Summary: Voluntary Counseling and Testing

UNICEF's Role in VCT
for Young People, Children
Pregnant Women and Their Partners

Prepared by Family Health International
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EXECUTIVE SUMMARY ON UNICEF'S ROLE IN VOLUNTARY COUNSELING AND TESTING (VCT) FOR YOUNG PEOPLE, CHILDREN AND PREGNANT WOMEN

There are no instant prescriptions on how to provide VCT and counseling for young people and children, as well as VCT for pregnant women and their partners. Further **learning by doing** and **expanded partnerships** in action are required. Effective and **innovative responses** to the psychosocial needs of young people and children (including counseling) require investment *in addition to* VCT services. The United Nation's Children's Fund (UNICEF) has a crucial role to play in this area.

UNICEF has a key global role in **coordination and dissemination** of emerging practices and key documents, including those in existence and those being developed in relation to VCT in antenatal clinics (ANC), counseling for infant-feeding options, antiretroviral (ARV) regiments within prevention of mother-to-child transmission (PMTCT) of HIV, models of VCT for young people, and case studies for scaling up and implementing VCT and care and support. UNICEF has considerable **convening power**, which should be used to bring together stakeholders to facilitate effective coordinated support for VCT and related activities.

In addition, help will be required to ensure that access to **sharing of documents, including training materials, handbooks and curricula**, can be developed in order to prevent further vertical programming and to increase the rate of response to such urgent community needs.

The following issues warrant UNICEF's urgent attention: support for **capacity building of service providers via training** that relates to VCT in ANC (including address of drug adherence, coping capacity, infant-feeding options, disclosure issues, couple counseling); counseling of children (support for children living with HIV/AIDS and working with families to enhance their capacity to cope, including effective communication skills); and providing care and support services that adequately meet the needs of young people (including fostering of supportive attitudes by health care providers).

Investing in strengthening of service provider skills in counseling (without testing) for young people and children through **support to regional training networks** warrants UNICEF support.

UNICEF has a pivotal role in continued **advocacy** for addressing **psychosocial needs** of young people and children within family and community contexts beyond VCT. **Support for indigenous intergenerational helping models** that address health information, skills-building and problem-solving needs of young people, children and couples requires considerable investment.

UNICEF has a distinct strategic advantage in its strong **relationships with governments and line ministries**. This is a gateway for **facilitation of supportive policy development** (including age of consent) and for access to VCT, clinical and psychosocial care and follow-up support for young people, children, pregnant women and their partners.

Disclosure is a cross-cutting theme. **Facilitation of beneficial disclosure** must be programmed across all aspects of VCT for young people, children and pregnant women.

Communication strategies and materials that are developed by UNICEF and other stakeholders **should ensure comprehensive integration** of related thematic areas (VCT, PMTCT, ARVs, stigma, etc.).

Realistic and achievable expectations should be developed in relation to programming for the **increased involvement of men in VCT for PMTCT**. Other programmatic areas, such as partner involvement in syphilis treatment, have not achieved the desired outcomes in many countries, even after a decade.

There is an increasing number of players on the **commodity management** bandwagon. UNICEF's role should ensure support to governments to effectively coordinate such efforts in country and to support streamlining of distribution mechanisms (for commodities including HIV test kits, infant feeding formula, diagnostics and drugs for sexually transmitted infections, TB drugs and laboratory diagnostics).

UNICEF can greatly assist in **fostering cross-fertilization of learning across PMTCT and VCT** (youth and couple focused) **sites and service providers**.

Commitment to quality is pivotal. The quality of interventions dramatically affects uptake by clients. Quality (address of minimum standards) must be ensured across all levels of counseling, testing and care.

Why is VCT important?

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

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

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

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

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

Investment in and expansion of VCT services is now more pivotal than ever. An increasing number of countries are rapidly addressing the quality and quantity of care-related programs. Care-related activities include **increased access to ARV therapy**. Given this dynamic context, and given that access to care (including ARVs) requires people to know their HIV serostatus, VCT services must be made more widely available.

The purpose of this document is to provide guidance for UNICEF programmatic staff at the country level as well as regional and headquarters staff who are planning, implementing and monitoring programs in relation to the development and scaling up of:

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

This summary document is part of a three-piece package:

1. **Summary Document:** This contains a summary of specific recommendations (including "what needs to be done" and "how to do it") in relation to programming for VCT for young people, children, pregnant women and their partners. It is an internal document that provides insights into UNICEF's strategic advantage in relation to support and investment in VCT.

2. **Reference Guide:** This is a detailed overview containing state-of-the-art information on VCT. It provides more in-depth technical content that may be required for program managers, and may also be of use to a wider readership.

3. **Who is doing what in VCT?** This overview was developed to assist UNICEF in its coordination efforts and to enable UNICEF to lend appropriate support to the wide range of activities *already occurring* among stakeholders.

SUMMARY: VCT FOR YOUNG PEOPLE

1. ***What needs to be done: Increase access and acceptability of VCT for young people including young couples.***

How to do it:

- Train and/or retrain health care service providers and counselors to work more effectively with youth in providing VCT and HIV care and support. UNICEF could expand its programming emphasis on the provision of counseling and support services for young people. This could include promoting and strengthening existing guidance counseling curricula and services within primary and secondary schools to ensure staff are versed in addressing HIV prevention, care and ongoing emotional support needs of children and young people. This may require development or adaptation of modules for this purpose.

- Advocate for supportive policy frameworks and flexibility of interpretation of legal guidelines to encourage young people and adolescents to be able to access VCT (including age of consent).

- Work with ministries of education to include promotion of VCT benefits for young people within existing life-skills training and other related educational curricula.

- Work with relevant line ministries (e.g., ministries of health) to enhance and/or revise protocol to improve access to health services for young people. UNICEF has a significant role and proven track record in this area. Such re-visitation of policy guidance must explore issues relating to capacity for young people to give informed consent for VCT (without requiring parental approval/consent).

- Support innovative VCT promotional campaigns targeted to young people or subgroups of young people (e.g., married and unmarried young couples, youth at risk, young men, etc.).

- Develop communication materials targeting young people or subgroups of young people at national levels, as appropriate.

2. ***What needs to be done: Ensure and increase prioritization of counseling and follow up support for young people.***

How to do it:

- Young people value counseling services. When provided with quality counseling, young people may be more inclined to test. Even in the absence of uptake of testing, young people can address behavior change through counseling. Support systems must be in place to make VCT more attractive to cadres of young people who could benefit from such services.

