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Assessment of voluntary counseling and testing (VCT) services in Ekurhuleni Metropolitan Municipality

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CHAPTER TWO LITERATURE REVIEW

2.1 Expansion of VCT services

Many countries in sub-Saharan Africa – including South Africa - and elsewhere are developing VCT services where HIV testing is done for free or for a small fee. There has been a rapid expansion of these services. In 1998, Kenya had only 4 VCT sites but by 2002 there were 49 sites (Jackson 2002). Similarly in 2003 South Africa had 1500 sites nationwide, but by 2008 these had increased to 4327 (Office of Chief Director: District Health Services, NDOH 2010). However many of these sites are still not readily accessible to people in small towns and rural areas both in SA and other countries such as Malawi (Kelly 2002; Mfutso-Bengo and Muula 2003).

There is no ideal approach towards setting up VCT services, and approaches will differ in various settings (Magongo et al. 2002). VCT services may be free standing, integrated into the public health system, workplace based, mobile, NGO based, community based, private sector based, or may be integrated into other programmes such as prevention of mother to child transmission (PMTCT) (Jackson 2002; Magongo et al. 2002). VCT sites should serve one or more purposes for HIV testing as recommended by the World Health Organisation (WHO) – namely blood donations, clinical diagnosis, research and self referred voluntary testing (Martin 2000; Mfutso-Bengo and Muula 2003).

Expansion of services places an additional burden on both infrastructure and human resources. Shortage of healthcare workers has been found to be a bottleneck in the provision of HIV/AIDS services in resource limited settings hence the need to train and place community volunteers as lay counselors in order to complement the efforts of healthcare workers (Asante 2007; Sanjana, Torpey, Schwaizwalder et al. 2009).

In order to sustain the quality of services, counselors require ongoing education and training. This does not only help maintain the knowledge and skills that they already have but also ensures that they keep abreast with new information (Grinstead and van der Straten 2000; Nulty 2003; Sanjana et al. 2009).

The heavy demand and expectations of high performance result in counselors having to work in the face of sustained stress. It is therefore critical that counselors be regularly provided with supportive supervision and debriefings (Family Health International 2004; Grinstead and van der Straten 2000). However, supportive supervision for stress should be differentiated from supervision that is meant to ensure that policies, procedures and guidelines are adhered to (Doherty, Chopra, Nzibande et al. 2009; National HIV/AIDS Support Project (NHASP) 2006).

Lay counselors are in most cases not full time employees and are therefore always faced with the necessity of finding better paid employment elsewhere (Sanjana et al. 2009). Disputes relating to remuneration have at times led to lay counselors downing tools for extended periods of time thus compromising the provision of VCT services (Discussion with Chief Director: Ekurhuleni; Ekurhuleni District Health Plan 2008 – 2009).

2.2 HIV diagnostic methods

Since 1985, diagnostic HIV testing entailed the use of automated enzyme linked immunoassays (ELISA) for screening and the Western blot assay for repeat testing (Martin 2000; Phile and Vardas 2002). These methods of HIV testing require specially trained personnel, expensive processing equipment, reliable transportation of specimen and reliable dispatching of results (Phile and Vardas 2002). The turnaround time for results ranged from a few days to two weeks (Pronyk, Kim, Makhubele et al. 2002). This led to many people not coming back for their results. Some East African countries have reported non return rates of over 30%. The United States has reported non return rates of over 40% and South Africa has documented non return rates of well over 85% (Jackson 2002; Pronyk et al. 2002). The use of ELISA also meant that people in poor resource settings were deprived of VCT services (Martin 2000).

Studies have shown that rapid HIV tests – which provide results within 10-30 minutes – when used in combinations of two or more assays can provide results that are as reliable as those from the ELISA-Western blot combination (DOH undated; Phile and Vardas 2002). Rapid tests can be performed easily with minimal training (Phile and Vardas 2002). With rapid testing, the practical reasons for not returning are eliminated, the psychological stress of waiting for results is reduced and time and money are saved (Jackson 2002; Phile and Vardas 2002). This makes rapid testing a simple cost-effective tool that facilitates the introduction of VCT services at Primary Health Care (PHC) level even in remote rural areas and poor settings, including mobile services (Phile and Vardas 2002; Pronyk et al. 2002). However rapid tests put extra pressure on counselors to ensure that clients are really ready when they do take the test (Jackson 2002).

