BORDERNETwork project

Work Package 6. Access to early HIV and STI diagnostics for vulnerable groups

Report on the results of self-assessment of the voluntary counseling and testing services

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Background

Sexually transmitted infections (STIs) are a major public health problem in Europe. Many European Union countries saw dramatic reductions in the incidence of many acute STIs in the late 1980s. These decreases coincided with the emergence of the global HIV/AIDS pandemic, and have been attributed to population-wide behavioral modification in response to HIV campaigns during that time (Fenton 2004).

STIs are known to have a direct effect on HIV transmission, especially those with genital ulceration – such as syphilis and HSV-2. STIs are unique in the infectious disease world as they are completely dependent on behavioral factors for transmission (except for mother-to-child transmission). Worldwide STI incidence is highest in adolescents and young adults. Not only is the absolute number of sexual partners important, but the type of sexual partner also contributes to potential infection risk. The constellation of an in individual's sexual partners, and their partners' partners, constitute a sexual network. Persons with serial partners are less likely to spread STIs than persons who have multiple concurrent sex partners (Nelson 2007).

Even though in many European countries the rates of STIs have somewhat decreased in recent years, some vulnerable groups are still highly affected. For example in 2008 almost three quarters of syphilis cases were diagnosed among men and this may be influenced by the ongoing epidemic among men who have sex with men (ECDC 2010a).

Several vulnerable groups are at increased risk for infectious diseases, including STIs, HIV and viral hepatitis. For example, infectious diseases are among the most serious health consequences of injecting drug use and can lead to significant healthcare costs (EMCDDA 2010). Sex workers as well are at increased risk for HIV, sexually transmitted infections (STI) and other sexual and reproductive health and rights problems (Lafort 2010). Sex between men is the most prominent mode of HIV transmission in several Western European countries.

Across Europe the number of people infected with HIV continues to rise, and the problem of late diagnosis has been described in many countries (ECDC 2010b).

Considering these issues, scaling up STI and HIV testing and other related health services is critical to reduce the number of people unaware of their infections and prevent further transmission.

HIV testing is often used as an umbrella term to refer to both testing and counseling services. HIV testing is the gateway to treatment, care, and prevention (Makhlouf 2007). It is an integral component of HIV prevention and care strategies worldwide. International guidance stresses that HIV testing and counseling (HTC) must meet the needs of most-at-risk and vulnerable populations as well as expand beyond clinical settings and involve civil society and community-based organizations in providing the HCT services (ECDC 2010b, WHO 2010).

Efforts to increase access to and uptake of HTC must be tailored to different settings, populations and client needs (WHO 2010). It is possible to modify health services to make them more responsive to clients' needs and preferences and hence promote the utilization of testing. Improving the quality of testing and counseling services can lead to significant increases in rates of testing (Makhlouf 2007).

BORDERNETwork is a EU funded (Public Health Programme) networking project with 13 participating organizations from 8 EU countries, and above 20 collaborating partners, 5 of them from non EU countries. The main goal of the project is to improve prevention, diagnostic and treatment of HIV/AIDS (including co-infections) and STIs through bridging gaps in practice, policies and cross-country cooperation and enhancing capacity in interdisciplinary response (medical, prevention, research.) Work package 6 (WP6) focuses on early diagnostics and its main aim is to intensify efforts in early diagnosis of HIV and STIs for most at risk groups based on human rights and gender equity and to decrease the number of those unaware of their infection status. One task in the framework of WP6 was to assess the good practice level of HIV counseling and testing services. For these purposes "Self-Assessment Checklist for Voluntary Counseling and Testing" developed by International Planned Parenthood Federation was used. The current report presents the results of the self-assessment and summarizes the main findings.

The project Bordernet tackled the issue of quality of HCT counseling in its first phase, the current assessment is being conducted under the follow up project Bordernetwork, which devotes a special area of cooperation on early HIV/STI diagnosis among most at risk groups.

Methods

The assessment was conducted between September 2010 and April 2011.

Sample and setting

All BORDERNETwork project partner organizations (n=10; see Appendix 3) involved in WP6 identified relevant services providing HIV counselling and testing in their region and invited them to participate in the self assessment of services. The criteria for selecting organizations were rather wide and basically included only provision of HIV testing to HIV risk groups and/or general population.