- **Ongoing emotional support** can be provided by post-test clubs, through individually tailored care or through referral to other agencies. Young people not only have HIV-related counseling needs but may also require help for other problems. Some of these needs may also be effectively addressed through group peer support.

3. ***What needs to be done: Ensure continued access for young people to factual information, skills-building opportunities and linkages to referral agencies.***

How to do it:

- Life-skills training and VCT should be mutually reinforcing approaches. Young people must have opportunities to obtain information on modes or transmission, accurately assess their potential risk practices and be given opportunities to practice skills to reduce risk and to modify harmful behaviors as desired. The needs of many young people can be adequately met through access to life skills, skills

building and referral for additional services (that may include counseling alone or VCT). By ensuring that these approaches are mutually reinforcing, young people should not need to present for VCT simply to obtain information (as has been identified in Kenya and Uganda).

4. What needs to be done: Continue strengthening health services to be "youth- friendly," including meeting young people's needs for family planning, STI and HIV care, and linkages to such.

How to do it:

- **Strengthen comprehensive medical care** within existing services as well as learning sites (e.g., schools or attached/linked to schools) for family planning, STI and HIV care (including specific services such as preventive therapy, treatment of opportunistic infections, STIs, ARV therapy, etc.). Services for seropositive young people following diagnostic counseling linked to VCT are not well developed in most countries. Some VCT services provide TB preventive therapy and cotrimoxazole prophylaxis for seropositive people following VCT, but few have tailored their services to young people. With plans to make **ARV therapy** more widely available, how access to ARVs for seropositive symptomatic young people will be organized requires careful planning. Young people will require ongoing counseling to help them with *adherence* to ARVs to help *cope with adverse effects, and to uphold positive living practices.*

- Integrated support services must also be available for young people following VCT. These should include HIV-prevention services (including the free provision of male and female condoms), youth-friendly health services for STI diagnosis and treatment, and reproductive health services (including the provision of family planning, fertility counseling and antenatal services for young pregnant women).

- Linkages with youth-friendly health services by potential referral services and visa versa are essential.

- Support for youth-friendly health services are part of the UNICEF and United Nations Population Fund (UNFPA) agenda, yet there is limited data demonstrating sufficient coverage and efficacy of such, as well as models and examples that could be adapted in relation to provision of VCT. **In-depth critical evaluation of existing youth-friendly health services that have been supported by UNICEF and other donors such as UNFPA are required to provide a framework for further strategic development**. Such an evaluation should explore existing levels of uptake and strategies addressing uptake by young people to date. Where successful models that could be replicated are identified, especially those demonstrating broad coverage and comprehensive service provision (with VCT, potential to offer VCT or strong linkages to such), these should be documented in a case study and widely disseminated to relevant stakeholders.

5. What needs to be done: Develop innovative ways of reaching vulnerable young people (injecting drug users, sex workers, victims of rape and sexual abuse, orphans, street kids, etc.).

How to do it:

- In countries with low prevalence or concentrated epidemics[1] the first priority is to provide HIV prevention and care services, including VCT, for young people who are particularly vulnerable to HIV infection. The groups of young people to be targeted will depend on local factors and should be based on formative research. VCT services should not be confined to pre- and post-test counseling but also include supportive counseling to address underlying vulnerabilities and risk behaviors. Counseling of family members may also be desirable. When targeting particular groups, it is important not to increase marginalization and stigma that may already exist. This can be avoided through implementation of outreach and mobile service delivery models while lobbying for supportive policy frameworks.

[1] UNAIDS/WHO HIV epidemic definitions:
1. **Low-level:** below 1 percent in the general population, under 5 percent in high-risk groups.
2. **Concentrated:** below 1 percent in the general population, over 5 percent in high-risk groups.
3. **Generalized:** over 1 percent in the general population.

6. What needs to be done: Conduct evaluation, research, documentation and dialogue relating to young people's experiences of VCT and associated care and support interventions.

How to do it:

- Outcomes for young people following VCT are poorly understood. There is need to develop effective behavioral interventions to help young people sustain safer sexual practices following testing and emotional support options adapted for the needs of young people who test seropositive. These interventions will also need careful evaluation. In addition, the uptake of ongoing care and support services by young people following VCT is not known. Although follow-up of young people following VCT is difficult, particularly in sites where anonymous VCT is offered, operational research to determine the long-term outcomes of young people following VCT should be considered to ensure that young people (particularly those who test seropositive) are not left unsupported and disadvantaged following testing. **Research questions that UNICEF could support include:**

- Does VCT help young people make therapeutic changes in their sexual behavior?
- How do young people who test seropositive cope? Whom do they share their test result with? Who provides emotional support? Are they able to access support services following VCT?
- What is the incidence of HIV over time among young people who initially test negative?
- What are the long-term outcomes following VCT for young people (for those who test positive as well as those who test negative)? What are the adverse consequences for young people following VCT?
- Is a VCT package more effective in addressing behavior change when compared with good-quality counseling alone? What do young people value?
- What are the most appropriate models of HIV/AIDS-related care for young people in various country contexts?

SUMMARY: VCT AND COUNSELING ISSUES FOR CHILDREN (< 15 YRS)

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

How to do it:

Lobby, advocate and support agencies and governments in developing conducive policy guidelines that relate to:

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

2. ***What needs to be done: Provide guidance documentation relating to disclosure issues.***

How to do it:

Support and disseminate guidance information relating to:

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

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

How to do it:

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

4. ***What needs to be done: Build capacity of service providers that work directly with vulnerable children.***

How to do it:

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

5. ***What needs to be done: Promote and invest in initiatives led by and involving HIV-positive and -negative children and adolescents.***

How to do it:

- Foster support to Anti-AIDS Clubs, youth ambassador programs, post-test clubs, drama clubs and edutainment initiatives that involve HIV-positive and -negative children and adolescents in fighting stigma and discrimination.

SUMMARY: VCT within PMTCT

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

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

UNICEF has a significant role to play at <u>all</u> levels.

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

The Major Challenge in Determining Appropriate VCT Models for ANC/MCH

- How to create a time-efficient, non-labor-intensive, simplified package that normalizes HIV testing and increases uptake without compromising quality or individual rights (including provision of informed consent or right of refusal).

