Transcript provided by kaisernetwork.org, a free service of the Kaiser Family Foundation[1]
(Tip: Click on the binocular icon to search this document)

Provider Initiated Counseling and Testing: Linking Clinical Services and Counseling and Testing
PEPFAR; the Global Fund to Fight AIDS, Tuberculosis and Malaria; UNAIDS; UNICEF; the World Bank and the World Health Organization
June 6, 2008

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

[START RECORDING]

ALLISON SCHILSKY: Hello everyone. I am Allison Schilsky and I am a member of the counseling and testing team at CDC Atlanta. On behalf of all my fellow authors, I am going to talk today about the experiences of health care providers in South Africa during a pilot study looking at HIV testing and counseling and health facilities.

Several international agencies and donors including WHO, UMA and PEPFAR have called to the scale-up of provider initiated HIV testing and counseling in health facilities around the world and particularly in countries with generalized HIV epidemics like South Africa.

At 5.5 million, South Africa has the highest number of persons living with HIV in the world today. In 2006 the national prevalence rate was estimated at 19-percent among adults between the ages of 15 and 49 years and the South African government estimates that 30-percent of South Africans have ever been tested for HIV.

In order for many more South Africans to learn their HIV status, the government set targets for provider initiated voluntary HIV counseling and testing and the national strategic plan for the five year period spanning 2007 to 2011. The national strategic plan calls for 75-percent health facility

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

coverage by the end of this year and 95-percent health facility coverage by the end of 2011.

While the national plan has set lofty goals for the country's health facilities, there are no national guidelines to assist provincial health departments with the planning and roll out of what is now being called routine offer of HIV counseling and testing.

So, in order to determine how best to feasibility implement PITC in health facilities, the housing province department of health approached CDC South Africa and CDC Atlanta to assist with a pilot study and just a brief note on terminology. Although South Africa is using the free routine offer of HIV counseling and testing, during this presentation I will use the more generally recognized term of PITC to refer to counseling and testing services in health facilities.

The pilot study was designed to compare how counseling and testing services were currently being provided in health facility outpatient departments with a newly introduced PITC protocol. Two study sites were identified and data was collected from each site in two phases.

First, each site collected data on the counseling and testing standard of care over 12 days. Following a PITC intervention in both facilities, data was collected over an additional 12 days to assess the new PITC protocol.

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

The pilot study was designed to look at issues of counseling and testing services as they related to both patients and providers. Patients were interviewed in both phases of the studies. This presentation however is focused on the study only as it relates to health care providers.

The objectives of this aspect of the study were to assess the acceptability and feasibility of PITC from the perspective of health care providers and to assess operational questions related to PITC including the impact of PITC on provider work load.

The study sites included two community health center outpatient departments and housing province. One site was in Suato and had a daily adult outpatient count of approximately 500. The other site was in a more rural township and had a daily outpatient count of approximately 300 adults. Both sites were government operated public health facilities that provided free outpatient services. Except for labor and delivery rooms, no inpatient services were provided at either site.

The first phase of the study looked at how counseling and testing services were currently functioning within the outpatient department. In the standard of care phase, providers were asked to continue with their usual practice of referring patients to a VCT site located within a facility. During the 12 days of Phase I data collection, providers were

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

expected to refer to VCT any patients that they normally would which mainly included STI and TD patients as well as patients who identified themselves as study participants. Patients who were referred to standard of care VCT services were asked to cue in the VCT waiting area. When called, these patients would receive approximately 30 minutes of individual pre-test counseling by a lay counselor.

The national policy in South Africa requires that a trained nurse or laboratory technician perform any HIV rapid tests. Therefore, after pre-test counseling, a trained nurse in the OPD would be called to prick the patient, administer the test, and later interpret the test results. When the test results were available, the lay counselor would deliver individual post-testing counseling to the patient for approximately 20-30 minutes.

The second phase of the study looked at the functioning of a new PITC protocol in the OPD. This protocol required providers to offer and perform HIV testing and counseling as part of their clinical assessment of a patient. During the 12 day period of Phase II data collection, providers were expected to offer and perform HIV counseling and testing in their consulting room with patients identified as study participants along with as many other patients as they felt they could fit in during the course of the day.

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

During the PITC phase of the study, patients were provided with three to five minutes of pre-test information by their health care provider. When the patient agreed, HIV testing was performed following the national serial rapid test algorithm inside the same provider's consulting room. Once the test results were available, the health care provider would deliver the test results along with five to ten minutes of post-test counseling.

Between the two phases of the study, providers underwent a PITC training which included training in HIV rapid test performance, 20 nurses from both study sites were trained together in a 15 hour course provided over five working days. Four doctors were trained separately from the nurses with the same training curriculum adapted slightly to better suit their needs. After the week of PITC training, there was one week of implementation observation and support in order for providers to practice the new PITC protocol before data was collected.

The results of the study are broken up into the standard of care phase and the PITC phase with the data from both study sites combined. As I mentioned earlier, data was collected over 12 working days in each phase of the study. Over these 12 days, it is estimated that 5,000 adult patients were seen at the two OPD's.

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

In the first phase of the study, when patients were referred by their provider to on site VCT, 133 of approximately 5,000 adult outpatients or around 3-percent were tested. During Phase II of the study, when providers were able to offer and perform HIV testing and counseling for patients within their consulting room, 359 of approximately 5,000 adult outpatients or 7-percent were tested, 98 of these 359 patients tested HIV positive.

Over the 12 days period of Phase II data collection, each provider tested somewhere between one and 48 patients with a median of 10 patients tested per provider during the entire study period or an average of approximately one patient tested per provider per day. While these Phase II numbers may seem low, it is important to note that there was an over 100-percent increase in the number of patients tested during PITC implementation.

Three months after data collection concluded, we returned to the study sites to look at the effectiveness of referral and the sustainability of the PITC intervention. We found that only three of the 98 patients who tested HIV positive were documented to have access to any follow-up medical services in the same facility in which they were tested.

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

In addition, it became clear that there had been a marked decrease in the frequency of PITC performance by health care providers. Very few tests had been recorded in outpatient department counseling and testing register since the study's end and the nurse in charge of supplies reported that no resupply of test kit had been required.

At the conclusion of the study, focus groups were conducted with providers to gain more insight into their views on the acceptability and feasibility of PITC.

The providers identified four major barriers to successful PITC implementation. The first barrier was that the provider's work load was already excessive and including an additional service in the consultation room greatly added to the burden.

Secondly, providers were concerned about the operational issues related to patient flow including concerns about sufficient confidentiality for patients seen in shared consulting rooms and questions about what to do with patients during the time it takes for their tests to develop.

The third major barrier identified by the providers was that they were concerned about how they could effectively train new staff on PITC and particularly on HIV rapid testing while on the job. Finally, providers were concerned about their ability to replace HIV testing consumables including HIV rapid

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

test kits, gloves, and Sharp's containers, in the absence of a defined ordering system for such supplies in the OPD.

In spite of these challenges, providers also identified some significant benefits to the implementation of PITC. There was an overwhelming sense of empowerment among the providers, performing HIV rapid tests, better equipment to more fully diagnosed their patients. One doctor said as a clinician, PITC made me confident that I am managing this patient.

In addition to feeling more confident in their diagnoses, providers also emphasized the convenience and confidentiality enjoyed by their patients when HIV testing and counseling was available to them in their consulting rooms no longer requiring the patient to wait in an additional cue or see an additional health care provider. Also, providers appreciated the increases in HIV testing updates in their facilities.

So just to once again summarize the results of the studies, there was a low rate of HIV testing in the study sites under the standard of care referral to VCT model. After PICT training and implementation, testing rates more than doubled. There was an extremely low rate of affected referral among those tested in the PITC phase of the study and the increase in HIV testing appeared to be driven by the pilot study since PITC decreased after data collection concluded.

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

To help ensure effective PITC implementation in South Africa in the near future, we recommend that ongoing policy debates be resolved and guidelines be published. The current lack of counseling and testing policies at both the national and provincial levels, frequent changes and improved terminology, and the fact that lay counselors are not permitted to perform HIV rapid tests are all issues contributing to delays in effective PITC implementation. We also recommend the procedural barriers to PITC be removed.

Successful implementation of PITC requires that as many health care providers as possible be trained to ensure that the service becomes integrated as part of routine patient care throughout the entire facilities and while training is essential, in order for PITC to become fully operational, providers must be supervised and supported during implementation.