Instruments

For assessing the HIV counseling and testing services and collecting background information on services and clients, the following instruments were used:

1. For assessing the good practice level of HIV counseling and testing, the "Self-Assessment Checklist for Voluntary Counseling and Testing" was used. This self-assessment checklist is based on the Code of Good Practice for NGOs Responding to HIV/AIDS (more information can be found at www.hivcode.org) and has been developed by the International Planned Parenthood Federation (The questionnaire is included in Appendix 1). The Code identifies accessible and confidential services as one of the key principles of HCT. The instrument has been designed to help assess the degree to which the organization is successfully implementing good practice on this principle. The questions are designed to be thinking points/guidelines to help service providers to identify areas that are already at a 'good practice' level, and areas that need to be developed and strengthened. The checklist contains two main sections – focusing on organization preparedness and service provision, with two and seven subsections, respectively. Responses are categorised as „Yes, we undertake this work/activity", „Insufficient, in preparation, or being considered", „No, we've not yet tackled this work/activity", and „Not relevant to our work". There is no formalized scoring process for this assessment. It is suggested to look at the questions that were answered 'no' or 'insufficient' to, and then select areas that are most relevant for the organisation to improve upon in the short-term. At the end of each subsection there is space to write actions needed to support the respective activities.
2. In order to collect background data on the profile of the services (populations served, mobile or stationary services, number of tests conducted, etc) and clients a short semi-structured questionnaire was used (developed by the project lead partner NIHD). Data was collected for years 2008 and 2009 (two years prior to the assessment). The questionnaire is included in Appendix 2.

Both instruments were self-administered, possible to fill in in electronical format, and recommended to be filled in by a team of people directly involved in organizing and providing HIV counselling and testing in their organization. Both instruments were in English and no time and resources were available to translate it into national languages.

Results

Participants

The total number of organizations participating from eight countries was 17 (five from Latvia, four from Germany, three from Estonia, one from Austria, Bulgaria, Poland, Romania, and Slovak Republic each).

Profile of services and clients

Seven organizations provided services for general population, including HIV risk groups, the rest focused on more specific target groups (e.g. sex workers, injecting drug users, Roma people, or men who have sex with men). The number of clients served per year ranged from 6–11 to 5,500–5,600 (in 2008–2009). Across all 16 organizations the mean number of clients tested for HIV per year was 994. In general, a larger number of clients were served in organizations providing testing to general population. Some smaller services, where less than 30 clients per year were tested, focused only on one target group – for example men who have sex with men or injecting drug users and their partners.

Most services were stationary, but four organizations also provided mobile services for some specific HIV risk group (for example for sex workers (female and transgender) and their partners, and injecting drug users). Personnel included most commonly medical doctors and nurses, in some organizations also social workers and/or a psychologist.

In ten organizations HIV rapid testing was available, the rest provided only blood tests (usually ELISA method with confirmatory Western Blot). The waiting time for receiving test results for HIV blood tests ranged from 1–2 days to 10–14 days (most commonly 7 days). Besides HIV testing, 14 organizations also provided testing for hepatitis B and C markers, five tested for syphilis, and three organizations provided testing also for other STIs (chlamydia, gonorrhea, etc).

Self-Assessment Checklist for Voluntary Counseling and Testing

In the following sections general overview of the responses by sections and subsections (based on the questionnaire) is given. Not all organizations answered all the questions, therefore responses do not add up to 16 in every single question. Most organizations answered the questions in English. In Estonia two organizations were helped with translation to Estonian and for all five participating organizations of Latvia the online-tool was available in national language.

A. Organization Preparedness Assessment

This section helps to identify whether the organisation has a system in place to assess the community's need for VCT and the organisation's capacity to provide the relevant services.

A.1 Community Assessment

- Eight organizations out of 17 had conducted a clients' survey before initiating the HCT services. Two organizations answered they had done it insufficiently, and seven had not yet tackled this activity.
- Ten organizations had the relevant information regarding HIV/STI data available, three reported that this information was not sufficient, and the rest four had no such data available.

