

Who volunteers to test? Experiences from an integrated VCT program in Tanzania.

Peter Kintu, Marie-Laure Kurzinger and Marc Pechevis
Axios International

Introduction

Voluntary counselling prepares the individual, both psychologically and physically, to understand and accept the results from an HIV testing exercise, and this directly influences the acceptability of the available care options. Voluntary Counselling and Testing (VCT) is thus an important entry point for HIV prevention and care in rural sub-Saharan Africa. However, not all population groups have an equal likelihood of accepting VCT and therefore public health interventions on HIV counselling and testing should be specifically tailored for each population group (Misiri *et al*, 2004). Before implementing any VCT intervention, it will therefore be necessary to understand how different population groups and categories are likely to accept VCT and the reasons driving this. This could guide implementers in designing strategies for accelerating VCT interventions at similar rates in all population categories.

VCT services have not been widespread in Tanzania. Several factors have contributed to this, including lack of adequate trained personnel, irregular availability of testing kits and related supplies as well as high start-up costs. In June 2002, local authorities with technical support from Axios and funding from Abbott Laboratories, started providing VCT services in the rural Tanzanian districts of Mbeya, Rungwe, and later Muheza and Ilala municipality. The aim was to increase the access to VCT, promote safer sexual behaviour and reduce stigma in the population.

This paper describes the different categories of the population that have voluntarily participated in the district VCT programs, including factors that have prompted them to participate.

Methods

In early 2002 and later in 2003, a needs assessment was done in four districts of Rungwe, Mbeya Muheza and Ilala municipality using the Axios mobilisation methodology. The assessment, which was done for a period of 1 week in each district, covered a number of selected health centres and hospitals in the districts. Health facility records were reviewed to assess the VCT utilization rate. Client and service provider perceptions were explored as a basis for organizing user-friendly services and the patterns of organization of existing services were observed to find out mechanisms that could be used to integrate VCT into the existing health services. It was observed that the majority of clients were referred

to the regional hospitals for testing and yet there was evidence of an increasing demand for VCT services nationwide.

Based on these findings, 63 health facilities were selected (see *Table 1*) to provide integrated VCT services in the districts in order to enable access to the majority of the population.

Table 1: Number of health facilities selected for integrated VCT implementation

District	Number of hospitals	Number of health centres	Number of dispensaries
Muheza	1	5	9
Rungwe	3	5	21
Mbeya	1	7	6
Ilala	1	1	3
TOTAL	6	18	39

Implementation of the integrated VCT program started with VCT-focused training of health workers and IEC was strengthened through provision of materials and information dissemination meetings. Each site was supplied with rapid test kits, drugs for opportunistic infections and other supplies. Laboratory capacity and waste management systems were also strengthened with test kits and diagnostics, coupled with essential training in testing to all staff. HIV test quality control mechanisms were instituted. Every tenth test done using rapid tests was sent to the regional referral laboratory for quality control.

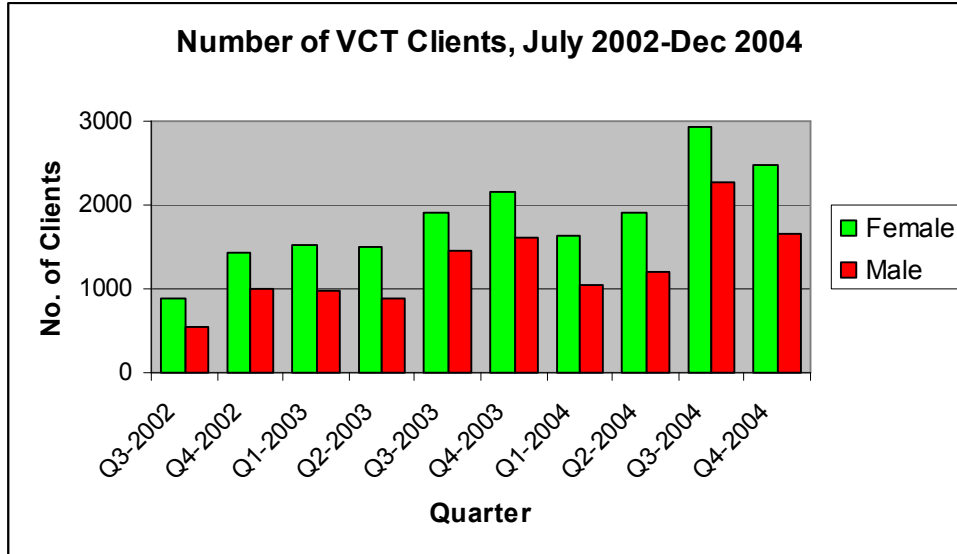
A standardised recording and reporting system was set up. Health facilities were provided with standard registers to record particulars of VCT clients on a routine basis and a VCT client registration form was designed to capture this information for analysis in the central project office. Registration forms captured information on clients' socio-demographic characteristics, history of HIV testing, reasons for accepting VCT, HIV test results and willingness to share results with other people. A double data entry system and rigorous data cleaning mechanisms were set up in the central project office to ensure a high data quality. The cleaned client dataset was analysed using *Stata* statistical software to determine the variability of socio-demographic characteristics of the VCT clients, HIV prevalence, VCT service utilisation rates, reasons for testing and other variables, and making comparisons between the different sites and periods.