<table>
<tr><th colspan="2">MODELS OF VCT DELIVERY IN ANTENATAL SETTINGS</th></tr>
<tr><td colspan="2">Model 1: Classic VCT model (individual pre- and post-test counseling with follow-up counseling as required).</td></tr>
<tr><td>Advantages:

Quality one-on-one service;
Client-centered;
Test decision-making addressed;
Personal risk assessment and risk-reduction planning addressed;
Follow-up support provided;

Disadvantages:

Time consuming;
Labor intensive.</td><td>Comments:

Unsuitable for most PMTCT settings where health workers are expected to include VCT within routine antenatal care.</td></tr>
<tr><td colspan="2">Model 2: Group information, optional shortened individual pre test counseling, individual post-test counseling. Health information is provided by group information via a talk/with or without a video or providing written information, and encouraging women to discuss issues around VCT/ PMTCT. Following pre-test information, women can opt for pre-test counseling and receive a shortened individual counseling session.</td></tr>
<tr><td>Advantages:

* Acceptable in many antenatal settings;

* More time- and human-resource efficient than Model 1.

Disadvantages:

* Uptake may be low;
* Vocal group members may persuade/dissuade other members to be tested;
*.Less comprehensive individualized package;
* Is not client-centred.</td><td>Comments:

* More successful if women already have knowledge of HIV and PMTCT. Advocacy and community awareness are important in ensuring this.

Ongoing support must be available for seropositive AND seronegative women. This may be provided by referral to services off-site or from post-test support groups or peer support groups.

The health educator/counselor must be trained in group education and handling group dynamics.</td></tr>
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Model 2b: Group information, simplified individual pre-test counseling, routine individual testing (with right of refusal), individual post-test counseling (e.g., EGPAF site in Cameroon). All women access group information followed by simplified individual pre-test counselling.

Advantages:

* Comprehensive (group information and pre-test counseling provided);
* HIV testing is normalized within routine testing yet women have the right to decline the HIV test;
* Promising uptake.

Disadvantages:

* More labor-intensive than Model 2;
  Potential for coercion of testing if staff are not adequately trained and supported.

Comments:

A promising model for VCT in ANC.

Banso Batist Hospital, Cameroon

Supported by EGPAF. Figures from February to November 2000:

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

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

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

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

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

Babies who have received NVP, 27.

Site offers:

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

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

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

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

Advantages:	**Comments:**
* High efficacy and acceptability in low-prevalence settings with established support services for seropositive women; * In low-prevalence countries, counseling can be focused on the small minority of women who test seropositive; * Human-resource efficient. **Disadvantages:** * Models 3/3b depend on availability of treatment and support for seropositive women and their infants; * When no or inadequate services are available for seropositive women they may be vulnerable/disadvantaged following testing. Unlikely to be suitable for rural sites at onset; * Limited intervention for seronegative women (including opportunity to address prevention); * Women with limited understanding may not use the right of refusal; * Some women may fear exclusion from other medical services if they refuse; * Refugees/ immigrant women with language barriers/low literacy may be disadvantaged.	* Adopted in some **low-prevalence** countries (UK and United States). Also adopted for PMTCT in Thailand; A similar model is recommended for VCT/ PMTCT in the United States.[i]

Model 3b: Group information/written information, routine individual testing (with right of refusal), individual post-test counseling for seropositive women. Seronegative women are not informed of their negative serostatus.

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

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

Advantages:

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

Disadvantages:

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

Comments:

"Shared confidentiality" must always be voluntary and women who decide after shared pre-test counseling that they wish to be tested alone must be allowed to do this.

A promising model for quality VCT for PMTCT.

Model 5: No pre-test information, screening/testing (with right of refusal), individual post-test counseling for those found to be seropositive (used in some parts of Eastern Europe and other countries of low prevalence).

Disadvantages:

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

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

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

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

VCT within PMTCT

1. ***What needs to be done: Implement international guidance and advocacy for national policy on VCT within PMTCT.***

How to do it:

- Play a role in MTCT working groups at the country level to develop and assist in disseminating national standards (that emulate global frameworks as appropriate) and provide **guidance for VCT within PMTCT** (including infant- feeding counseling, VCT service delivery models, **pre-test counseling models**, **VCT/PMTCT training curricula** and training program development).

- Support the development of realistic national plans for PMTCT that include VCT as a potential entry point to PMTCT interventions.

- **Support WHO and UNAIDS** in their development and dissemination of appropriate tools and guidelines for VCT design, implementation, monitoring and evaluation within PMTCT. This would include:

  - Briefing papers on the role of ARVs for PMTCT (especially NVP) with and/or without VCT (ensuring that access to ARVs for PMTCT for women of unknown serostatus is not denied where VCT is declined or inappropriate, and at the same time, that universal use of NVP is not implemented).

  - Technical updates building on the existing WHO/UNICEF breastfeeding modules on infant-feeding options within PMTCT (including objectively presented guidance on supporting safe alternatives to breastfeeding where reasonable, and guidance on exclusive breastfeeding with abrupt weaning between 4-6 months under all other conditions).

  - Rapid collation, documentation and dissemination of site-based models and experiences (UNICEF/CDC/EGPAF/FHI) of implementing VCT services within ANC/MCH. This should include development of proposed criteria by which VCT services could be advocated for in relation to ANC/MCH services (e.g., integrated VCT services within ANC/MCH sites and/or development/ strengthening of free-standing services that are linked and either on or off site (but within proximity).

2. ***What needs to be done: Develop behavior-change interventions that have an impact on PMTCT.***

How to do it:

- Support development of communication activities to increase awareness around MTCT issues, including VCT at the community level;
- Support activities to improve health-seeking behavior related to MCH, STIs and HIV;
- Support activities aimed at reducing stigma and discrimination;
- Support interventions to reduce risk and vulnerability to HIV infection;
- Support activities to improve contraceptive use
- Support initiatives to promote appropriate infant-feeding options;
- Support governments to develop comprehensive communication strategies that integrate VCT/PMTCT/stigma reduction and access to care.

3. What needs to be done: Conduct ongoing Strengthening of MCH/ANC services.

How to do it:

- Assess the availability, quality and use of existing maternal and child health services, and identify opportunities to integrate PMTCT interventions;
- Support appropriate MCH upgrades based on assessment results;
- Support curricula development, training plans and training (e.g., counseling, obstetrical practices, use of ARV) for MCH staff based on assessment results;
- Support the introduction and implementation of VCT and MTCT interventions in MCH services;
- Support activities that encourage greater participation/impact of men/fathers within PMTCT (including promotion of and strengthening of VCT services for couples).