A.2 Organisational Capacity

Policy and guidelines

- 14 organizations considered creation of an enabling environment for quality services, including HCT, to all people to be part of organization's vision and mission. Two organizations considered this not relevant to their situation and one did not consider it to be a part of their vision and mission.
- 14 organizations have policies and/or guidelines on HCT which emphasise voluntary and non-coerced counselling and testing, confidentiality and accessibility to all people without discrimination.
- 14 organizations follow national government reporting requirements. For two organizations this is not relevant and one has not tackled this activity yet.
- In all 17 organizations women are able to receive confidential HCT without the presence or knowledge of their spouse.

Staff

- 14 organizations have adequately trained staff to provide and support comprehensive HCT. Two organizations have marked that staff training insufficient. One organization has not tackled this activity.
- 13 organizations have identified training facilities that can provide HCT training to selected staff.
- 11 organizations undertake meeting(s) with staff in which community needs, epidemiological data, policy/law, resources and staff's opinions are discussed. One organization reported that they have done it insufficiently, four organizations have not done it at all (the same four organizations did not have relevant information regarding HIV/STI data available).

Facilities

- 13 organizations have enough private space in their facilities that can be used to ensure clients privacy and confidentiality, three consider their space insufficient.
- In 13 organizations the facility has private and secure storage space that can store clients' personal information, in three there is insufficient space, and one organization did not consider this issue relevant.
- 16 organizations consider their recording and reporting system used by the HCT staff to be confidential. One organization considered this insufficient.
- 15 organizations have the required electricity, running water and waste disposal system for successful HCT services. Two organizations consider their systems insufficient.
- 16 organizations have reliable suppliers for the provision of HCT services (HIV test kits and other necessary supplies). One considered their suppliers insufficiently reliable.
- Adequate and sustainable supply of free, accessible condoms is ensured in 15 organizations. One organization has not tackled this activity yet.

Finance

- 13 organizations considered their funds to provide and sustain HCT services to be sufficient, and 4 – insufficient.

B. Service Provision Assessment

This section assesss whether the organisation has systems in place and provides high quality VCT services.

B.1. Access to services

- 11 organizations have clear signs to show the facility/clinic location on access streets and/or outside the clinic building. Four organizations considered their signs insufficient and for one it is not relevant.
- Ten organizations have marked that there is an entrance to the building discreetly located to avoid embarrassment of clients. Three organizations have not tackled this yet, for two it is insufficient, and for one not relevant.
- In eight organizations there are guiding signs indicating the location of different examination rooms and other facilities inside the facility/clinic itself. Two organizations have not tackled this yet, for four it is insufficient, and for two not relevant.
- 12 organizations consider their clinic working hours convenient for different target groups, four organizations – insufficiently convenient, and one considered this aspect not relevant to their work.
- In nine organizations there is a list of services and cost/fee charges of services clearly displayed for all clients to see, in one organization this is insufficient, four

had not tackled this activity yet, and three organizations considered this is not relevant to their work.

- In seven organizations there is a system in place to enable clients who cannot afford to pay to access HCT services. In three organizations this is insufficient, one has not dealt with this yet, and for the rest six organizations it is not relevant.
- Three organizations have procedures in place to periodically assess and review the cost of services in accordance with clients' willingness and ability to pay, five have not tackled this yet, two have not dealt with this sufficiently, and seven did not consider this relevant to their work.
- In 12 organizations there are the systems in place to ensure that HIV positive clients are treated in a non-discriminatory way (for example, complaint forms/client exit interviews/checklists for staff). In two organizations these systems are insufficient, and three have not tackled this yet.
- In 14 organizations staff members who are trained in information, education, counselling and testing are always present and available during opening hours. In three organizations this is insufficient.