The data was divided into 5 semesters according to the date when the testing was done and the chi-square test for trend was applied to determine the significance of the changes in the socio-demographic characteristics of the clients.

Results

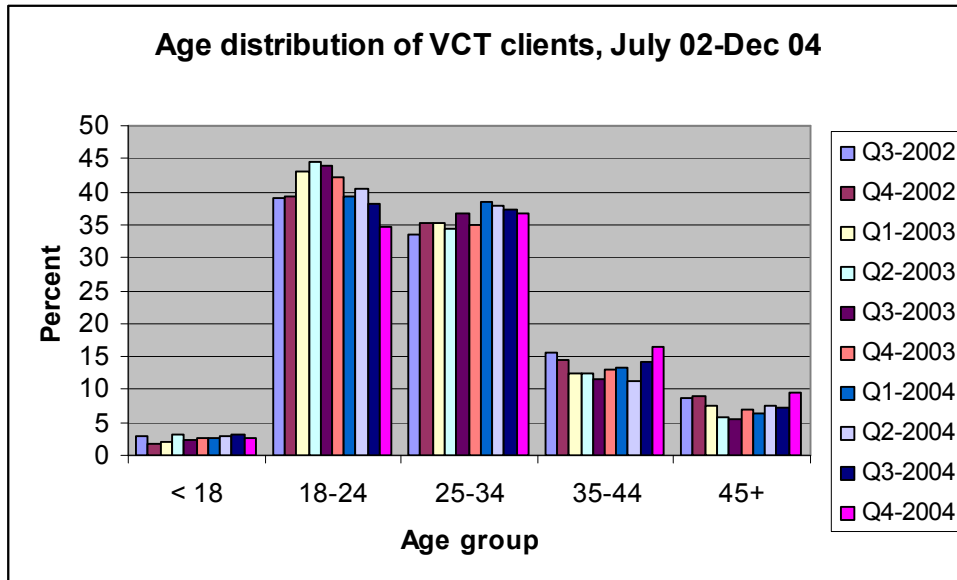
During the period July 2002 to December 2004, 31 196 clients (59% female, 41% male) volunteered to be counselled and tested (see *Figure 1*). A significantly increasing number of clients was registered during each quarter (*chi-square for trend=19.0, $p < 0.001$*).

