



Service Delivery Models for HIV Counseling and Testing

DECEMBER 2005 – A number of counseling and testing (CT) service delivery models are being used to expand entry points to HIV testing and to promote testing as a more routine practice. Expanding the number of models will help more people learn their HIV status and benefit from prevention, care and treatment services.

The models are designed to reach different target groups and achieve different goals. One testing model may provide an entry point to clinical care for those living with HIV/AIDS, while another may help prevent mother-to-child transmission of HIV (PMTCT), and yet another may serve as an HIV prevention tool for the general population.

CT models include stand-alone, integrated, quasi-integrated, private sector, mobile and home-based. There is no best approach or model for CT. Each has strengths and weaknesses and should be implemented appropriately to suit the targeted populations and regions. In most cases, a combination of models is appropriate to maximize coverage and improve the accessibility and acceptability of CT services.

When selecting CT models, one should consider program goals. Is the primary purpose to enhance access to care, support and treatment; to provide services to a general population that needs to know their HIV status for both prevention and care; or both? One should also consider cost, cost-effectiveness, sustainability, affordability, appropriateness to the target group, epidemiological profile, socio-political situation and convenience to the clients.

Although service delivery approaches may differ within and between countries, the recommended public health approach for scaling up CT remains the same: the test is voluntary (the client has the right to refuse), the client must give informed consent, the results are kept confidential, the test is accompanied by counseling and the quality of the testing and counseling is ensured. Below are overviews of some existing models and their respective benefits and challenges.

Stand alone

Stand-alone sites, also known as freestanding sites, are generally operated by nongovernmental organizations (NGOs) and are not associated with medical institutions. Usually CT is the only service these sites offer, and the staff is dedicated full-time to providing counseling and testing. Because clients most often self refer to stand-alone sites, they are commonly called voluntary counseling and testing (VCT) sites. For reasons of cost and cost-benefit, stand-alone sites are often located in high population density areas and where HIV infection rates are high.

Benefits

- Quality control is easier because staff are completely focused on providing CT.
- The model offers a unique opportunity to focus extensively on prevention and risk reduction counseling.

- Sites attract population groups that might not otherwise attend health-facility based CT. (Studies show that young people, couples and men in some settings prefer to use stand-alone services.)
- Flexible hours of operation and adequate staffing levels improve accessibility.
- Sites can meet increasing demand for CT services. (Experience from Malawi, Thailand, Uganda and Zimbabwe has shown this.)

Challenges

- The model has high start-up and operating costs, usually requiring longstanding external support.
- Medical and psycho-social follow-up can be difficult to ensure because sites are usually not associated with medical infrastructure or other support services.
- Stigma may surround services because they are associated only with HIV.

Integrated

In the integrated model, CT services are offered in medical settings (primarily public sector) and are initiated by the health care provider. CT is provided alongside other services such as general in- and out-patient, tuberculosis (TB), antenatal, and sexually transmitted infection (STI) care. It is also quite common to support client-initiated VCT within medical settings.

The two main approaches to provider-initiated CT in the integrated model are diagnostic CT and routine CT. Diagnostic CT is offered to patients who present at the health facility with clinical HIV symptoms. It maximizes identification of HIV-positive individuals for the purpose of referring them for treatment, care and support. Diagnostic CT may be located within any department of the health facility.

Routine CT is integrated into settings such as the antenatal, STI or TB clinics as a regular part of standard care. CT is regularly offered alongside other tests, and a client can opt out if he/she does not wish to be tested. CT within the antenatal care setting has received special focus since it is integral to PMTCT interventions.

Benefits

- CT is promoted as part of general health services, allowing the “normalization” of HIV.
- Health care workers are involved directly in HIV prevention activities.
- This model allows direct referral to other relevant care, such as antiretroviral therapy, management and prevention of opportunistic infections, TB, PMTCT, family planning and welfare support.
- CT is brought to the high volume of potential clients who visit public facilities.
- Potential for replication and scale up are high due to lower start up costs and more opportunities for outlets.
- Staff can provide services beyond the basic counseling typically available at stand-alone sites.

Challenges

- This model has potential to dilute other health care services and lower quality CT services.
- It is difficult to enforce quality assurance measures and maintain the quality of CT service delivery, especially where client load is high.
- Integrated CT can cause a shortage of personnel and competing demands for service providers’ time.

- Policy may not allow the use of non-health care workers — such as people living with HIV/AIDS, teachers, social workers and volunteers — as counselors in these settings.
- It may contribute to low motivation, especially among the public sector employees.
- There may be limits in administrative and managerial capacity to run these complex services.
- It can create long waiting times and inconvenient hours of operation.

Quasi-integrated

In quasi-integrated sites, an NGO provides CT in a public sector health facility; both the NGO and the facility contribute to managing the services. This model capitalizes on the strengths of both stand-alone and integrated models. This model's success greatly depends upon the quality of the partnership. Thailand and Uganda offer good examples of NGOs linked with health facilities.

Benefits

- Sites can reach many clients, through both client-initiated and provider-initiated CT, in health facilities using NGO staff dedicated full-time to CT.
- Services can be better funded and managed than if the health facility were running them.

Challenges

- Services can suffer from the difficulties of ineffective partnership.

Private sector

In many countries, private medical practitioners offer CT in their offices. This model, a variant of integrated CT, reaches people in higher income brackets who are less likely to use public-sector services.

Benefits

- Practitioners are committed to high quality care because the client is paying higher fees for services.
- Clients perceive private providers as a source of private, confidential services.
- Services are responsive to client needs.

Challenges

- Private-sector services are inaccessible to the poor and uninsured.
- Services do not always adhere to national/international quality standards.
- Providers often have no or inadequate training in HIV counseling.
- Time-consuming counseling does not always fit in a direct-fee model.

Mobile

Mobile CT takes the services into the community by offering CT either out of a van or from designated places in the community. In some cases, bicycles and motorcycles are used. Under this model, a team of providers sets up a temporary site where they offer services to the general population, to defined groups such as a church congregation, attendees at cultural and sports events, employees of a company, or to hard-to-reach groups such as injection drug users, sex workers, truck drivers, street boys or those with no fixed address.

Benefits

- Mobile CT improves access for hard-to-reach and rural populations.
- It brings the services to the beneficiaries.

Challenges

- Mobile CT can be expensive and not cost-effective; it requires a lot of resources (equipment and manpower).
- It can be difficult to ensure follow-up after post-test counseling.
- Extensive community mobilization is required to ensure uptake on the service date.
- It is challenging to ensure quality (especially of testing) at temporary sites.
- It can be difficult to prioritize HIV testing where clients have other pressing health needs.

Home based

Home-based CT is relatively new and is still being piloted. It is similar to the mobile model in that CT is offered within the home to family members, including children where appropriate. For this reason, it is sometimes referred to as the family-based model.

Benefits

- Home-based CT addresses the needs of the entire family at once.
- Discussion on prevention and behavior change may be more effective in the context of the family and the home.

Challenges

- It is expensive and time consuming as the provider must move from home to home.
- Family disclosure, especially of parents to children, may be difficult as the parent(s) have to deal with knowledge of their status first. Testing everyone at the same time may mean premature disclosure.