Since each facility is different, attention to issues concerning patient flow will need to be individually evaluated. Procurement processes for HIV testing consumables at both the facility and district level will need to be established or improved in order to ensure continuity of services and referral systems will need to be strengthened.

Finally, we recommend that health facility administrators be engaged in the roll out of PITC. Provider

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

attitude can be a serious barrier to the success of PITC and health facility administrators can be key advocates for PITC among the health care providers they supervise as well as within their own larger communities.

I would like to acknowledge the involvement of the South African National Department of Health and the Housing Province Dept. of Health as well as the hard work of the health care providers to study sites and the pilot study staff. Thanks. [Applause]

DONNA HIGGINS: Thank you Allison. During the session, we will take three questions after each talk and I ask that each person please identify who you are and where you are from, which agency, and also please keep your questions short and to the point. Okay you can go to the microphones and line up. Thank you.

IRENE: Thank you so much. I listened to your presentation. I am sure we share many of the challenges across countries. My question is the following: Why did you choose the outpatient setting for the pilot, just simply because I would imagine once you start introducing PITC the kind of lower hanging fruit seems to be the TB services or inpatient departments because of the longer patient contact and sort of repeat visits which result and then you do not get to do it all the first time around, you have another chance a second time

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

around or during an extended period of time, of context between provider and patients. Thank you.

LELAND: I am Leland from CDC France. I have one question about the expenses for VCP and PITC, whether PITC is free or if they have to pay?

DARREN GOFF: My name is Darren Goff. I am from South Africa, an organization called the Institute of AIDS Development where we practice in the eastern capital, we have been using oral swabs, using a volunteer to do oral swabs, how does that set with the national protocol? Just a question.

ALLISON SCHILSKY: Thanks for those questions. I will address Leland's question first. It is the easiest. The tests were free in PITC. All the outpatient services were free including the HIV tests. Irene's question, why did we choose the OPD? That is a good question and I think the reason that we chose it was mainly because the outpatient departments are the most complicated. Inpatient services, TB clinics, it is a lot easier to catch people because inpatient they are actually there longer so you can have more time with them and TB clinics you are pretty much guaranteed some repeat visits so I think what we really wanted to try to address is how do you get this done in outpatient settings where people are flowing through really quickly?

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

And regarding oral swabs, I am not sure about what the South African government says about oral swabs so I do not want to comment too specifically but I do not know, my guess is they are not looking at them very closely but that would be a question for someone from CDC South Africa or the Dept. of Health if they are here in the room. Thanks.

DONNA HIGGINS: Next we will hear about a project that is local from here in Uganda on rolling out PITC in non-urban Ugandan health centers.

MOSES ISABIRYE: Thank you, chair. My name is Isabirye Moses, working with Miguel Vasatory [misspelled?] predictors and HIV counseling and testing coordinator. I am going to share with you on the successes of [inaudible] and unexpected benefits in the model roll out of testing and counseling to four rural Ugandan health centers.

The focus of my background will include location. My accreditation will include location and background, challenges, intervention, I will also go on to share with you the results and lessons learned. And finally I will give you some recommendations.

Just a quick look at the location of Kyunga district on the map of Uganda and Uganda on the map of Africa, this is a map of Kyunga district showing the major health care centers. Kyunga as you can see is surrounded by water bodies on the east

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

we have River Nile and on the west we have River Sezzevwa, far north we have Lake Choga.

We have [inaudible], one district hospital, [inaudible] and two health center [inaudible]. Now [inaudible] project has been focused on providing all residential Kyunga district with the opportunity to determine their HIV status and access to necessary care.

In 2005, we upgraded HIV AIDS services in the district including VCT services, but mobile and fixed services. However, that will not come without any challenges. Kyunga district is rural in nature and therefore suffers the disadvantages of raw settings like rampant poverty and transport difficulties. This in turn afflicts or negatively impacts on access to counseling and testing services and like you know, one problem leads to another because of the many untested residents out there improvement in to the HIV AIDS clinic was negative, also impeded.

What did we do about this? One division was we developed routine testing on counseling at the Port Royal Care Centers. Here, health workers approach the patients, visitors and attendants for routine testing and counseling.

What was our intervention strategy? We held approval and objective meetings between us, Miquel [inaudible] project and district administrators and the health workers. This

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

offered a great opportunity to address some of the challenges, issues of attitude and fears. One of the many things that came up was lack of space where RCT production had been produced in the sections we are intending to introduce it. Second, reason, actually RCTO drives away the health service users.

Nevertheless we all agreed to move on and we, using administrator of health trainers, we trained all health care workers in the four health sites on rapid [inaudible] HIV testing, counseling, and policy issues. This method goes to prove to be faster, user friendly and cheaper. Before, in the whole district they were using the Vacutainer method or venous method if you like.

On the inception of RCT in the different sections, we also identified an experienced counseling and testing staff and put them in all the sections where we initiated RCT to provide additional on job training and support provisions. We also put a policy control system in place.

What were the results and lessons learned? The first major benefit was that we were able to realize the major objective of increasing new referrals into the HIV AIDS clinics. In the district hospital alone, new referrals run from an average of 38 per month to 72 per month. In greater health center #3 the inception of routine testing and

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

counseling coincided with the opening up of an ERT clinic and in the first month they were able to enroll 56 patients.

Decrease in patient costs, in the VCT mode a patient will be asked to come back when the VCT days for an HIV test. In this method, they would not have to come back for an HIV test, thus reducing on their output costs and time.

We were also able to identify HIV positive friends and family in the other category outside the patient's. Little did we know that there was an opportunity to capture in couples on the male ward. In our setting or tradition, when a husband falls sick, they are attended to by the wife, and in such a setting we have an opportunity to get the two together. The other benefit in that is that if in the AIDS rate of those being testing in the district, change to include many more children and adolescents, HIV issues became less to be [inaudible].

When we introduced RCT, the health workers were actually overwhelmed by the acceptance rates and the thinking that the introduction of unofficial driver way, the health service [inaudible] and at the end of the day the health workers had to actually [inaudible].

Task shifting big rewards. The price within a VCT place that we were holding closed, actually closed down because the old B-class in the VCT area were being tested in other

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

sites on the wards, outpatients department and therefore those subsequently in the VCT clinic were redundant and so that space, that created more space in the VCT area for other activities and also the staff that were being engaged in the VCT clinics were able to engage into other activities.

Again, there was less work load in the last, since some of the HIV tests were getting done outside of the lab. In the training of other policy requirements, we trained all health workers, this included researching staff, support staff, and the technical staff. However, there was no direct benefit in training the support staff.

Issues of space, like I said, there was a fear that these settings are already busy and too congested. However, during our approval meetings we agreed, we assigned each other tasks and the health workers took on the tasks of identifying space within their settings and that made everything possible.

Just a quick look at health workers in action, we have a female ward and a pediatric ward and below is outpatient department. Some of our [inaudible] materials emphasizing certain messages, this one is about couple counseling.

I would also like to give you some recommendations. RCT can be a very protective method in urgent find raw HIV positive individuals during routine clinic visits. As we all know that no private investor is going to invest in a rural

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

setting simply because of the poverty in those settings so there is a certain alternative by to use the traditional health centers.

Again, the work load for HIV health care workers can be reduced. In the lab I have already mentioned but again in the VCT model we have a specialist within the HIV setting that it was only a few that would carry out HIV counseling and ART so those tasks were overwhelmed at the ART clinics growth so with the closing of the VCT clinics, those tasks spread the ART clinic and introduced on the work load during the ART clinic days.

A big thank you to the following organizations and individuals for the contribution they give us to make this work effective, partly PEPFAR for its generosity reaching the likes of many positively, Kyunga District Health Team for their cooperation, [Inaudible] project, the MJAP for their consolidation services, Henry Jackson Foundation for Advancement of Military [Inaudible], and the individuals listed below. Thank you very much. [Applause]

DONNA HIGGINS: Thank you Moses. It is great to see studies coming out that are about task shifting and PITC. Three questions? Cue up, one line, first three. I will take the first two at the front mic and the man in the back. We will do more questions at the end.

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

FEMALE SPEAKER: Thank you, a very interesting talk. The initial speaker from South Africa talked about provider difficulty in dealing with the down time, you know, what do you do in the meantime when the test is developing? How did you all deal with that? And the other thing I wanted to ask is how did you deal with group testing if a group of family comes to see somebody, did you test brothers and sisters and mom and whoever was coming to visit? And then the third thing is about coercion, did you feel like maybe wives who are coerced just because their husband is there?