Figure 1: Number of VCT clients serves between July 2002 and December 2004



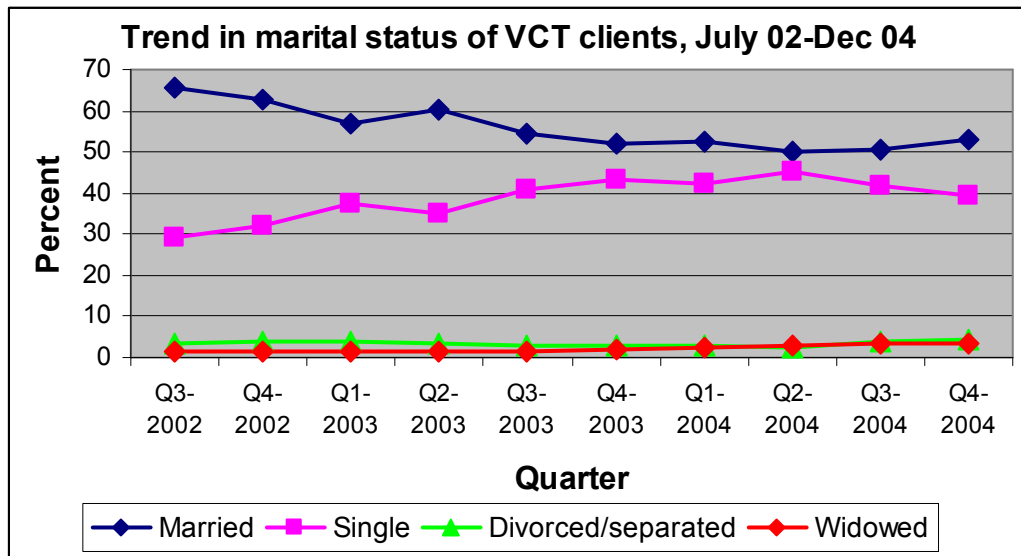
The majority of the clients (77%) were aged between 18 and 34 years, and this was similar during the entire period (see *Figure 2*). However, analysis of trend in each age group did not yield any statistical significance.

Figure 2: Age distribution of VCT clients



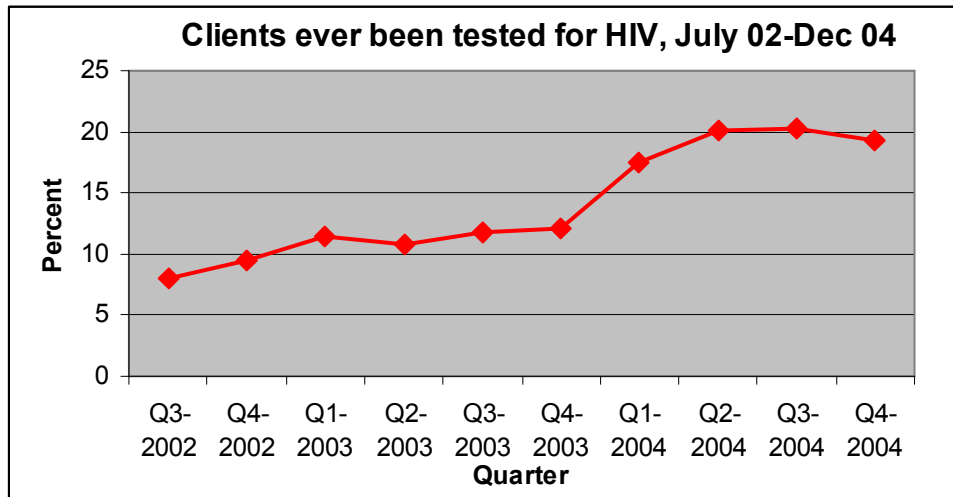
More than half (54%) of the clients were married, followed by 40% who were single and the rest were divorced, separated or widowed. During the period under study, a significant drop in married clients from 66% to 53% (*chi-square for trend=8.4, p=0.004*) and an increase in singles from 29% to 40% (*chi-square for trend=6.4, p=0.012*) were observed. This means that more and more young people were continuously yearning for the VCT services and are likely to out-compete married couples in future (see Figure 3).

Figure 3: Marital status of VCT clients



Overall, only 15% of the clients had previously tested for HIV. However, when data was compared for the different time periods, it was observed that the number who had taken a prior HIV test and now seeking for another test was increasing significantly (Figure 4). Among those tested in the period under review, clients with a prior HIV test increased from 9% to 20% (*chi-square for trend=7.4, p=0.007*).

