport, lost wages and fees.
REFERENCES


5 : www.unicef.org/programme/youth/hiv/lilongwe.html. Malawi Meeting on Young people and HIV/AIDS.


26 Tanzania DHS 1996.

27 Zambia DHS 1996.


34 Fouchard JR, Worm AM. (1997) Knowledge, attitude and behavior among patients with


Dillon B., CDC (1999).


137 Revised US public health service recommendations for HIV screening of pregnant women 20/10/00 US Public Health Service.


139 Moses Sinkala (2001) University of Alabama Chaiwama PMTCT trial.


CDC Atlanta (personal communication) 2001.