4. What needs to be done: Disseminate learning documents and support operations research and evaluation.

How to do it:

- Support the implementation, collection and dissemination of lessons learned in relation to scaling up experiences of PMTCT;
- Expand opportunities for staff and projects at pilot sites to learn from each other. This should include learning from within and across sites where UNICEF, CDC and EGPAF/FHI are working. Foster site visits to established PMTCT programs for countries starting PMTCT interventions;
- Disseminate review findings and recommendations, monitoring and evaluation tools and training materials/handbooks across projects to those who may benefit by adapting materials to their own contexts;
- Undertake and/or support research and documentation of lessons learned within existing sites and disseminate findings in relation to:
  - How is uptake affected when NVP versus other interventions (AZT) are used?
  - How does the chosen regime affect issues such as compliance and adherence?
  - What can we learn from those who are given the ARV intervention and do not comply versus those who comply?
  - The use of NVP with and/or without VCT;
  - Integrating VCT services within ANC: What to do and what NOT to do; a comparison study of different models of VCT within ANC (as presented in the models section of the main document);
  - VCT in PMTCT case studies;
  - What pregnant women actually value within a PMTCT package;
  - Client satisfaction outcomes for VCT in PMTCT and PMTCT in general;
  - Male involvement in PMTCT: Does involvement of men in PMTCT interventions have an actual impact on PMTCT in terms of uptake of testing, adherence to drug interventions and infant-feeding options?
  - Community mobilization and support for PMTCT;
  - What can be learned from countries that had generic VCT coverage before introducing VCT for PMTCT versus countries where VCT for PMTCT precedes general VCT coverage?

UNICEF'S Strategic Advantage in Scaling Up VCT

UNICEF's response to the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) goals and universal targets for scaling up will need to address the wide range of political contexts and operational diversities of VCT service delivery. Issues for consideration include:

- The severity and magnitude of the epidemic as felt by national policy and decision-makers;
- Impact on social and economic sectors;
- Potential risk of a rapid increase in HIV prevalence;
- Availability of alternative sources of funding;
- Relationship to UNICEF priority areas;
- Strength of host-country partnerships.
- Community attitudes and existing program support to date.

Scaling up initiatives should start with national policy development for which UNICEF is well placed to play a pivotal role. If targets and indicators are required they are best developed at the country-specific level in collaboration with governments.

UNGASS goals have been set for which indicators are being developed. MERG is providing the United Nations response to develop UNGASS indicators. USAID, MEASURE and collaborating partners are also playing a significant role in developing and field testing programmatic indicators related to VCT, care and support, orphans and vulnerable children (OVC) and stigma which UNICEF could draw upon. Within the international guiding framework, UNICEF should work toward the following related international targets by 2005, in line with its Medium-term Strategy and guided by UNGASS principles:

- Reduce HIV prevalence rates among those 15-24 years of age by 25 percent in high-prevalence countries;
- Maintain prevalence below 1 percent among 15-49 year-olds in low-prevalence countries;
- Ensure that at least 90 percent of young men and women aged 15-24 have access to the information, education, including peer education and youth-specific HIV education, and services necessary to develop the life skills required to reduce their vulnerability to HIV infection, in full partnership with youth, parents, families, educators and health care providers;
- Ensure that at least 80 percent of HIV/AIDS-infected mothers in high-prevalence countries have access to interventions to reduce HIV transmission to their infants;
- Help develop and implement comprehensive care strategies to strengthen family and community-based care and health systems to provide and monitor treatment to people living with HIV/AIDS, including children, and to support individuals, households, families and communities affected by HIV/AIDS, improve the capacity and working conditions of health care personnel, and improve the effectiveness of supply systems to provide access to affordable medicines, including ARVS, diagnostics and related technologies, as well as quality medical, palliative and psychosocial care;
- Help local institutions to strengthen existing infrastructure to provide psychosocial support services to at least 25 percent of young people, children and their families affected by HIV/AIDS;
- Build capacity of teachers, health care providers and community caregivers to provide quality educational preventive and psychosocial support-based outcomes for at least 25 percent of children and young people affected by HIV/AIDS.

UNICEF'S Proposed Strategic Advantage in Scaling Up of VCT for Youth and Pregnant Women by 2005

Strategic Area of Investment	Activities	Prospective Partners	Outputs
National policy development and advocacy with governments via line ministries.	1. Ensuring supportive policy frameworks that facilitate access to VCT and care and support services for young people and children (including address of disclosure and age of consent). 2. National policy development and action planning for PMTCT interventions (including infant-feeding guidance). 3. Advocating for replacement of mandatory testing of youth subgroups (as appropriate) with VCT. 4. Advocating for children's rights frameworks to be applied in relation to right to medical and psychological care for children. 5. Advocating for youth representation on NACs (where not present) and other pertinent fora at global and regional level.	Governments and line ministries, WHO (for technical input), National AIDS Councils National and Regional working groups. IATTs, VCT/Care and support-focused NGOs. Human rights lobbies/international NGOs. NGOS/CBOs Young people's organizations, young people PLHA groups.	Conducive policy frameworks developed, documented and disseminated in at least 25 countries most affected by HIV/AIDS. Mandatory testing practices of youth subgroups revised or abolished in at least 25 countries. Youth representative occupying a place on at least every NAC in a country with a generalized epidemic.
Advocacy and promotion of youth VCT and VCT for couples as thematic areas of investment.	Sponsor satellite sessions at Barcelona and other international/regional symposia.	FHI (for technical input), Horizons, UNFPA,UNAIDS, WHO, UAB (Univ. of Alabama for couples work), CIDA, SIDA, DANIDA, DFID Clients (testimonial speakers).	Minimum of two satellite sessions held on VCT/youth and two sessions on VCT for couples.
Communication campaigns for: - VCT and youth (may require targeted interventions for subcultures of youth in some countries depending on nature of epidemic). - Pregnant women AND partners (must be linked to endeavors to increase uptake of women for MCH services).	IEC materials, Multi-media promotion (TV spots, radio), Community outreach/ mobilization.	IATTs PSI PATH WHO EGPAF CDC FHI Local VCT providers Ministries of health National AIDS Councils	At least one youth-based campaign in each country with active VCT services that can cater to young people (testing is available with client consent versus parental consent.). At least one broad-based promotional campaign to be held in each country with a prevalence rate of 5 percent or more among ANC attendees.