B2. Client-Centeredness

- In 11 organizations there is a comfortable waiting area in the facility, in two the waiting area is insufficient, and one considered this not relevant to their work.
- Reliable lighting system is in 15 organizations. In one it is insufficient and needs improvement.
- Gender equity in the staff has been ensured in 10 organizations. In two organizations it is insufficient, two have not tackled it and for one it is not relevant.
- In 12 organizations staff is trained to provide tailored services to different groups without discrimination, in one it is insufficient, and two have not tackled this.
- In 14 organizations there is a system in place to ensure that clients are treated with respect and dignity and are not discriminated. In one organization this is insufficient, and one has not tackled this issue yet.
- In 13 organizations written materials (poster, leaflets, and flipchart) are available in the local language(s). Audio-visual materials (video, TV) are available only in three organizations.
- In 16 organizations all people receive their test results face-to-face with a counsellor in a private space.
- In 12 organizations people who receive an HIV-positive test result are encouraged to ask and encourage their partner(s) to access HCT services, in three this is not done and one organization considered this not relevant to their work.
- Three organizations provide 'contact tracing' (the person receiving an HIV-positive result informs staff at the facility of prior sex partner(s), and staff contact these and encourage them to test, without the person who tested HIV-positive having to take on this responsibility). One considered their activities in this area to be insufficient. Ten organizations have not yet tackled this activity, and one considered this not relevant to their work.

B.3 Privacy, Confidentiality and Informed Consent

- 15 organizations have a private room for counselling and related clinical services. One organization considered it insufficient, and for one it was not relevant.
- In 15 organizations women and young people are given the option of doing their HIV test and receiving their results without the permission or presence of a family member, in two organizations this option is insufficient.
- In 14 organizations there is a standardised record-keeping system where forms are kept confidentially according to national governmental standards. In one organization it is insufficient, in one it has not been tackled yet, and for one this is not relevant.
- In 15 organizations there are procedures in place to ensure that HIV test results are only reported to the client. In one organization there are no such procedures, and one organization considered this not relevant to their work.
- Five organizations schedule and carry out health education talks and sessions for clients on a regular basis. In six organizations this activity is insufficient, five have not tackled this, yet, and one organization considered this not relevant to their work.
- Ten organizations have procedures in place to ensure complete information is given to each client during counselling sessions in a language that they understand, according to guidelines (checklists/copies of guidelines distributed to all service providers/assessment of service providers). In five organizations these procedures are insufficient and one has not tackled this activity yet.
- 14 organizations have procedures in place to ensure that the client has given voluntary and informed consent before the test is performed. For one this is insufficient and one has not tackled this activity yet. For one this was not relevant.

B.4 Safety and Supply Management

- There are reliable supplies of clean water in 15 organizations. In one organization it is insufficient.
- 15 organizations consider their facility to be clean. Two organizations consider this aspect insufficient.
- Sufficient and well organized storage space is in 12 organizations. In two organizations that it is insufficient, one has not tackled it yet and for two it is not relevant.
- In 15 organizations all equipment is maintained in good working condition. In two organizations it is insufficient.
- In all the 17 organizations medical waste is properly handled according to guidelines.
- In 16 organizations there are protocols/guidelines available on infection prevention (IP), HIV testing and counselling, post-exposure prophylaxis (PEP), and logistical management. One organization considered their protocols to be insufficient.

- In 10 organizations the protocols are visibly displayed in order for staff to follow the protocols when performing their tasks. In three organizations it is insufficient, three have not tackled this and for one it is not relevant.
- Staff is trained in logistic management as necessary in 10 organizations. Four organizations considered this training to be insufficient, one has not tackled it yet, and two considered it not relevant to their work.
- Stock of supplies is adequately monitored in 12 organizations. In two organizations monitoring is insufficient, two considered this not relevant, and one did not know.
- Three organizations have systems in place to follow up clients and to track down dropout clients. Four considered their system to be insufficient, five did not have such system and, three organizations did not consider this relevant to their work.

B.5 Staff Competency to Deliver Services

- 14 organizations have periodical staff meetings to discuss and update information related to the service, three considered their meetings to be insufficient.
- 14 organizations have staff that is trained on current information, education, counselling and testing procedures. In three organizations training is insufficient.
- 14 organizations have policies and guidelines on HCT including procedures, client flow, price, counselling, education, testing, and referral available and accessible to all staff. In two organizations it is insufficient and one has not tackled it yet.
- 11 organizations have procedures in place to ensure all staff is using the materials listed above, in four these procedures are considered insufficient and two have no such procedures.
- In 16 organizations staff is trained on issues of stigma and discrimination in relation to the HCT service. One has not tackled this, yet.
- In 16 organizations documents related to HIV epidemiology and STI prevalence are available and accessible to all staff. One has not tackled this, yet.
- In 12 organizations staff members are trained to provide clients with appropriate information about HIV prevention, including information about all contraceptive options and pregnancy choices. In three organizations this activity has been insufficient, and two have not tackled this, yet.