MOYE MUSHASHARI: Thank you very much for that presentation. I happen to be working for the same organization. My name is Moye Mushashari [misspelled?]. Before our government, before we start our [inaudible] in counseling, you must have an announcer, [inaudible] and positive. So because of this program, we think [inaudible] if you like, besides by rolling out HIV care including free access to our [inaudible] in all the health centers in the district.

In this case all to be accepted of this service have no reason to fear because service is available free and very close to their homes, then with involvement we address counsel to discuss, to own up the program. I would say this program was owned up and rode by the political leadership in the district,

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

so maybe just explain why our acceptance is well above [inaudible]. Thank you.

MIGUEL QUAY: My name is Miguel Quay from Nigeria. Mine is just a clarification I need. I want you to please help me understand who performs the counseling and the testing, the doctors within the consulting room or what, please?

MOSES ISABIRYE: Thank you for those good questions. I would like to say that routine testing and counseling in Uganda is not yet mandatory so you set up the benefits and pitfalls will come with integrity to test and this is what is happening like for instance in OPD or outpatient department, in the health talk, HIV messages are included like we also do testing, these would be the benefits and then people come in and [inaudible]. They are also waiting for other services.

The question on waiting time, so the nurses know how to register these patients specifically, like OPD area or they can either book and see a medical officer as they wait or go into the clinical room and then they are sent for an HIV test if they like or start the other way around. So, this redistribution, waiting time you can ask them to go back and then you call them for results if it is like on a ward. There are so many waiting so as you wait for these results you ask the other person to go away and again there are so many people involved so they know how to redistribute work amongst

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

themselves, somebody can [inaudible] concentrate both to the testing and somebody will give the results so it is not one person handling everything and the patients are taken through the process.

There was a question to do with a group, if a group showed up. Again, like I said, the health workers also have to bear in mind the time they have to do their counseling and also give the results. In these methods the results are given instantly and that is why I mentioned that it is faster because they are aware of their results and very few walk away without their results.

So, if a family wants to test, they test, but many times if the health practice they can talk to their wife and so it makes some things easier, easier talking to two couples than when somebody shows up in a VCT clinic as a single individual. It has become very challenging for them to take back the news at home but here in a special way, say if you are talking to us about these issues and I invite my wife and so if they agree, you still take them through the challenges of being two individuals on how they are going to share the results, how are they going to disclose, how are they going to handle it, there is a lot of information that is taken through the client during this time.

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Clarification, this RCT is in a health setting so therefore it is the health workers themselves that are doing this, a kind of convenience as they interact with patients, it is kind of different in the different areas, like OPD is not as uniform as the T's and on the wards. Sometimes on the wards they talk to patients during their interaction with the patients on ward rounds. Again, the nurses are also involved so the doctors have a role to play. Everyone in RCT has a role to play and that is why the minister of health talked about training everyone, involving everyone including the support staff because they have their role to play in promoting the services. Thank you very much.

DONNA HIGGINS: Thank you very much. Next we will hear from another program here in Uganda.

JENNIFER NAMUSOBYA: Ladies and gentlemen, my name is Jennifer Namusobya. I am from Uganda. I work for Research Triangle Institute [inaudible] International on a project called the Uganda RCT/BC project, RCT standing for routine HIV counseling and testing. The first speaker used the PITC. The last one used the RCT and I am using RCT. I think this country consensus that it is provider initiated HIV counseling and testing but by the time of writing this project, we are still confused about the nomenclature. Thank you. I do recognize my coauthors as listed.

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

I will briefly tell you about the background to this project. I will give a brief description of the RCT approach and I am glad that the previous presenters have gone through the steps taken. I will share with you the gaps that we needed to address before scaling up RCT and the interventions. Some of the results including coverage by security level, lesser is last and the conclusions.

According to the Uganda HIV survey, behavior survey conducted in 2004-05, only 85-percent of Ugandans knew their HIV serostatus as opposed to 25-percent who actually had the desire to know. In view of this and recognizing that knowledge of one's HIV serostatus is the key entry point to the different HIV prevention care and treatment services, the Ugandan Minister of Health revised the counseling and testing policy which was by then a VCT policy to include additional approaches, HIV testing, and one of the key approaches is provider initiated HIV counseling and testing or RCT.

So given that policy environment, RCT International partnered with AIDS Health Care Foundation or Uganda Cares to pilot RCT in a total of four facilities, three of these being hospitals and one health center. As I speak now, the predictor has been scaled up to eight districts and a total of 21 facilities.

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Again, the previous speakers have gone through the process as it happens, but I will just recap the RCT approach is providing service as opposed to VCT where family estimated [inaudible] come to the facility for testing. However, it is very important to note, this is trace in all trainings that it is still the person's right not to test if they so wish, so what happens?

When persons are waiting to see their clinician, they are given a health talk. The health talk contains information about HIV, the best facts as we know them, the protocol for offering routine HIV counseling and testing, pointing out issues of the patient's rights to walk out, issues of consent before testing and confidentiality of their test results, the waiting time that you will get them their results, referral for those who are HIV positive, and other aspects before they go in to see the clinician.

So after the health talk, when each person goes into see their clinician, the recap, a brief recap of the information that has been obtained during the health talk and during this time the offer is made, the offer for HIV counseling and testing, using the opt out approach. Now, opt out approach is whereby a patient will be tested unless they definitely say no to the test. Similar to exclusion whereby

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

someone has a privy of other symptoms, the default is that they will have maybe a black flag for malaria and it is they say no.

For those persons who consent or who do not opt out, a rapid HIV testing is done and the user practice is whereas enough blood. They get them their results. Usually we have 15 staffing, depending on how many persons are available. They get a MOH results sleeve and for the HIV positive person, they are counseled on prevention, care and treatment options. They are given [inaudible] to the next HIV clinic day and then they are referred to the HIV clinic, usually within the facilities where the testing is happening. In the clinic, they get [inaudible] ART and other care and support services.

Now the HIV negative persons are given counseling on risk reduction and retesting as needed. Now in Uganda, in spite of findings that, the window period that is exchanged, the policy as of now is that people who test HIV negative get retested after three months. That is what we are still practicing.

So before we could rule out routine HIV counseling and testing, they were obstacles for at risk and we needed to know what these obstacles were so after holding that up with the district managers and administrators to get their support, we conducted an assessment for testing on several [inaudible] areas which are required to implement these programs

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

successfully. One of the key areas was human resource. We looked at the training, which are HIV related, as well as the numbers.

Now, in many, actually all of the facilities that we went into, health workers were already providing HIV counseling and testing using the VCT and POCT approaches and so they needed to be oriented to the new approach of provider initiated counseling and testing so to date we have trained over 1,000 health workers to be able to provide the counseling, to run the rapid HIV test and provide the best care.

As you can imagine, many of the facilities are grossly understaffed and although we did not want to create a prior assistant for staffing, we worked together with the facility managers to identify and train volunteers to meet to get to the [inaudible] of staff shortages.

Now testing was happening in the laboratory as expected, so what we did is to decentralize the testing faction by creating additional testing points within the OPD but also in each and every ward, so what did we do? We worked with the departmental head to identify space which sometimes is redundant maybe, they use it for [inaudible], some things we have provided, simple furniture like a table and a chair and we provided infection control materials like buckets and other items to set up testing points.

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Now, about HIV testing logistics, we did not want to introduce a parallel system for managing of logistics just because it is not sustainable and for all the other reasons that you all know so we went in with the intention of strengthening the existing means of health reduce risk management system so we trained the staff to be able to ultimately forecast their findings over time and make time requisitions. We realize that sometimes the items are lying in the means of health stores but the staff have wrote requisition for them so we worked on that area.

Also assigned the staff has reported that the Ministry of Health transported system who has not delivered the items so what we do is we follow-up the requisitions and then if they give us permission, we can go ahead and set a re-transport of these items so as to minimize delays in delivery. In [Inaudible] as well there is a national shortage of these items, we go ahead to procure them.

Another gap was in quality assurance, again [Inaudible] by regular [inaudible] provision and it was of note is it established the quality of HIV counseling and testing so following that training, which followed the national curriculum for Minister of Health, we provided standard operating procedures for counseling and testing. We do conduct [inaudible] support provision to reinforce [inaudible] and we

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

also do periodic assessments, what were the counseling and testing components as well as data and logistics management.