Counselor training/retraining: - VCT and youth. - Child counseling (regarding HIV/AIDS for infected and affected children). - VCT and PMTCT (re ARVS, disclosure, adherence, infant feeding, working with couples).	Standardized curriculum development, Strengthened regional training sites, Dissemination of training materials. Support implementation of training, especially within ANC/MCH services, youth-based services (or those with access to large numbers of young people), schools (head teachers, principals and guidance counselors).	RATN Regional Center for Quality Health Care FHI Universities Ministries of health Local VCT service providers UNICEF Botswana UNICEF South Africa USAID	Standardized curriculum developed and disseminated to all relevant stakeholders in at least 25 countries with generalized epidemics impacting upon youth and child populations. At least two regional training sites in Africa and two regional training sites in Asia offering courses. Standardized curriculum developed and disseminated to all relevant stakeholders in countries with prevalence of 5 percent or more among antenatal attendees. At least two regional training sites in Africa and one regional training site in Asia offering courses. Minimum of 10 trainees funded per country per course.
Training resource video kit:	Support development of video training package/s modeling quality counseling practices in relation to: - Youth - Children - Couples (especially sero-discordance) - PMTCT issues. (For use in counseling training.)	FHI CDC WHO VCT service providers who also undertake training (Kara Counselling, KAPC, AIC, TASO, Thai Red Cross)	At least one generic training video resource per thematic area per geographic region (Asia, ENE, Africa, ENE, LAC) and one child counseling video available for use/adaptation within southern and eastern Africa. One PMTCT training video available for use in Southern and Eastern Africa.
Life skills. Life skills continued.	Integrate VCT-related information within life-skills curricula (focus on assessing and reducing risk, enhancing intergenerational communication, referral to service providers, including counselors). Create a basic care and support module for countries with generalized epidemics. Support TOT teacher/guidance counselor training and TOT to strengthen implementation capacity. Support guidance counseling training curricula to ensure capacity to facilitate life-skills interventions.	Ministries of education Ministry of youth Peace Corps Community schools Teacher training colleges UNDP	VCT-related information integrated in all life-skills programs. Basic care and support module created and disseminated to countries with emerging and high prevalence. At least 10 teachers/guidance counselors trained on a TOT in implementing life-skills training. Guidance counseling training curricula strengthened in at least 25 countries with active life-skills programs and guidance counselors in country.

Procurement: (Focus on HIV test kits, ARVs for PMTCT, infant feeding formula, STI drugs, diagnostics and related technologies.) UNICEF via country programs may have a facilitative role to play in helping governments and other bodies to access required commodities.	Utilize existing multilateral structures (IATTs and UN Theme Group on HIV/AIDS) to host a forum on roles and responsibilities of UN agencies in supporting governments to streamline distribution mechanisms in relation to strengthening of supply systems (building on capacity of existing supply systems in country.) Where UNICEF has promised to procure supplies to date (e.g., formula, HIV test kits, STI drugs), ensure commodities are obtained and distributed effectively.	WHO UNAIDS UNFPA USAID FHI MHS WORLD BANK Medical Stores Axios Ministries of health	One technical working group workshop held by mid-2002. Roles and responsibilities defined and action plans developed. Supplies procured and distributed at sites to which UNICEF has currently committed.
Operations research:	Support operations research related to: Outcomes following VCT for young people; Uptake of care and support services by young people; What pregnant women value in VCT/PMTCT; VCT in PMTCT models and client satisfaction.	FHI HORIZONS NGOs CBOs Service providers Ministries of health Young people/clients of services EGPAF CDC	Operations research carried out in Africa, Asia, South America. Dissemination workshops held and findings distributed to stakeholders.
Youth-friendly health services: (In direct collaboration with UNFPA.)	In-depth evaluation of acceptability and uptake of YFHS in four countries and feasibility for integration of VCT. Collaborative meeting with UNFPA and other stakeholders to define lessons learned, models and way forward.	UNFPA Ministries of health Ministries of youth NGOs CBOs	One cross-country evaluation completed. Four dissemination workshops held. Findings distributed to key stakeholders.

Investment in strengthening promising "youth-friendly" health services and VCT sites, including PMTCT sites.	Top-up salary and transport support (for clients to access services). Creation and funding of coordinator positions within existing VCT and PMTCT sites to strengthen capacity and leadership.	Ministries of health UN Theme Group on AIDS IATTs	UNICEF policy revision regarding investment in top-up salaries and transport support. In 25 most-affected countries funding secured and coordinator positions created and filled.
Promote a united platform and language surrounding the role of counselors and peer educators (focus on VCT for youth and VCT in PMTCT).	Support the promotion and dissemination of an information sheet regarding the roles, responsibilities and qualities of peer counselors versus peer educators in relation to VCT.	FHI WHO	Information sheet publicized and disseminated to stakeholders.
PLHA associations.	Support capacity and involvement of HIV-positive young people and children (as positive speakers, educators, facilitators and trainers).	PLHA organizations HIV-positive young people and children Ministries of youth UNAIDS	Increased number of HIV- positive young people and children as positive speakers, educators, facilitators and trainers in 25 countries most affected.
Strengthen university departments and reputable training institutions to offer higher-degree training in counseling and child psychology.	Curriculum development and course implementation, sponsorship or partial subsidy of prospective students, placement and financial support of technical course coordinators. Support to Ministry of Education to endorse initiative and to support continued infrastructure development.	UNESCO Universities (e.g., Zambia, Makerere, Natal) UNISA RATN (including Network members) Ministry of Education Embassies	At least two individuals funded to attend higher-degree training from each of the 25 countries most affected. Higher-degree counseling and child psychology courses offered in Asia, Africa (Southeastern and West Francophone country), South America. Curricula available through UNICEF or another body as a clearinghouse.