B.6 Monitoring and Evaluation

- 10 organizations have supervision/monitoring plan that is used regularly. Three organizations recognize that it is insufficient, three have not tackled this activity and for one it is not relevant.
- In eight organizations staff is trained on supervision/monitoring. Four organizations consider it to be insufficient, three have not tackled this yet, and one considers it not relevant.
- Service statistics is collected and analysed periodically and findings shared with staff members in 13 organizations. In two it is done insufficiently, and two considered it not relevant to their work.

- 13 organizations report data to the national government as required. One has not done it yet, one organization has done it insufficiently, and two consider it not relevant to their work.
- There are systems to gather client and providers' feedback on service delivery (i.e. suggestion box, client's exit interview, additional surveys etc) and they are used to bring changes to the service in seven organizations. In five organizations it is insufficient, four organizations have not tackled this activity yet, and one considered it not relevant to their work.

B.7. Collaboration with Other Care and Support Services

- With 13 organizations there are no care and support services provided in the same facility (for example, antiretroviral (ARV), sexually transmitted infection (STI) management, the prevention of mother to child transmission (PMTCT), etc). In two it is insufficient and two have not tackled this yet.
- 13 organizations agree that there is a referral system in place to other care and support services (for example, PMCT, opportunistic infections, ARV, tuberculosis, STIs, mental health, income generating activities, food aid), two have not tackled it yet, one has done it insufficiently, and for one it is not relevant.
- In 14 organizations the services are linked to support groups for PLHIV (either inside or outside the clinic/facility), in one it is insufficient, and two have not tackled it yet.
- There are PLHIV, both men and women, involved in HCT service delivery as counsellors, peer educators, etc only in four organizations. In five organizations this aspect is insufficient, and eight have not tackled yet.
- Addresses for referral services and support are available in 15 organizations, in two organizations this it is insufficient and needs to be improved.

Discussion and conclusions

Our experience shows that the "Self-Assessment Checklist for Voluntary Counseling and Testing" is easy to use, covers all the major aspects of service provision and quality issues and is suitable for rapid assessment of HIV voluntary counseling and testing services in different settings. The instrument provides a checklist which can be used in staff discussions to identify areas in need of improvement. Additional value is the possibility to use the instrument repeatedly to monitor the process of developing services. At the same time the instrument does not cover the quality of counseling in detail.

There is no formalized scoring process for this assessment. Rather, it is suggested to look at the questions that were answered 'no' or 'insufficient' to, and then select areas that are most relevant for the organisation to improve upon in the short-term.

In general it can be concluded from our assessment that the majority of participating organizations have adequately trained staff, systems and regulations in place, and sufficient resources to ensure provision of good quality and confidential HCT services.

There are some common areas where there is more or less need for improvement (presented not necessarily in the order of importance):

1. Organizations may benefit from further development and implementation of specific guidelines on counseling and testing procedures as well as general management procedures, which should be introduced and available to all staff members. In case there are national guidelines in place, it is strongly recommended to follow these.
2. Provision of regular trainings and supervision for staff members on different issues, including counseling (both pre- and post-test counseling as well as behavior change counseling), stigma and discrimination. Training content should take into account the needs of specific vulnerable populations (for example IDUs, sex workers, mobile populations, and others).
3. Collaboration with governmental organizations (or academic institutions) working in the field of HIV epidemiology in order to be updated on HIV trends on regional/national level.
4. Community and target group assessment to identify needs and increase accessibility of services. Client perspective should be taken into account while planning and providing the services, making sure the services are developed based on the target population's actual needs. This includes identifying and ensuring appropriate hours of service provision, so they would be available at different times of day. Ensuring the "visibility" of services – making sure that community is aware of the availability of services. Providers must also make sure that services can be easily reached by the target group members (close to the places where they frequent). Ensuring adequate service supply to meet the needs of all clients, is essential as well.