And in order to check on the quality of the results being given, we established a standard quality assurance system whereby we retest all HIV positive samples and 5-percent of the HIV negative samples to the national reference lab and [inaudible] the levels of concordance between the results from the facility and the national reference lab have increased.

So for care and treatment, again we know that to test somebody with the aim of bringing them to care among other resources so we assess the available options of care. Fortunately many of these facilities already had HIV care clinics but for those which did not have, we worked with the minister of health and our personnel, Uganda Cares, to get the staff trained and then we worked with [Inaudible] to get appreciation for the facilities to be able to access ART and again there was the gross under staffing in these facilities where you had to draw the line which had actually been made well by the fact that now each department was testing so the waiting lines after the ARC clinics became longer so we needed to do something about the staffing. We procured [inaudible] thing to cover guards for HIV positive persons.

The other key area was data management, again there was a data management system in the facilities but it was not very

appropriate for provider initiated counseling and testing so after several attempts to the existing system and realizing that was not giving us some of the data we needed, we designed simple to use that collection tool, data collection and summary tool.

We oriented the staff on how to use these tools, for them to be able to report to us. We worked with them to identify data for [inaudible] persons and in almost all cases these were the existing HMI [inaudible] persons and then we provide regular [inaudible] to ensure quality and timeliness of the data.

During the provision visits we do data validation to make sure that the data we received through the report works on the ground. So, from the intervention, I will just go back a little bit, from those gaps in intervention, there are key results that have happened. One is that there is minimal [inaudible] of logistics. The data college has improved and the ownership of the program.

I just want to pick out a few consecutive results. One of the pleasant operators that we had and after this had been borne out by previous studies was that over 99-percent of the persons offered the test actually accepted to take and this was surprising most to the health workers and the other people.

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

So today, we have tested over 110,000 persons and 30-percent of these were after nine patients somebody asked about what if a family comes if they want to test they will get a test. In fact, even some people who previously have come for VCT would come to facilities and say that I want the shortened version of HIV counseling and testing. They [inaudible] shorter.

The therapy [inaudible] at 13-percent and 53-percent of these persons had been in [inaudible] to care within the same facilities. I must note at this point that while our intention is to get all the HIV positive persons into care, we do not have at this point a tracking system to make sure that even persons which is not to obtain care in those facilities we support getting the care and that is one area that we need to work with.

So, comparing outpatient and inpatient, you consider in the inpatient the coverage is higher. For the patients who are eligible for testing now, eligible means that either you have never had a test or you had a negative HIV test more than three months ago and you have been exposed to the risk of HIV.

Again, this is kind of obvious because in the inpatient you have more clinician patient contact time. Also, in the health center of course we know that there may be more health workers compared to the available patients so the coverage

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

again is higher in the health center of course compared to hospitals.

So what have we learned over time? One is there are high acceptance levels, that when you train [inaudible] and non-counselor health workers they can ably provide RCT, frequent staff turnovers, necessitated retraining, simple to use data tools, improve the quality of data. When you decentralize testing you improve access, you need to pay attention to logistics and data management and partnerships improve effectiveness.

So, in summary ladies and gentlemen, it is feasible to integrate HIV counseling and testing within the clinical services, even in under sourced facilities but one, you need a needs assessment to identify the gaps, train all staff, decentralize the testing faction, you strengthen the logistics management system, pay attention to data, quality assurance have to be there in terms of training and FOBs. You need strength and linkages to care because you are testing so that people get care among other reasons.

In turn, we have taken [inaudible] because you are asking people who are not traditional counselors or lab technicians to perform these factions and then you need to do program monitoring and evaluation. I wish to acknowledge those organizations. Thanks so much for listening to me. [Applause]

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

DONNA HIGGINS: Thank you very much. Three questions? It looks like there are only three. That is great. So step up to the microphone please. Okay we will take the gentleman in the front, please.

MALE SPEAKER: Okay thank you very much. That was a nice presentation. My concern is that if we look at [inaudible] guideline on provider in shared testing it is skewed around testing for specific groups of people, TB patients, minority children and some other things, my concern is how were you able to cope by providing a routine testing that a wrap around testing for everybody in a health system that is already over stressed? Thank you very much.

TADI WANDA: My name is Tadi Wanda [misspelled?] from Tanzania, my concern is I do not have in house patients or clients who need the longer version of the counseling during the PITC and if yes, what do you do with them?

LOU ETCHET: Thank you very much. My name is Lou Etchet [misspelled?] from Uganda, I guess I have a short question about why you opted to do venous draw of blood as the approach to finger stick for blood collection, given the fact that maybe the finger stick is less traumatic and maybe even cheaper? Thank you very much.

FEMALE SPEAKER: I will make an exception and have four questions this time because I nodded to you and so please.

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

MALE SPEAKER: So one question about HIV positive you found from your care called OCP, so you said you provide coturmicrozol [misspelled?] to all, whether you do the CD4 test and only provide for those whose CD4 is below 200, because that is the guideline by the CDC, and second one for the HIV negative so you say it is necessary to provide risk reduction in other counseling so who will provide this counseling to HIV negative? And if provide, what is percentage have got this kind of negative counseling?

JENNIFER NAMUSOBYA: Thank you for those questions. I will begin by the question on why we choose to provide PITC to all patients, given that the system is already overloaded, I think there is reference material that was provided to you which is at the back there and the guidance is that for a generalized epidemic you cannot afford to just go to the TB ward or the STD clinic just to be called, even people who may not be looking like the HIV after [inaudible].

So that is the recommendation by WHO that in a generalized HIV epidemic like we have in Uganda, you have to offer it for everybody and again, after what we have said and it is true that when you go in for testing everybody, do not expect 100-percent of the results because it will not happen. I think I can group the answer like that.

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Then, the second question I got it right and if I did not please correct me, but what I got is the issue of people who need material counseling, yes this is a very important issue because in the PITC testing you do not have a lot of time for each individual person compared with what you have had in the VCT settings so what happens is that VCT has continued to exist in the facilities where we are working. Those rooms are still required to VCT counseling so what happens is that if the health worker identifies a person who needs further counseling they are referred to the VCT rooms because in most facilities there is a counselor waiting.

The other thing we have also done is that because this training for PITC is five days, you cannot expect it to cover all the issues of crisis counseling, [inaudible] counseling or couple counseling in there so what we do is we partner with a project called Strength and Counsel Training in Uganda. They normally have specialized training, pediatric, [inaudible] counseling, it is so. We sent some of the staff in the facilities which supports to attend this training so when they come back they are kind of above the rest of the patients to them.

Why we use venous blood, again I must say in some facilities they were using the fingerstick but it was partly to do with the fact that health workers in spite of training they

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

said for us, we are used to drawing blood, you know, using the venous approach and also remember that if a person came to the facility, they also did not come for the HIV test but they came maybe because they have malaria so the advantage of using venous blood that you, draw more blood which can be used for other investigations and so there was a bit of resistance on the part of the health workers to just go the fingerstick way.

The other reason is that because they needed to do examples of [inaudible] we needed to keep blood samples for retesting at the reference lab. Of course, later we will just get a little sample and do the dry blood [inaudible] to the reference lab but that was the other reason why we needed blood that you could keep for some time.

There was a question about CD4, again our project is mainly aimed at we test people, provide the best care [inaudible] and then refer them to the chronic care clinic. Right now, we realize that while we assumed that the people who test HIV positive will be adequately cared for by the clinic, sometimes that is not so, that is why we went into looking at beyond just testing and referring. Like I mentioned in my presentation, we trained the staff, got them accredited and within the clinics as of now the policy is that HIV ARC treatment is started on somebody who is below a CD4 of 200 so again we are supporting some CD4 tests in selected facilities

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

but in each area that was the entire major kind of focus but we are going there as well.

HIV negative counseling, again I must say that somehow the health workers are so busy and so overloaded that they normally spend more time with HIV positive persons although we insist that even an HIV negative person, to them may be [inaudible] by tomorrow if you do not do anything about maybe their sexual behavior, they may come up with an HIV positive test.

So what we do, again they give some counseling [inaudible] human resource counseling, but they give counseling and in those facilities they [inaudible] health system for provision of condoms so they give them condoms for those who wish to use them and then they refer them for maybe [inaudible] or something like that but again I will tell you that there are a lot of challenges. Thank you.