Intergenerational communication initiatives that relate to VCT and psycho-social support for children and young people.	Supporting parental-based communication initiatives in youth-friendly health sites and VCT sites. Support education that promotes intergenerational communication for a variety of settings and familial structures. These could include preventive interventions during initiation ceremonies and other traditional rites of passage, interventions targeting parents (especially fathers) aunties and uncles, and aged carers (e.g., grandparents).	Ministries of youth Ministries of community development NGOs (including Save the Children, Hope Worldwide, Salvation Army) CBOs, including traditional groups Religious groups including Family Life Movement UNESCO YFHS VCT sites	Increased number of intergenerational initiatives occurring at the community level in Asia, Africa, South and Central America and the Caribbean. Curricula developed and distributed to key implementing agencies in all regions.
Caring for caregivers	Advocate for investment in caring for caregivers programs (counselors, home-based carers, VCT and PMTCT staff). Support: policy development, staff supervision, exchange visits, regular case presentation, debriefing; Flexi-days, In-service training; Model caring from within through leading by example: UNICEF Caring for Us program	UNAIDS WHO Governments ILO FHI	Increased formalized support (policy and practices) to service providers in 25 countries most affected that have the least infrastructure and human resource capacity. Establishment of Caring for Us standards in all UNICEF offices by 2002. Establishment and dissemination of UNICEF HIV/AIDS workplace strategy by 2002.

Considerations for Scaling Up VCT Services

The objectives of expansion: What are the objectives of scaling up the VCT service and the desired outcomes? Is increased access to VCT going to lead to increased access to HIV-prevention services or access to HIV care and support? If so, are these services available?

Current VCT experience: Have smaller-scale VCT services for young people or for pregnant women been effective and have any problems encountered been overcome? Are generic VCT services operating? What is the level of uptake by the general population and what percentage of young people, pregnant women and couples are already accessing these services?

Monitoring and evaluation of current experience: What VCT services are effectively operating on the ground at present? What can be learned from these services that might guide potential replication, integration or expansion of VCT services?

Funding: How is the scaling up of VCT services to be funded and can coordinated and consistent long-term funding be achieved/guaranteed?

Commitment to VCT: Is there a commitment to the provision of VCT services for young people, pregnant women and couples (in the community, politically and among health care workers) and to expanding VCT services?

Cost of VCT service to clients: Is it possible to offer free VCT services to young people? And if so, who will carry the burden of such costs? Can low-cost VCT/no-cost services (especially in sub-Saharan Africa) be provided to pregnant women and/or are they covered under the cost of generic ANC services?

Impact of VCT on other health and social services: How will the expansion of VCT services affect the impact of existing VCT and HIV prevention and care programs? For example, what effect will increasing access to VCT services have on other HIV health care and psychosocial support services (including human resources), especially if these are not expanded in parallel?

Meeting the needs of young people, pregnant women and their partners post-VCT: If VCT services are made more widely available, the clients' needs (particularly those who test seropositive) must be considered. It is important that whether ARVs are available or not, there are other psychological, social and medical services provided; otherwise, people testing seropositive may be left more vulnerable and unsupported following VCT.

Obstacles and barriers to VCT: Is legislation in place to ensure that people who test seropositive are not discriminated against? Have areas such as age of consent to VCT and disclosure issues been considered?

Country-specific Factors to Consider When Scaling Up

The role of seroprevalence rates and epidemiological factors: The magnitude of the HIV epidemic is an important consideration if large investment in scaling up of VCT services is proposed. However, VCT for young people or pregnant women should not only be seen as a priority in high-prevalence settings. It will also play a role in rapidly emerging epidemics, and low-prevalence epidemics with pockets of high prevalence among subpopulations, where targeted VCT may be appropriate.

Where does VCT sit in relation to other health priorities? Where is VCT in the competing priorities for health care funding, including both HIV prevention and care and non-HIV-related priorities? In low-income settings with other urgent health care needs, VCT may be considered too costly for widespread implementation. Coordination will be needed between donors to plan strategically in the context of countries with limited health resources.

What levels and windows of funding are available? What existing funding is available for scaling up? And what potential future funding windows exist (from government, bilateral donors and other funding)?

Projected cost–recovery/cost-sharing will be limited: Young people will usually have limited access to funds to pay for health interventions and cost-recovery is unlikely to make a significant contribution to funding of VCT for young people.

Length of funding impacts upon service delivery: How many years of funding are available? Developing VCT services is a long-term undertaking. Creating awareness about the benefits of VCT and availability of the service resulting in high levels of demand has been a lengthy process in many operational VCT services. Intermittent or insecure funding of VCT services results in demoralization of counseling staff, poor quality of services and mixed messages to potential clients.

Current low levels of funding available for VCT should not be seen as a major barrier for planning the expansion of services as the environment where VCT is now being promoted has changed and donor funding increased.[2] Countries that are currently involved in national VCT service development and "scale ups" include Zimbabwe, Zambia, Kenya, Rwanda, Senegal, Rwanda, Cote D'Ivoire, Mali, Ethiopia and Brazil.

Capacity of Existing Infrastructure

Available sites: Are suitable sites that require minimal adaptation already available (e.g., school or college health services or a network of youth-friendly services within primary health centers)? Or if free-standing sites are preferred, will adaptation of rental sites or a building program be considered? If freestanding sites exist, can these be adapted simply to make them youth-friendly?

Commodity Management

What commodity management mechanisms exist in country for test kits and for supplies of related prevention and care services? How well do these systems function at present? What needs to be done to strengthen such mechanisms to ensure continuity of VCT and associated care and support programming?

Rapid Testing Availability and Options

Licensed tests: Which HIV tests have been licensed for use? In some countries, attempts to provide VCT in remote areas have been hampered because rapid tests were not licensed for use. This can be a lengthy process and forward planning is important.

Laboratory capacity and infrastructure. This will depend on the testing method considered.

Quality control: Does the laboratory infrastructure exist to ensure quality control of testing at all proposed sites? Are quality-control measures in place that can ensure quality control on 5-10 percent of HIV test samples?

[2] UNGASS Declaration of Commitment

Use of lay (non-clinical) staff to implement rapid HIV testing is **NOT** advised at this time, even though testing regimes are becoming simplified.

Availability of counseling staff to provide quality services: One of the limiting factors for VCT provision is the availability of trained personnel to provide counseling of adequate quality. In many high-prevalence countries, there is already a general shortage of health workers, particularly nurses, who have traditionally provided the majority of counseling. Furthermore, there are even fewer health workers who have had training in communicating with young people. HIV among nurses themselves and poor working conditions and pay leading to immigration to industrialized countries have resulted in an acute shortage of nurses in many high-prevalence countries in sub-Saharan Africa.