Figure 4: VCT clients with a prior HIV test

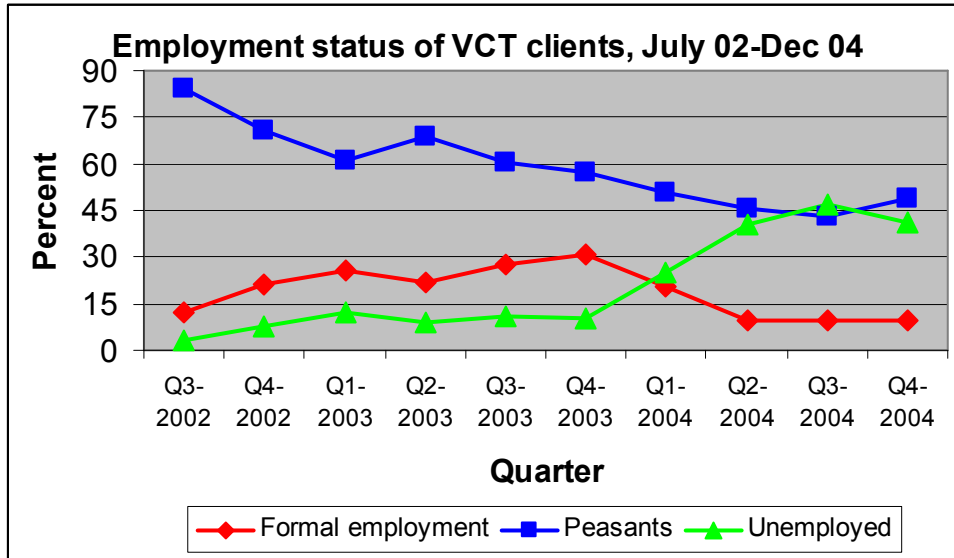


Clients were asked why they had chosen to take the HIV test. Sixty-percent of the clients were motivated to know their HIV status and 10% indicated PMTCT as the main reason for testing. However, among the female clients who were HIV-positive, 18% were pregnant and 18% were breast-feeding, indicating the need for PMTCT interventions in this community.

HIV prevalence among the VCT clients was 18.4% (95% CI 17.9 – 18.8) and this was higher than that officially reported in the general population in this community (14%) based on routine antenatal surveillance. The male-female ratio of HIV-positive clients was nearly 1:2 (35% male, 65% female). An increasing proportion of HIV-positive clients of either sex was registered every quarter. However, their trends were not statistically significant.

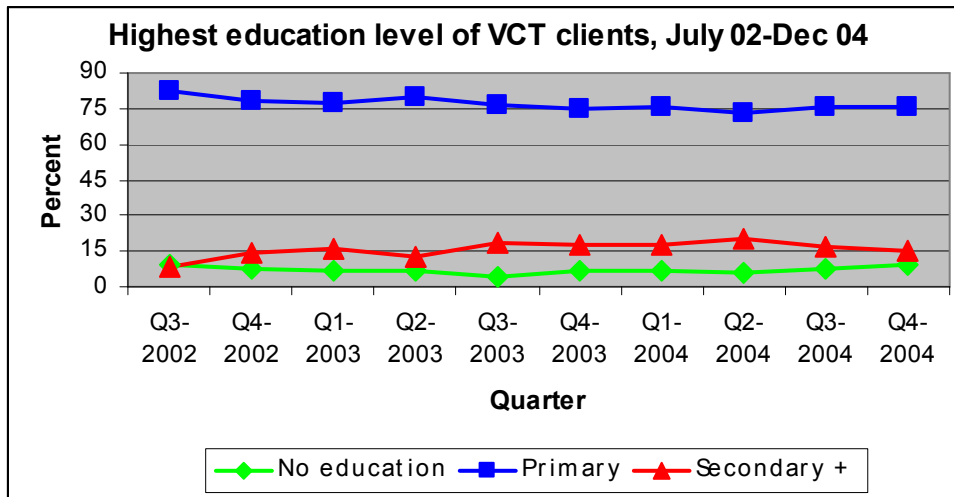
The employment status of VCT clients was also assessed. Only 18% of the clients were in formal employment. Peasant farmers were the majority (56%), followed by 24% who said they were totally unemployed. Declines in clients with formal employment (*chi-square for trend=7.4, p=0.007*) and peasants (*chi-square for trend=50.6, p<0.001*), and an increase in unemployed clients (*chi-square for trend=117.0, p<0.001*) were observed (Figure 5).

Figure 5: Employment status of VCT clients



Clients were also asked to state the highest education level they had attained. More than three-quarters had only finished primary education and only one quarter had attained at least secondary education. There were, however, no significant changes across the period under review in the education status of the VCT clients served (Figure 6).

Figure 6: Highest education attainment of VCT clients



Conclusion

Since introduction of the programme, there has been rapid uptake of services reflecting that demand is high. Analysis of the trends in the socio-demographic factors of the VCT clients over time will facilitate understanding the dynamics of those who volunteer to be tested and will pave way to the development of appropriate interventions to further control the AIDS epidemic in sub-Saharan Africa.