FEMALE SPEAKER: Thank you. I think we have all noticed that our previous moderator, Donna Higgins, has left for the airport. So, we wish her safe travels and no traffic. I think with that, we will move on to the next presentation which will be on counseling and testing in health, a public health approach to increased access to health promotion in Mozambique by Melinda Hochgesang.

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

MELINDA HOCHGESANG: Hi. I am Mindy Hochgesang. I am part of the U.S. government team in Mozambique and I am happy to be presenting today and part of a collaborative team that has been involved in this effort. I will be talking today about counseling and testing and how is a public health strategy to improve access to health promotion in Mozambique?

I guess just as I start, this is really about a counseling and testing that is an integrated approach. It is actually client initiated so it has ended up in his provider initiated session but it is actually client initiated counseling and testing. It is a new approach to client initiated HIV counseling and testing, voluntary counseling and testing or client initiated counseling and testing has been well established in Mozambique for some time but in 2006 Mozambique updated its strategy as part of a broader strategy to better integrate HIV related services into primary health care. This move was initially motivated by a desire to minimize stigma related to HIV, specific service delivery and to increase the number of people who access these HIV services. It was also based on a desire to expand the package of services provided in HIV counseling and testing to include health promotion and prevention for key public health issues.

So what is counseling and testing in health? The new strategy was developed by the Ministry of Health with input

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

from a number of programs within the ministry as well as site implementing counseling and testing and the key cornerstone of counseling and testing in health continues to be science initiated, HIV counseling and testing with individual level risk assessment, HIV testing, provision of results, and post test counseling. But as part of this new model, it will also institutionalize more systematic screening and appropriate referral for key public health issues including TB, STI's, tuberculosis, sexually transmitted infections, and hypertension.

I will note that when we look at screening, this is done by asking a series of questions around symptoms with space on the national guidelines for symptoms for tuberculosis and sexually transmitted infections. Hypertension is actually measured through a blood pressure cuff to assess, to measure individual's blood pressures.

It also added a component of health education on malaria, safe motherhood, and hygiene. These new aspects included in the model were based on the public health relevance in Mozambique, primarily the prevalence of key issues, areas where there were high rates of coinfection with HIV, primarily sexually transmitted infections and tuberculosis, and topics that would not require specialized personnel to provide the

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

services, consider the dire human resource crisis in Mozambique.

While there was strong political commitment to roll out counseling and testing in health nationwide, this was a new untested program in Mozambique and therefore the ministry adopted a phase, stepwise approach. The first phase has involved initial implementation in selected sites with the following objectives listed here. The introduction of systematic screening of clients for tuberculosis, sexually transmitted infections, and hypertension, expansion of health promotion activities, and then really looking at strengthening referrals made among HIV infected clients to care and treatment services as well as referrals made to both HIV infected and non infected clients to other health care services where needed.

As I noted before, Mozambique is committed to the counseling and testing health model so the initial phase is really to look, was not to look if counseling and testing in health should be rolled out but really how it could be rolled out across the country, and experience to date represents a lot of learning by doing. You will see that we have some very promising areas as well as some lessons learned in considerations for scale-up.

So, Phase I implementation began with the development of protocols and training materials, 12 counselors were trained

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

with support from the Federal University of Rio De Janeiro and Brazil. Three sites, all Ministry of Health sites supported through PEPFAR through the population services international were selected for Phase I implementation. All three sites were located in Maputo in urban, Ursa [misspelled?] my urban settings and during the Phase I period, approximately 10,000 clients were tested.

As part of service delivery in individual, an existing individual level of clients questionnaire has been used and has continued to be used in Mozambique that includes questions on client demographics, risk assessment, HIV testing and results information as well as referrals and risk reduction information.

A supplementary form was also developed during this initial phase that included information about the screening that was done, referrals that were made, provision of health education in the various areas according to the model and the length of the counseling and testing session. As I mentioned before, there were approximately 10,000 clients that were tested during this period and for analysis we used a random sample of 10-percent and ended up with 950 clients that we used for some of the analysis.

The counseling and testing forum includes as one of the questions why people were tested and there are a number of possible reasons that people would report being tested. W

e re-categorized these as two broad categories, one being client initiated reasons, for example that the person was sick, the partner was sick, the person reported concern over high risk behavior, where the other was being provider initiated reasons, primarily that the person was referred from a health care facility. Within these two broad categories, 70-percent of the clients tested during this period were considered client initiated.

As you can see, approximately one half of the clients tested were women of reproductive age and nearly a quarter were women 15-24, which as we know in countries with the generalized epidemic such as Mozambique, are really critical populations to target for HIV as well as other public health services. Of the women who were tested, only 2-percent were known to be pregnant at the time. Nearly everyone was tested, and you can see that 46-percent of clients were HIV infected and 54-percent were uninfected.

For the analysis, we first looked at the HIV infected clients in terms of what kinds of services and health information was provided. So as you can see, approximately 70-percent of the clients were documented as being referred to a

care and treatment facility, 80-percent were screened for tuberculosis and more than 50-percent were found to have at least one symptom for tuberculosis and by symptoms we were looking at did they have a cough for more than three weeks, had they had a fever, the questions according to the national guidelines, 80-percent had been asked screening questions for sexually transmitted infections.

A quick note on the tuberculosis and the screening around tuberculosis and sexually transmitted infections, when we looked further at these findings, we did discover that there were considerable site level variations. Two of the three sites reported screening more than 95-percent of clients in these areas while the third site had screened or at least documented that they screened only 40-percent of clients which clearly affects the overall screening rate.

Nearly 90-percent had blood pressure measured and approximately 20-percent were found to have elevated blood pressure. Approximately 80-percent received basic messages on malaria prevention and intervention and hygiene, and I would note that we ideally would have hoped to be able to look at the percentage of clients who were reported as having symptoms for example for tuberculosis or sexually transmitted infections.

And then some that to look at the proportion who were referred to services although, as we were doing the analysis we

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

found that the data were not collected in a routine enough manner for all clients to be able to look at this information in the analysis.

Looking at the HIV negative clients, 72-percent were screened for tuberculosis and a similar proportion were screened for sexually transmitted infections. Nearly all were screened for hypertension with approximately 25-percent of clients found to have elevated blood pressure and the majority, approximately 75-percent of clients, were provided with health information key issues including malaria and hygiene and as with the HIV infected clients, when we looked at the screening rates for tuberculosis and sexually transmitted infections, there were two sites had again more than 95-percent of clients screened were the lower implementation than the third site affected overall screening rates.

As I noted before, more than half of the women were of reproductive age and there were two health education components to the health promotion aspect of counseling and testing in health.

The first was looking at early diagnosis of pregnancy, really to try and better link women into antenatal services at an early time, 25-percent of the women of reproductive age did receive or were reported to receive information on early diagnosis on pregnancy and as you can see there was a fairly

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

significant difference between who received information when we break it down by HIV infected women versus HIV uninfected women.

The HIV uninfected women were more likely to receive this information than the HIV infected women and similarly a slightly higher proportion, 37-percent received information promoting institutional delivery and we see again here there was a difference where more, a higher proportion of HIV uninfected women received the health information and counseling than did the portion of HIV infected women.

One of the concerns both within Mozambique as well as potentially within other settings is around the length of time needed for such an expanded strategy. Does it increase the length of time of the session and perhaps ultimately decrease the through put of clients in the country? I would note that Mozambique and national guidelines for counseling and testing recommend that a session would last between 25 and 50 minutes including the actual HIV testing process.

We would typically expect a session with a person receiving an HIV positive result would be longer than that for a person receiving a negative result due in large parts to the need for increased delivery and discussion about test results, psychosocial support, referrals and risk reduction planning. In this analysis we found, however, that there was no

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

difference in the length of the session between the two groups, which clearly raises questions about the delivery of post-test counseling being provided to individuals, especially those receiving HIV positive results.

What we are seeing at this point, we believe that counseling and testing in health appears to be a promising strategy for broadening the package of HIV and public health services provided. In particular, promoting general health issues for persons accessing in HIV counseling and testing services as well as more and more clients may come in over time to access general public health services to increase the access of those population to HIV counseling and testing.

It also shows that some of the initial concerns about the affects of stigma and how that would impede persons accessing counseling and testing maybe relieved a little bit, looking at how many clients were coming in based on clients initiated reasons.

From the data that we have, the strategy seems to be most successful at identifying HIV infected individuals in need of a referral for tuberculosis, persons with high blood pressure, and the delivery of health education messages where areas of unclear mixed success are around the screening and referrals for sexually transmitted infections, promotion of safe pregnancy, and follow through referrals.