Availability of counseling training: Does a training program for counseling already exist? Can this be adapted for young people VCT training or VCT/PMTCT training? Is there sufficient capacity to scale up training to meet the needs of the proposed VCT service? How will the longer-term training, support and supervision of counselors be ensured?

Adequate numbers and competency of trained counselors: How many trained counselors are already available? How many have had training in providing counseling for young people, couples or pregnant women? How many health service personnel are available who could be trained to provide VCT?

Cadres of other workers available to train: Are there groups of people (other than nurses) who are available and willing to be trained as counselors for VCT (e.g., clinical officers, social workers, guidance counselors, teachers)?

Availability of care and support services: What ongoing care and support services are available to young people or pregnant women (especially those testing positive)? How can existing services be strengthened or developed in parallel and made more accessible?

Socio-cultural factors that have a negative impact on knowing one's serostatus. What are the gender dynamics at play? What level of decision-making power and autonomy do young people (especially women) have? How does gender-based violence manifest? How does HIV-related stigma manifest and what are the country- specific norms surrounding knowing one's serostatus? What national legislation exists or is needed to prevent or respond to stigma, discrimination and gender-based violence?

ADVOCACY MESSAGES FOR UNICEF HQ AND FIELD OFFICES ON VCT

🗣 **Young people are not a homogenous population.** VCT programs and policies must target different subpopulations of youth with appropriate interventions as they relate to the epidemiological profile within a given country (e.g., target couples/singles aged 15-25/young IDU/young MSM [identifying or non-identifying], etc.).

🗣 **VCT is an effective entry point to prevention and care services.** This is particularly pertinent in the current environment with increasing investment in ARV and PMTCT programs.

🗣 Increase acceptability and decrease barriers to VCT by **promoting strategies that normalize testing** (including stigma and discrimination reduction).

🗣 **Increase access through support for conducive policy frameworks** (including age of consent for VCT and prevention and care interventions, affordability, confidential and convenient locations and hours).

🗣 **Increase the quality of VCT interventions** through adherence to confidentiality of test results and continued strengthening of primary health care services, MCH services, health delivery infrastructure and personnel capacity (through training/ supervision/monitoring and evaluation) for both counseling and testing components.

🗣 Continue efforts to **increase access to health care by children and young people**.

🗣 **Increase linkages and referral systems** across the health sector as well as other key providers (legal, religious, psychosocial, financial).

🗣 **There is no one prescription** on how to provide VCT for youth, children, pregnant women and their partners (though *guiding* documents are in development).

🗣 **Counseling for young people should not be "one off" interventions.** It takes time to develop rapport with young people and to gain trust. Capacity to promote sustainable behavior change is only likely to occur when more than one session is provided.

🗣 **Caution should be taken when attempting to translate lessons from dissimilar contexts** (e.g., from the United States to Africa, Asia to Africa, Africa to Europe) by giving thorough consideration to the range of variables at play, including: socio-economic, gender relations, service delivery infrastructure capacity, nature of the epidemic, health priorities, political and legislative framework, etc.).

🗣 **Ongoing investment in providing VCT services within ANC is necessary** (in high and emerging prevalence settings). In addition, **mechanisms and guidelines to offer ARV interventions to women who present late and/decline VCT** must be developed. Where appropriate, pregnant women who could benefit from ARVs for PMTCT should not be denied this opportunity and choice.

🗣 **There is need for ongoing learning by doing** (in a planned and coordinated manner), **documentation of lessons learned, and evaluation of emerging service delivery models** in relation to VCT for young people, children, pregnant women and their partners.

VCT COMMODITY MANAGEMENT SYSTEMS

Supply and commodity requirements for comprehensive VCT programs are substantial. **HIV testing alone** requires at least two different types of HIV test kits at all VCT sites. In addition, there must be a third tiebreaker kit available at a reference laboratory. These kits have relatively short shelf lives and in some instances, kits have further handling requirements such as refrigeration or laboratory equipment. In addition to kits, supplementary supplies are required including infection control supplies (gloves, sharp disposal containers, disinfectant and cleaning materials) as well as medical supplies, laboratory consumables, and blood drawing equipment.

The quantity of these commodities will vary from country to country depending on the prevalence of HIV, volume of clients expected and the adopted HIV testing protocol. Information on the recommended WHO testing strategy is available in the *weekly epidemiological record, 1997,72,81-82* or in the *Guidelines for using HIV testing technologies in surveillance: selection, evaluation, and implementation by CDC, WHO, UNAIDS, sponsored by USAID Office of Health and Nutrition-July, 2001.*

In order to determine the quantity of tests that will be required to set up a VCT program: Assume that country X, which has HIV prevalence of 20% among those aged 15-24, is embarking on VCT activities targeting this population. Country X are planning to have 10 operational VCT Youth sites by the end of a calendar year and they intend to maintain the same number of sites for the next three years

Estimated number of young people envisaged to receive VCT in the next 3 years.

YEAR	*Estimated cumulative number of Clients/month*	*Total Clients per year*
Year 1 (2001) (January-December 2,001)	2,200	26,400
Year 2 (2002) (January-December 2,002)	3,300	39,600
Year 3 (2003) (January-December 2,003)	3,850	46,200
Total Clients		112,200

Note: Client attendance is based on **22 working days (Mon – Saturday**). Calculations are approximated on the assumption that same day testing with the Rapid Test Kits will lead to a nearly **1.5 increase in demand for VCT in year 1**; **1.75 in year 2** and **2.0 increase in year 3.** In addition service promotion and other factors may impact upon increase in demand. In year 1, (2001)-100 clients/day will be seen from all 10 operating sites. In year 2(2002) 150 clients/day will be seen from all 10 operating sites and in year 2 (2003), 175 clients /day will be seen from all 10 operating sites. It is also assumed that the Sites will be able to handle higher volumes of clients through the addition of trained counsellors to the staff.

With these numbers in mind, the following number of test kits will be required, assuming that country X adopts WHO
strategy II and have chosen the following three tests that are in the WHO bulk procurement list.

