THE ROLE OF VOLUNTARY COUNSELLING AND TESTING IN EARLY DIAGNOSIS OF HIV INFECTION

Predrag Đurić, Smiljana Rajčević, Svetlana Ilić • *Institute of public health of Vojvodina*

Introduction Voluntary counselling and testing is an important part of HIV prevention and also an excellent opportunity for early HIV diagnostics. VCT centres could provide support and referencing of newly diagnosed people living with HIV to treatment centres. In the early 1990's 2000's VCT was often seen as an ideal tool in HIV prevention and early diagnostics, that lead to establishment of VCT centres, but experience from last decade, especially in resource limited countries, leads us to more realistic approach.

Objectives The objective of the study was to describe results of voluntary counselling and testing (VCT) in Autonomous Province of Vojvodina, Serbia (AP Vojvodina) in 2002-2010.

Methods Analysis of surveillance data from all VCT centres in APV, including public health institutions, prisons, outreach activities and drop-in centres. In 2002 VCT program in APV is expanded, followed by surveillance system of VCT uptake and its outcomes. Data about age, gender, sexual orientation, drug use, sexual work, presence of other sexually transmitted infections and HIV, HBV and HCV test results are collected.

Results Expansion of VCT in AP Vojvodina started in early 2000's, when HIV treatment became largely available. Significant increasing in VCT uptake is observed, with maximum in 2006, following Global fund project as a resource for HIV tests with the rate 143.2 per 100,000 population (Figure 1). Declining was observed in 2007, when Global fund project was temporarily interrupted. Another increasing in VCT rates was not so significant later, with even a declining in 2010, as a result of difficulties in procurement of test kits, limited human and other resource in VCT centres and low motivation of VCT staff. Even higher declining could be observed, but some non-governmental organisations started with outreach VCT programmes.

Most of the clients are 20-39 years old and about 60% of clients are males (Figure 2). About 90% of all PLWHI in AP Vojvodina are males with majority of men having sex with men. Highest age-specific testing rates for males were observed in years when VCT was especially promoted for injected drug users, but none of them was diagnosed with HIV.

The significant increasing of the most vulnerable population covered by VCT is observed, especially in men having sex with men. Before 2000, when VCT wasn't available in most part of AP Vojvodina, only symbolic number of MSM was tested for HIV and diagnosis of HIV infections was generally established very late. In the beginning of last decade, prevalence of HIV in MSM tested in VCT centres was high – most of the clients were referred to VCT centres by their peers. Later, huge majority of HIV diagnosed cases in VCT centres in AP Vojvodina was in MSM population. It is estimated that only half of MSM declare sexual orientation in VCT centre.

Most of HIV infections in this period were diagnosed in VCT centres, compared to patients tested in health care facilities. HIV cases diagnosed in VCT centres are more often presented in early stage of HIV infection than HIV cases diagnosed in health care facilities.

Large regional differences were observed in VCT uptake in AP Vojvodina. Most of the VCT clients were presented in Novi Sad, capital of AP Vojvodina. Small number of VCTs is done outside institutes of public health in seven largest cities in AP Vojvodina (figure 4). Only few primary health care centres provide VCT to their patients. VCT in prisons, which started in 2005 suffers from organisation problem (centralised management by Ministry of justice, high fluctuation of health personnel). Since 2009 some NGO's started with outreach VCT in vulnerable communities (MSM, injected drug users, sexual workers).

Conclusion VCT could be important tool for early HIV diagnosis, but it depends on organisational capacities of VCT centres, procurement procedures, and sustainability of programmes and promotion of VCT. Clear and sustainable strategy is needed, including sustainable financing, sufficient human resources and decentralisation of management of health programmes.

Figure 1. VCT rates per 100,000 population in AP Vojvodina, Serbia in 2002-2010

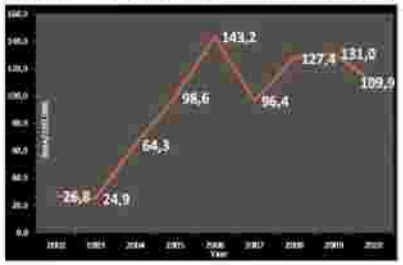


Figure 2. Gender specific rates of VCT per 100,000 population in AP Vojvodina, Serbia in 2002-2010

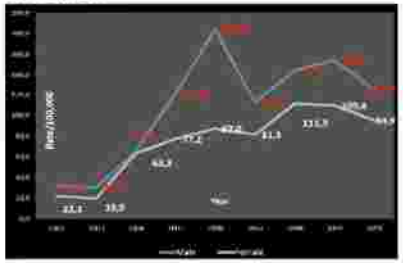


Figure 3. Number of MSM covered by VCT in AP Vojvodina, Serbia in 2002-2010

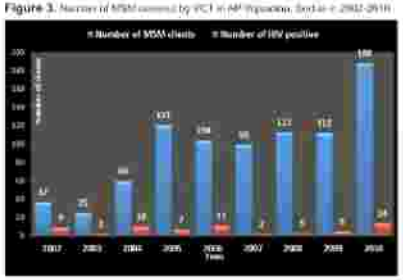
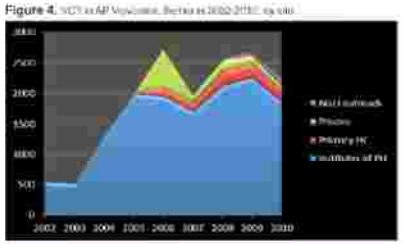


Figure 4. VCT in AP Vojvodina, Serbia in 2002-2010, by site



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