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

One of the clear documentations, one of the clear limitations was the lack of information or documentation we had about some of the symptoms and referrals made as well as the information on follow-up and impacts and referral.

So to conclude, Mozambique will continue to think about how to roll this out nationally and some of the key considerations as it is being scaled up is how to ensure that there are more standardized implementation across sites of all the core interventions.

How do we update the many tools to reflect the new model, how to ensure that the length and content of this session provides adequate risk assessment and reduction, how we can improve the referral process and documentation, for a woman of reproductive age how we can strengthen the safe pregnancy component and how we can develop ways over time to measure the impact of health education and promotion components.

As I mentioned before, this has been an initiative of a number of different organizations, just to acknowledge the Ministry of Health for their leadership, CBC, Population Services International, the Federal University of Rio De Janeiro, and clients at the three Phase I sites. [Applause]

FEMALE SPEAKER: Thank you. That was really an excellent presentation. I have two quick related questions, one is I took it that these are stand alone testing and

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

counseling services and so I guess my question would be for those individuals who were screened for these various diseases, do you have any idea of how many actually followed through with the referral and got the care that they needed?

And then my related question is something about Mozambique in particular, and I can see, I am trying to get my head around this myself, I can see some value of certainly offering stand alone counseling and testing centers, but in a presentation yesterday by another person from Mozambique, implicitly defined integration as introducing HIV services into existing health facilities, and so the combination of these two presentations makes me wonder is there something particular and peculiar about Mozambique that there seems to be this stand alone sort of beginning? Thank you.

MALE SPEAKER: Thank you very much. It is a very exciting presentation. From the media, we implementing a network of VCT sites and I am very much interested in the additional services for VCT as we are moving from traditional testing and adding new services.

We are in the process, we have actually identified the mercy composition screening, ICI, TB, family planning and alcohol, now I am particularly interested in the issue of time, the time challenge, because here we are trying to cut short like the other presenter said, people are in favor of shorter

counseling sessions because they want quickly to get to know, and here is a client initiated plan, initiated testing where you need to focus on risk assessment, risk reduction, and additional services are going to add more time that the patient, that the client is going to spend at the site, I did not get clearly how did you deal with that challenge?

Because you have the actual counseling, 15 minutes, a standard 15-50 minutes, and in the testing time and the processing time, but you also have a waiting time when the patient is in the cue, the client is in the cue, so these patients end up spending 3-4 hours, I did not get, we really need to understand how can we really make it work?

Because each of the services, STI needs four questions, TB needs four questions, MC about four questions, all of them, and you add them on the risk assessment and risk reduction, it becomes very difficult. I really want to get at practically how did you get it where you, it took me about 96 minutes there. I do not know if that is eventual extreme of time that you used. Thank you.

MALE SPEAKER: Thank you very much for that one, that presentation, it has been said on HIV or the other problems, Monday, Sunday, or now, but a [inaudible] which is very impressed in the hypertension, very high prevalence, did you try to look at other issues and comorbidities like diabetes,

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

renal disease, issues to do with the body mass index? You know, the [inaudible] and activity levels of these individuals?

MELINDA HOCHGESANG: Great. Thank you for the question. The first question just in terms of was this a stand alone facility or part of a health facility, and perhaps I did not clarify that initially, all of them are actually part of health facilities that are client initiated within that health facility, so Mozambique is expanding over time and we will hope to see both an increase in provider initiated client testing in TB and to natal care but also will continue to provide clients' initiated counseling and testing in health facilities.

The issue about follow-up and how many of these, many of these health facilities do include TB, would have TB clinics and care and treatment sites, not all of them in Mozambique, but these three in particular do. I think that the issue of how do we strengthen referrals and actually document that and look at that over time is a really important issue and I think we are still trying to figure out what is the best and most feasible way to do that.

The question about time, we found that the sessions on average took about 30 minutes. You are right, there was a wide range that went up to 96 minutes but the mean time was 30 minutes and as I mentioned there was no difference based on test results. That was really only the time of the session so

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

I think your point about looking at the overall time that a client spends in counseling and testing including the waiting time is important as we try and think about how to increase access is something we did not look at but I think is an important issue over time.

We had expected that this expanded model might actually increase the length of time for counseling and testing and that is why we looked at it. I think 30 minutes is within, it is actually on the low side of the guidelines so I do not think we are concerned that it is too long at this point. I think probably the bigger concern is how do we make sure that we are adequately addressing some of the prevention and risk reduction and referral issues that need to happen for both HIV positive and negative clients?

The last question was why was hypertension as opposed to some other public health issue chosen? There was a lot of discussion and input. It was a very participatory process and as I mentioned some of the factors were around the prevalence of these issues.

The prevalence of hypertension in Mozambique is 30-percent whereas the prevalence of diabetes is estimated to be about 2-percent so there were some prioritization based on the public health relevance here as well as what were some aspects

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

that could be, most counseling and testing in Mozambique continues to be through lay counselors.

I believe it is about one third of people providing counseling and testing are trained health care workers. The other two thirds are trained lay counselors as well so we need to make sure that interventions can be supported by these kinds of lay counselors and so that is why there were some other prioritization about the most important public health issues.

FEMALE SPEAKER: Thanks again. I am going to introduce our last speaker. Before I do so, I just want to make a quick announcement. In addition to the materials that we have in back I want to note that there are also some materials up in the front of the room so at the end of this presentation, please come up front and take these materials. We have a PITC, provider initiated testing and counseling training curriculum that is being developed by WHO and CDC.

It is still in draft form but you can get that and we also have a couple of HIV counseling and testing CD’s that you can collect but please do that at the end of the session and with that I will introduce Dr. Ramsama Lolaka to talk to us about pediatric HIV disclosure in Thailand.

RAMSAMA LOLAKA: Good afternoon ladies and gentlemen. My name is Ramsama Lolaka. I am from CDC Gap Thailand. Today I am representing for the Thailand pediatric HIV closure

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

working group to present you a pediatric HIV closure model, "Lesson Learned from Thailand."

This project is a collaboration of pediatric and psychiatric departments at two hospitals in Bangkok and Cover Aids program in Thailand. As you know, certain HIV infection are an antiretroviral treatment are surviving to mid childhood and adolescence. Approximately 30-percent of 16,000 HIV infected children in Thailand in 2008 are all over 10 years of age and many of these children are responsible for their own medication administration.

Studies suggest that students who know their HIV status have higher self esteem and better antiretroviral [inaudible] than children who are unaware of their status. So, disclosure is particularly important among these children, for example in adolescents who have poor [inaudible] and adolescents who become sexually active.

However, there are no standard practice guideline manners of choosing Thailand for disclosure of HIV status to HIV infected children. Therefore, in Thailand there was an urgent need to develop and evaluate disclosure model for HIV infected children in Thailand. Beginning in 2004, we developed and implemented of the model pediatric HIV disclosure model at two hospitals in Bangkok and training has been provided at additional hospitals across Thailand.

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

And, today I am going to present to you what the pediatric HIV disclosure model is and it is presented with implementation of pediatric HIV disclosure at the two hospitals in Bangkok and also how the model has been expanded to additional hospitals in Thailand. Evaluation of this process is ongoing.

So first of all let us see what we saw that are needed to provide disclosure for HIV infected children. First, we need private housing room, second we need train our personnel, at least one to two health care providers or counselors are needed in resolve [inaudible] settings. However, in all the settings that we saw them all viable, multidisciplinary team is useful to include in a disclosure process. Sadly, that type of a need is standard procedures to materials such as disclosure manual and supplementary HIV educational material are so useful.

This slide shows you the steps of HIV disclosure for HIV infected children that we use. Overall they are [inaudible]. In step one, [inaudible] screening steps include for children is at least seven years old and has no CV or physical or psychological illness. For caretakers, they should have willingness to disclose the child's status to them.

In step two is the care giver and child readiness assessment and counseling. In this step is just to make sure

that care giver and child are ready for disclosure. Step three, disclosure costly step and the last step is step four, disclosure assessment for care givers and children which is done at one to two weeks, two and six months.

Each child and family requires a very amount of time for each session, depending on that problem and what are the fact that the basic knowledge for HIV. However, there are some [inaudible] 15 to 30 minutes and time, further amount of time between sessions between step one to step two are in each step, very depending on in each patient because in some case step one, two, three can do all in only one visit but in some cases may take the [inaudible] in multiple visits.