Table 2: **Hypothetical Situation in Country X based on WHO bulk procurement prices using WHO strategy II**

		# Of test/ test kit / based on attendance p.a.				
	Unit Cost In US $	2001	Cost for 2,001	2002	Cost for 2002	Total cost fo
Determine	1.2	26,400	31,680	39,600	47,520	
Capillus	1.1	7,920	8,712	11,880	13,068	
Sero Strip HIV1/2	1.75	528	924	762	1333.5	
QA	3.5	2,640	9240	3,960	13860	
TOTAL	7.55		50,556		75,782	
Assumptions:						
30 % of the target will test positive on first test and will require a second test to confirm						
2 % of all tests will need a tiebreaker, as they will have indeterminate results.						
10 % of all samples will be sent out to Reference laboratory for quality assurance						

If other prevention, care and support services are envisaged as part of the Youth VCT service, other commodities will also be necessary. Condoms, antibiotics for treatment of STIs, reagents for STI diagnostics, contraceptives, and ARV for prevention of MTCT may be required as part of supply and commodities. In addition, essential drugs for palliative care and treatment of opportunistic infection, ARVs (where those are available and accessible), and any other diagnostics and supplies for clinical and home based care of PLHAs may also be required within a comprehensive service or as associated costs.

Ministries of health may request the UN and other donors to assist in strengthening commodity supply. Any commodity to be ordered must be approved and regulated in the given country by the National authorities. **No single donor** will be able to support all aspects of commodity management systems in any given country. UNICEF may play a supportive role in contributing to a coordinated donor response to national commodity supply needs. Some countries have done well with donor coordination through use of a phased approach to supply that enables long-term planning and early identification of resource gaps. This process may assist Ministries of Health to make the most of each donor's comparative strength in applying resources to specific expenditures.

Other countries have been less successful in initiating a coordinated response. This has resulted in establishment of uncoordinated vertical supply systems (with in some cases, up to 2O different HIV test kits being used by various implementing agencies within a given country) which also results in limited capacity to streamline quality assurance.
Commodities management processes are inherently complex. UNICEF should explore the following existing complimentary mechanisms for VCT supply and commodity management.

1. **WHO HIV test kits bulk procurement process.** There are currently eleven ELISA based HIV test kits and eight Rapid HIV test kits available through WHO bulk procurement. All HIV tests available through the scheme have been evaluated by WHO and meet rigorous criteria. WHO bulk procurement is also cost saving.

Total Cost savings resulting from bulk procurement in 1999 and 2000

	Total Number of **Tests Purchased**	**Market Price (US$)**	**Bulk Procurement Price (US$)**	**Savings (US$)**
1999	4.0 million	5.9 million	3.2 million	2.7 million
2000	2.4 million	4.1 million	2.0 million	2.1 million

Source: *Sources and prices of selected drugs and diagnostics for people living with HIV/AIDS May 2001. Joint UNICEF- UNAIDS Secretariat-Who/HTP-MSF project*

2. The Private Sector.

The private sector has a role and potential contribution in expanding availability of products, transportation and warehousing (as was the case with social marketing of condoms). **UNICEF** is well placed to implement this through its re-structured **UNICEF supply division** by adopting "**the request for proposal**" mechanism akin to previous procurement of vaccine and immunization supplies [Global Alliance for vaccines and immunizations (GAVI)]. In this way UNICEF will be able to attract the private sector by inviting offers that cover long term supply which thereby ensure sustainable supplies.

In addition, private "non profit" sectors (e.g. the Churches Medical Association of Zambia and other similar bodies) could also be explored for their potential role in expansion of availability of products, transportation and warehousing.

3. An Integrated Approach

Efforts should be made to replicate rationalized or coordinated systems of commodity management across sectors. Ghana and Tanzania have succeeded in moving systematically from multiple vertical supply chains to relatively integrated and well-coordinated supply chains based on unified central stores. In both cases, the process required several years and substantial investment in buildings, equipment, management information systems and human resource development. . Issues to consider in relation to an integrated approach would

include: selection, quantification, actual procurement, warehousing and distribution, and monitoring and evaluation (including quality assurance).

Key Elements to consider in relation to commodity management systems

1. Ensure that program pilots build upon and strengthen infrastructure (including public sector systems where possible). When pilot programs are completed, they are usually not well integrated into existing systems. In Tanzania, UNICEF has provided Nevirapine for prevention of MTCT in 5 pilot sites since July 2000. Although the drug is registered in the country, it is not freely available, so UNICEF provides its own supplies of Nevirapine and HIV test kits and distributes them directly to the pilot sites. However, now that UNICEF is trying to scale up and support the government to provide these services nationally, they are encountering the following obstacles:

- Lack of government policy on treatment protocols for MTCT (in some cases AZT is the drug of choice, in others, Nevirapine);

- There is no national supply of Nevirapine through the public sector and thus no established commodity management procedure. Even if UNICEF is willing to continue to provide training and related service delivery support, the supply of HIV test kits and MTCT drugs is insufficient to support national rollout of MTCT services.

2. A role for UNICEF in close collaboration with National authorities could be to **ensure effective product quality assurance** to safeguard the integrity of essential commodities and guard against the procurement, distribution and use of counterfeit products. The use of supplier pre-qualification paired with selective lab-based performance monitoring provides some such practical benefits. In Kenya, Crown Agents manages procurement for a large portion of the MOH drug supply. For recent vaccine procurements they have limited bidding to manufacturers who have been approved as suppliers for the UNIPAC system.

Summary recommendations on support for commodity management

- Efforts that focus on strengthening just one function or activity will have limited impact. Evidence from child survival, reproductive health, malaria control and other programs demonstrate that without continuous and coordinated effort, commodity management programs will operate sub-optimally. The same could be expected for HIV/AIDS related commodities.

Donor support is essential to the **development and implementation of long-term national** health commodity management plans. Coordinated donor support for the development, revision and adaptation of standard testing protocols and country specific lists for HIV test kits and other commodities are a good investment for the success of VCT programs.

- Planning and implementation of the commodity management system should be based on the current understanding of local systems and context.
- Long-term commodities plans should be included in all pilot activities. A useful plan will conform to national norms and standards. It should forecast needs (taking scale-up into account) and include a realistic financing and procurement plan that identifies future sources for all required products. Pilot activities should utilize existing routine systems to the greatest degree possible, to facilitate expansion beyond the pilot stage.
- Quality assurance is an integral and essential component.
- Investment in commodity management should be part of any VCT program that UNICEF could consider supporting. UNICEF could use its own *or* other existing mechanisms to support national authorities and programs to facilitate bulk supplies of commodities.

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