2.3 VCT and other services

More than 90% of paediatric HIV infections are caused by mother to child transmission (Wilkinson and Wilkinson 2001). A 1998 survey of women attending ANC services in Kwazulu-Natal found that all of them were prepared to undergo VCT, take drugs and modify their feeding patterns if it meant reducing mother to child transmission (Wilkinson and Wilkinson 2001). This means that VCT is a key factor in PMTCT. Other similar programmes such as post exposure prophylaxis (PEP) – for rape survivors and workplace needle stick injuries – have also helped to create a sense that it is worthwhile to know one's status (Kelly 2002). It is therefore important that VCT services work in close relation with other services such as PMTCT, PEP, TB, STI, and HAART. However, VCT services should not only be linked to other medical services but should also have close relations with palliative, home based care, faith based and other community based services in order to expand the support base for those who test positive (Baggaley, Kelly, Weinreich et al. 1998; National Strategic Plan 2007-2011). While the majority of VCT clients may be self referred, there is a need for a referral system between VCT sites and the other services (Gilly, Ngatia, Rachier et al. 2005; NHASP 2006).

2.4 Factors that influence VCT uptake

The rationale for VCT is that it will help reduce stigma, fear and anxiety around HIV/AIDS and lead to increased openness in communities. However, Kalichman and Simbayi (2003) in a study carried out in a black township in Cape Town, found that although most South Africans were aware of VCT, only 1 in 5 people who know about VCT were tested for HIV. The reason for this was fear of discrimination and stigmatization by their communities. Other studies in SA and other countries such as Mali have also identified fear of stigmatization as a major barrier for utilizing VCT services (Castle 2003; Kelly 2002; Day, Miyamura, Grant et al. 2003; Gilly et al. 2005; Mfundisi, Chiranjan, Rodrigues et al. 2005; NHASP 2006). Other factors that have been found to discourage people from accessing VCT services include inadequate health workforce and infrastructure (Asante 2007), long distances from the service centres (Angotti, Bula, Gaydosh et al. 2009), fear of testing positive and equating that to death (Day et al. 2003; Gilly et al. 2005) and poor quality of services (Mfundisi et al. 2005).

One of the benefits of VCT is the change of behavior that comes with knowing one's status (Castle 2003; DOH undated; Kelly 2002). Those who test negative may resort to condom use in order to remain so, while those who test positive are expected to take steps not to infect others (Castle 2003). However, VCT uptake is likely to be poor when offered without treatment or social support (Castle 2003; Kelly 2002). Up until 2002, Brazil was the only developing country to guarantee universal access – beyond a privileged few - to antiretroviral (ARV) therapy. Botswana was the first country in Africa to offer ARVs through the public health system and South Africa has followed (Fleischman 2004).While the impact of these developments on VCT services is yet to be evaluated, some have suggested that the availability of Antiretroviral Therapy (ART) is one of the factors that lead to increased uptake of VCT (Day et al. 2003; Gilly et al. 2005; Mfundisi et al. 2005). Availability of healthcare workers and counselors (Sanjana et al. 2009), knowing someone who is on ART (Dickson and Mundy 2004; Mfundisi et al. 2005) and ensuring that the services are convenient, confidential and credible (Angotti et

al. 2009; Day et al. 2003) are some of the factors that also lead to an increase in the uptake of VCT.

In high HIV prevalence settings, sickness or death of a friend, family member, colleague etc serve to convince people of the reality of the disease and may therefore lead to an increase in uptake of VCT, whereas in low prevalence areas disbelief in the existence of HIV/AIDS is widespread and this may lead to slow uptakes of VCT (Castle 2003). Debates that question the causal link between HIV and AIDS – raised by former South African President Thabo Mbeki, among others – have resulted in people questioning the existence of the illness. This skepticism is wide spread even in educated people and hampers the uptake of VCT (Castle 2003).

2.5 VCT evaluation tools

UNAIDS has developed guidelines to evaluate both the implementation and effectiveness of VCT in HIV prevention. It has also developed tools for assessing the acceptability and quality of services. These tools are not prescriptive, but are supposed to be generic and adaptable so as to reflect specific needs and local circumstances. The tools, mainly in the form of structured questionnaires, evaluate among others national preparedness for VCT implementation, operational aspects of sites and services, counselors' requirements and satisfaction, counseling quality and content, counseling for special interventions, group counseling, client satisfaction and the cost of VCT (UNAIDS 2000). Ginwalla, Grant, Day et al. (2002) in their evaluation of VCT services for mineworkers in Welkom found that even though some of the questionnaires were rather long, the UNAIDS evaluation tools were be both effective and acceptable. In this study, a composite questionnaire made up of parts from various questionnaires in the UNAIDS tool was used. While this enabled a wide variety issues relating to VCT services to be covered, it also compromised the depth to which these issues were interrogated.

In their assessment of the public sector's voluntary counseling and testing, Magongo et al. (2002) stratified sites into provinces and then clustered them into urban, rural and township. They then used convenient sampling to interview site managers, counselors

and VCT clients using structured questionnaires. Pronyk et al. (2002) studied the feasibility of introducing VCT in rural settings by evaluating clinic testing registers and using semi structured interviews with counselors and mock-client encounters.