I would like to share with you the results from T-Bank Hospital from February 2005 to April 2008 about 320 safe, HIV infected children were screened for eligibility for HIV disclosure. Median age was about 10 years and most of these children were prenatally HIV infected children, about 40-percent of primary caretakers were parents and about two thirds of the enrolled students have asked caretakers about that unit prior to disclosure but only one third of caretakers believe the children already knew their status prior to disclosure.

Among 326 cases, screening for eligibility, 92-percent were eligible and willing to be disclosed and the reason for not being ready, not being eligible for disclose in children

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

were delayed development or cognitive impairment or have CVA illness.

Some of the reasons in caretakers that not be eligible are not willing to disclose whether they be afraid that child will be sad or have worsening claiming of illness. Sometimes they are afraid that they will been [inaudible] and some of them believe the child is too young to understand it, diagnoses, already would not be able to keep HIV status secret.

As you can see, in step two care giver and child readiness assessment and counseling, about 65-percent of them were ready for disclosure and the members of the caretakers wanted to disclose to their child because they feeling that they needed a better self care in children or need better hea;thcare in children as well as sometimes there are a thousand difficulties in the testing health care and retroviral issues with their student or they would like at least have some information about a dollar spent issue with them but it is difficult to discuss with them.

Some of the reasons that caretakers not being ready for disclosure were the lack of basic HIV knowledge or lack of confidence to discourse or have conference that were even in caretakers of the child's life. Sometime they share their opinion after they decided they would like to be [inaudible] child with their family, they make decision again.

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Among those who were ready for disclosure, you can see that most of them prefer provider's assisted disclosure [inaudible]. Only 3-percent then of the caretakers decided or chose to disclose by their own and after disclosure at one to two weeks and two and six months, providers ask about impact of disclosure to the spoke of both care givers and children including antiretroviral activins, child behavior, problems and also quality of life of the child after disclosure.

Observations from providers at T-Bank Hospital were that all the children were disclosed to more quickly than children under 10 years old and the most important step in HIV disclosure to students is readiness for disclosure, particularly for caretakers.

And in step two readiness assessment and testing is the most variable and time consuming step that reaches or supplies us in our projects is that originally we spotted a most difficult step is a disclosure counting step but from observation from providers in these, our project, found that the three or disclosure set is less difficult and can take place during one [inaudible] if their child and care giver are well prepared in step two.

Following the model development, training was provided to many hospitals in Thailand with very leveled up clinical staffing and resources. From May 2007 to April 2008,

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

approximately 450 health care providers from 50 hospitals in 10 provinces in Thailand were trained on pediatric HIV disclosure. Training was conducted by experienced providers from the original size and from CDC Thailand. Funding was provided by the Thai government and global fund. You can see that most trainees were nurses who work in their pediatric HIV clinic. Only few of them were doctors.

Training is typically done as a two day session and the top phase includes many things but however the training can be done in their charted time period according to the request from the site. Training topics include psychosocial considerations of HIV infected children and families, for example, are very child development and talking development for different age groups, process and guidelines for HIV disclosure according to the four steps that I mentioned earlier.

Examples of care giver and child readiness assessment, and examples of disclosure sessions for adolescents and younger children, and training methodology includes a combination of lecture and health discussion, we get all demonstration and practice sessions.

Lesson learned from Thailand were that a pediatric HIV disclosure, [inaudible] and manuals provide a framework for disclosure of HIV status to children and we also have provided them the questions and checklist that they can follow through

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

what topics should be included in the discussion. The disclosure process is first of all and can be individualized for each child and family and I would like to emphasize that it is a process, not one event. It is a process that may be [inaudible].

The last but not least is training along with practical truths and materials have made it possible to expand the model to many hospitals across Thailand. I would like to acknowledge the following organization for their support in model development in our software expansion of this model in Thailand. Thank you for your attention. [Applause]

FEMALE SPEAKER: Thank you very much, Ramsama. We will go ahead and take three questions.

FEMALE SPEAKER: Thank you very much for your presentation and this fantastic effort to really, really [inaudible]. I am really full of admiration. I have two questions, one is how do you deal with the situation where a child is clearly consenting, wanting to be disclosed, ready to disclose, but the caretaker is not?

Can you expand on this a little bit? The second question is, are your materials by any chance available in English and would you be willing to share them? Because I am sure they would serve as samples and models for many of us. That would be great, thanks!

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

BUTH SAE: Thank you very much for your excellent presentation and this was a challenging area for even our region here in Africa. I am Buth Sae [misspelled?] from here WHO in Zimbabwe. I would like to find out when you define pediatric, what is your upper age limit, and yeah, plus what developing guidelines for children into ranging from 0-18 years sometimes and you find that the pediatric cutoff point is very unclear in some cases. And my other request was related to what the previous because if you could share the models and the training materials it would really help us. Thank you.

TABIAN BUSHANT: Thank you for your presentation. It was very clear. I am Tabian Bushant [misspelled?] from Rwanda, I am curious to know about the criteria of readiness that you use for disclosure. That is my first question and the second one, you talk about whole disclosure as testament, so my question is do you have any kind of follow-up that you provide after the disclosure?

RAMSAMA LOLAKA: I would like to answer about the materials that are available in our project experience because now we are developing their pediatric HIV disclosure package which complies us all [inaudible], the Thai or pediatric HIV disclosure manner which is being or translated to English for us and that may be good for many, for the person who are

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

interested to come see whether as our supplementary materials in your field.

And in the package the manual and we also have the educational materials which complies us after four modules that are basic HIV knowledge [inaudible] our health promotion and last use which is we use for education children after disclosure, and then in each model we have kinds of presentations by power point presentations [inaudible] and also after VDO demonstration and other games and the games as well.

The last one that you have as a tools and materials is the VDO demonstration that has their disclosure session and their readiness assessment can be compacted by providers and we have two examples in that packet in the VDO demonstration that are for adolescents and for the young child which may be useful to consider. And I can tell you some of the materials of these sessions, I bring some other questionnaires that we use and so the check list for each that we can follow.

And your question about if the child would like to disclose but the care giver does not want to disclose, and because in Thailand what we found from our experiences is that the care giver can play a major role in taking care of the children so if the disclosure sessions will be successful or not, we need to discuss with care giver and Thai [inaudible] let them now that now is urgent need that because the child

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

already ask, they ask questions about their illness or they have some urgent need to disclose with them and they can help us in terms of medication administration to take care of themselves as well and we found that after when we disclosed with them for, after we talked with care givers, one or two visits, they might change their mind again.

The third question about upper age group, unfortunately the persons that have been working is at two hospitals in Bangkok and at these two hospitals in Bangkok it is true that pediatricians can take care of patients if only 15 years old. However, in this model I think it is still practical and can be applied to other age groups up to 18 years old.

The key point is that if the caretaker, the parents are involved, have some involvement in the disclosure process, they need to make some kind of decision on payroll and take care or the child it would be still okay to use this model for the age group.

And the lower age group are eligibility type where we select seven years old because according to our VVD with some recommendations from our Academy of Pediatrics we found that they recommended to do thought disclosure process at the school age for children and school age are the time for school accidents in Thailand is seven years old is the reason why we start at seven.

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

However, some care giver might say that the children are not ready yet to disclose or they can quick point to like one or two years and most of our kids takes about one year to disclose after discussion because there is to prepare caretaker's readiness and however in other countries, for example in the U.S. which is the legal age for testing without parental consent may be lower.

For examples just only 12 years old or in some countries it may be only 14, 16, 18. Their child maybe can decide by themselves that they would like to disclose or know their status by their own with no against the legal and other things but in Thailand the legal age is 18 years old. That is why I think that model can apply to 18 years old.

I think that is all the questions. [Applause]

FEMALE SPEAKER: All right well, I think at this point we have some time left for questions for any of the panelists. So, I will open up the floor and if you have questions for any of the panelists feel free to step up to the microphones and let us know who you are directing your question to and we will take your questions and if there are no questions, Patricia hold on just one second. I am going to let Moses respond to something.

MOSES ISABIRYE: Somebody raised the question on they already, the services that offered in some centers already

overwhelming to the health center staff, in my presentation you remember that I talked about holding approval on objective meetings. These will actually identify some of these issues that we discussed and we will also have made your home work with them.

Now what do the approval and objective meetings target? One, you discuss the attitude and stigma issues among the health care workers. Many of us think that people do not have the peer for the test, like we have all expressed that there is a lot of demand, only lack the services are not readily available to them. The other issues, these are probable meetings also, servers consent.