5. Involvement of PLHIV and vulnerable groups in planning and provision of services and ensuring gender equity among staff. Our-reach work (especially peer-driven) has been shown to be very successful in increasing access to services.
6. Ensuring informed consent and total confidentiality of all information provided by the clients. Providing adequate pre-test information and post-test counselling. All services should be provided on voluntary basis and no mandatory components should be used.
7. Further development and use of information leaflets, and audio-visual materials (where appropriate).
8. Strengthening the monitoring and evaluation of services, including analysis of costs related to services provision, and reporting to relevant governmental structures. Systematically collecting and analyzing clients' and providers' feedback on service delivery.
9. The single biggest benefit of HIV testing is access to treatment (ECDC 2010b). Further improving linkages with other care and treatment providers, including support groups for PLHIV, is essential. In case of anonymous services where follow-up of clients is difficult (if not impossible), provision of rapid testing and ensuring the presence of adequately trained staff at all times is necessary.
10. Even if partner notification by staff is not mandatory in certain countries, focusing more on partner counselling and encouraging newly diagnosed HIV-cases to invite partners to access HCT services, may help to identify people most at risk and diagnose HIV earlier.
11. Strengthening collaboration with national stakeholders and ensuring adequate funding for provision of services, including providing free of charge testing for those who cannot pay.
12. Not all organizations are able to offer additional testing besides HIV (for example STIs, viral hepatitis) which may decrease their attractiveness of services to clients. In recent years more attention is being paid to creating the so-called "one-stop-shop" services, which focus not only on HIV but other co-infections as well.

Ongoing quality assessment and improvement of the testing and counseling services in order to offer high quality services and meet the needs of clients (which may change overtime) should be a regular part of the service management. "Self-Assessment Checklist for Voluntary Counseling and Testing" is one of the tools which could be used to aid this process.

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Annexes

Annex 1. HCT service profile template

Year	Number of people receiving HIV pre-test counselling	Number of people tested for HIV (out of those who where counselled)	Number of people tested for HIV who returned for their test results	Number of people receiving post-test counselling
2008				
Stationary services (clinic or drop-in center)				
Mobile services (mobile van or outreach services)				
2009				
Stationary services (clinic or drop-in center)				
Mobile services (mobile van or outreach services)				

Target population (IDUs, sex workers, MSM, general population, etc)	
Stationary services (clinic or drop-in center)	
Mobile services (mobile van or outreach services)	
Type of HIV test used (ELISA, or rapid test)	In case you use ELISA method, please write how long does it take to receive the results. In case you use rapid testing please describe how is confirmatory testing done and what method is used for confirming the positive results (PCR, ELISA?)
Stationary services (clinic or drop-in center)	

Mobile services (mobile van or outreach services)	
Other tests provided (hepatitis B or C, syphilis, etc)	
Stationary services (clinic or drop-in center)	
Mobile services (mobile van or outreach services)	
Professional providing counselling (nurse, medical doctor, social worker, psychologist?)	
Stationary services (clinic or drop-in center)	
Mobile services (mobile van or outreach services)	
Professional administering HIV test (nurse, medical doctor, lab technician?)	
Stationary services (clinic or drop-in center)	
Mobile services (mobile van or outreach services)	
Work time (what days of the week are the services open, how many hours per day?)	
Stationary services (clinic or drop-in center)	
Mobile services (mobile van or outreach services)	

If it is the same person who provides counselling please indicate so

Annex 2. List of WP6 partners

List of associated partners and contact persons

Organisation	Contact Persons	Contact Details
AHW, Vienna (Austria)	Isabell Eibl	eibl@aids.at
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POMOST, Rzeszow (Poland)	Grzegorz Gola	grzegorzgola@wp.pl
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NIHD, Tallinn (Estonia)	Kristi Rüütel	kristi.ruutel@tai.ee
ENP country partner, involved in the assessment survey		
SALUS, Lviv (Ukraine)	Oleksandra Sluzhynska	salus@mail.lviv.ua

Collaborating partners: LRAC (Ukraine), THBB (Germany), LIC (Latvia), HUMANITARIAN ACTION (Russian Federation), CORRELATION II (Netherlands).

Annex 3. Code of Good Practice for NGOs. Self-Assessment Checklist for Voluntary Counseling and Testing