Many times health workers will tell you we are not ready, we do not want it simply because like in our kids, it is NGO partnering with government settings so they have their own settings. They are used to certain known, so to introduce something new, you need their consent.

Then you work with them [inaudible] and assign yourself [inaudible], that is why I said the task of a defined space went to them because they know their settings very well and if you work with them you realize that there is a lot of wasted space in some of these facilities and again many times you find that actually some hours except for the late cohesions there is a lot of time that where health workers may not have a lot to

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

do so we can use this time to take advantage of the would be list of opportunities.

Like I said we were able to identify 60 HIV positive individuals outside those that had actually intended to test with us. Those are included the visitors, and the attendants, so actually the benefits are there and if you involve everybody in your discussions and implementation strategies, I think it reduces on some of these problems that you might face so the fear is there but sometimes what is imagined may not be really realistic.

I appreciate that some, in some situations staffs are overwhelmed by the work load but you need to reorganize them sometimes. Thank you very much.

FEMALE SPEAKER: All right questions from the floor?

FEMALE SPEAKER: Thank you so much. The panelists, I think you have done a wonderful job and I want to commend Uganda for going forward with their routine testing and counseling.

My questions follows up on the last speaker's session and I want to look at the fact that the visitors who come to the hospital, you will be taking three to five minutes in the post test and then they are gone. And then in that example of Mozambique, we needed 96 minutes to do it on partner reduction, things like that in the post test.

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

And I am not wondering, I am thinking aloud, what observations have you made in the after behavior of certain individuals? Does this have an impact on the kind of meeting that a person who probably tests positive or tests negative after such a short encounter and the long encounter, what are the comparison?

FEMALE SPEAKER: We will take another question.

MALE SPEAKER: Thank you. I am [Inaudible] from the media. Routine testing and counseling is the way forward but I still want to ask a question to all the three panelists who have presented, I think the lady from Uganda said they owed 99-percent acceptability.

I still have a problem to understand how was it accepted, especially among those who came for instance for a road traffic accident or for any reason which is not treated directly related to any medical condition?

I mean, there was no malaria, there was no nothing, but just somebody sitting in a surgical ward and here you come and offer him or her HIV test because there is still that issue but is it all that is on earth, is it only HIV that we should be talking about? So, I want to understand if you were faced with this type of challenge, including Allison in South Africa.

My other question is to the gentleman who spoke about the test shifting for rapid testing, I have not understood to

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

which cutters did you shift the duty of counseling and testing for us to understand because in our media currently we have a very good example of rapid testing scale up using non laboratory, non health care, lay counselors doing rapid testing, so in your case, which cutters did you actually transfer there or shift there, to counseling and testing? Thank you.

FEMALE SPEAKER: We will take one more question and then give time to the panelists.

OSWANA RASHEED: My name is Oswana Rasheed [misspelled?] from Nigeria, my question is to the entire panelists, those on provider initiated, routine counseling and the disclosure, did you find, what is the rate of the loss to flaw among all the people that tested positive, what is the follow-up to ART or to other services within the prevention and care continuum?

FEMALE SPEAKER: All right I think we have questions more broadly for the panel as a whole. Maybe we will start with Moses since he also had a specific question and then we will move to Allison and then on down the line to give all panelists a chance to address these in the next five minutes before the session is over.

MOSES ISABIRYE: Thank you very much. The question on the different cutters that we use, we use those that are

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

actually like I said we train all health care workers, those people found already in the health center. Those included the nurses, doctors, and clinical cases including the nursing assistants.

Now for doctors, of course our patient doctor ratio if you look at this you cannot expect a doctor really to do the testing and that is why we have a section where we are referring for test to other areas.

To everybody including the records officer, all staff who are trained, and that is why we bless, of course in our approval meetings there were fears that the non laboratory staff would not be able to produce good results.

However, with our experience and I believe that many people have actually in this conference it has come up that actually now laboratory staff can run rapid tests very effectively with efficient results and we have not gone into any problems at the moment but also we need protocols, SOT’s, and then you provide support provision closely.

That is why we bless an inexperienced person to work with them, look at the judgement, because results so much depend on how you make your judgement. I do not know whether that really answers your question. Thank you.

FEMALE SEPAKER: Allison, let us open it up to you. I think the questions there were some questions about behavior

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

change after the session, and the different priming of the post test session as well as loss to follow-up.

ALLISON SCHILSKY: I will just comment briefly on these. The question about behavior change after testing in PITC is not something that we looked at specifically because we did not follow our patients up after testing, but I would say that since the PITC guidance is so new, I think it has only been out for a little bit over a year, I am not sure there are a lot of studies out there that would show the efficacy of PITC on behavior change at this time, but I do know of a few studies at least that are ongoing and so eventually down the line we should see some results from those.

And just to address the question about how is counseling and testing offered when counseling and testing was not the actual reason why the person came to the facility or was not related to the reason why the person came to the facility, in the training that we did with the providers.

We gave them several strategies on how they could think about offering the counseling and testing service to their patients and in cases where the patient was coming to the OPD for an STI or for TB related symptoms, those were very easy, but in the cases where maybe the person was coming because they just had the flu or there were several stomach ache, a head ache, those types of things, it was harder but what we

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

encouraged the providers to do is sort of explain that this was going to become the new clinic policy and that they were trying to offer the service to as many patients as possible and it was not singling anyone out or thinking that you look like you have HIV or anything like that, it was just a standard service that was being applied in the clinic.

I will let the Ugandan folks talk about the last follow-up because I think they have better data.

FEMALE SPEAKER: Jennifer do you want to address that?

JENNIFER NAMUSOBYA: I will briefly comment on the question that was asked and actually Allison has also covered that, the issue of high acceptability for HIV testing, again I will tell you that it was not that at the very beginning and thinking that even the health workers with care.

I am talking about HIV testing, for patient who actually came with the symptoms and said [inaudible] HIV but like Allison has said and as I explained in the process, the health drugs that people get as they are waiting to be seen by the clinicians and during this health talk they are given an opportunity to ask all the questions they want and a few things come out like this test is based on your symptoms.

If they were to go before the Ministry of Health now it is their policy and it is aimed at actually giving you the data health outcomes. Many of us have HIV and we do not know so.

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

It is not something you tell a person is that you must have an HIV test so the health drug does a lot to prepare somebody for that.

And then the example of a person who came with a truck accident, again HIV testing is never an emergency. It is not an emergency so in somebody who is very sick or they come because of a truck accident, again you [inaudible] patients. Actually nothing may be talked about on the first day but as we sort out the most urgent needs of the patients, then the following day you can actually introduce the topic.

About behavior, we also note down in the service to see the adverse effects of these testing and this is one area that could be studied further but again we hope that if this patient who are HIV positive show up in the HIV chronic care clinic there are more opportunities for them to be counseled on reduction of risk of transmission of HIV. I think that is it.

Lost follow-up, again we have not done studies and that is one area which I admitted is maybe an [inaudible] to our programs. We know that over 50-percent are showing up but that is not 100-percent and that is a problem that could be looked at but as for our program, we do not have a community [inaudible] and that is one area that we could probably look at. Thank you.

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

FEMALE SPEAKER: Moses just has something quick to add about lost to follow-up.

MOSES ISABIRYE: Again, you can draft a form, you can – it is also important for the health workers to fix appointments as follow-up with their patient because when they are interacting with this patient they build some kind of relationship, a friend relationship, so you can invite the patient to come back and then you lead them into the treatment and care services.

They sign a consent form whether they are willing to be followed-up wherever they are living or not and that helps in terms of tracking down these clients. Like I said, we work in a special way and some of them actually fading simply because of transport problems and you can get feedback if you have a signed consent form to follow them up.

We also use the treatment clubs so to provide additional support in terms of counseling to those who actually need support counseling so the system must be a little bit integrated and comprehensive where you refer to other person if you do not have time because if they are someone who has wandered if somebody really not comfortable with the results, what do you do? You refer to an experienced person for further counseling. Thank you.

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

FEMALE SPEAKER: All right thank you Moses. I think with that we will call the session closed. I want to thank all of our panelists. We have heard about a range of provider initiated testing and counseling programs today, a great program in Mozambique integrating a client initiated testing and counseling and to health care centers and very interesting presentation on pediatric disclosure of HIV status.

[END RECORDING]

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.