

**SUPPLY CAPACITY FOR SCALING UP
THE VOLUNTARY COUNSELING & TESTING
AND ART PROGRAM
IN THAILAND**

FINAL REPORT

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I. Introduction

Thailand has recently provided the antiretroviral treatment (ART) for all HIV/AIDS patients who are in need. The number of patients who access to ART in the National Access to Antiretroviral Programs for PLWHAs (NAPHA) was increased from 10,000 PLWHAs in 2003 to around 90,000 PLWHAs in 2006. However, most of them were symptomatic patients. A policy alternative is to early recruitment into ART. In a few years time the recruitment of symptomatic HIV patients will be exhausted. At that point, the next step in scaling up recruitment into ART will be to identify those who have asymptomatic HIV infection and have CD4 counts less than 200. Observation indicates that it is not uncommon that HIV infected individuals with low CD4 counts (below 200) are still clinically well and symptom free. Since treatment is most successful when initiated at CD4 levels between about 100 and about 200, the challenge is to first identify people early enough and then recruit them into ART.

To preserve the right of patients, many governments adopt a process of voluntary counselling and testing for HIV/AIDS (VCT). VCT can be defined as "the process by which an individual undergoes counselling enabling him or her to make an informed choice about being tested for HIV. This decision must be entirely the choice of the individual and he or she must be assured that the process will be confidential" (Baggaley 2001). Ideally, VCT should be composed of 3 elements: 1) HIV counselling, 2) Voluntary testing and, 3) Confidentiality. Several models could be provided such as: Model1 Individual pre-and post-test counselling and testing ("classic" model); Model2 Group information, opt-in individual pre-test counselling, individual post-test counselling; Model3 Group information, opt-out individual testing, individual post-test counselling for seropositives, seronegatives are informed of their negative status; Model4 Group information, opt-in couple/family pre-test counselling, individual/couple/family post-test counselling; Model5 No pre-test information, screening/testing (with an option to opt-out), individual post-test counselling for those found HIV+.

In practice, there are also other models of HIV test (Celentano et al. 2000). For example, Mandatory HIV testing, this is when HIV testing is a precondition for obtaining a service or benefit. Compulsory screening, this is where a person has no choice in being tested and is required to provide a blood sample. Counselling without testing, this can reduce HIV transmission.

In Thailand, understanding about the approach of HIV test and capacity of the supply side to provide a quality VCT is rarely documented. Lisa Guntamala and Orawan Duangchant have reviewed the AIDS Counseling services development in Thailand (Guntamala and Duangchant, 2002). The review documented chronological events of counseling initiatives regarding HIV/AIDS in Thailand before 2002. The situation of VCT after the universal access to ARV launched in 2004 has not been documented. Another study in 2002-3 reviewed the national counselling services and psychosocial care and support services (Casey, 2004). It reports the workloads for HIV counselling and supporting system for counselling delivery but there was no indicator to justify the quality of counselling. In the light of system preparation, more information is needed.

II. Objectives

This study aims to assess the current supply side capacity of VCT in Thailand. It is a part of the project "Stimulating VCT and Early Recruitment into ART in Thailand" supported by the ASEM Trust Fund.

Specific objectives are

1. To describe the existing system of VCT and ART delivery in Thailand;
2. To quantify the current workloads of VCT;
3. To identify factors determining quality of counselling which is measured by accessibility, rate of return, health system responsiveness and confidentiality.
4. To identify factors of the lost follow-up cases of the HIV patients

III. Methodology

The study conducted both qualitative and quantitative data collection methods including in-depth interview, group interview, focus group discussion, and self-administrative questionnaire to assess the current supply side capacity of VCT and the linkage to the ART delivery and to quantify workloads for VCT.

Data collection had been conducted during the period of November 2005-March 2006. **Table 3.1** describes the data collection methods for each type of issue.

The study purposively selected 8 provinces by stratifying provinces in Thailand to 4 regions and selected a province in a group of high prevalence of HIV infection in pregnant women and a province in the group of low prevalence of HIV infection in pregnant women in each region.

These provinces are Chiangmai, Tak, Suratthani, Trang, Udon Thani, Kalasin, Rayong, and Pratumthani, see **Table 3.2**.

Table 3.1 Data collection methods

Collected Data / explored issues	Data collection methods / approaches
The service delivery system, confidentiality, service hour, amenities, report system	In-depth interviews, group interviews, self-administrative questionnaire
Training support, peer support, network and incentives to provide services	In-depth interviews, group interviews, self-administrative questionnaire
Service hours and workloads	Self-administrative questionnaire.
Recommendations to improve the service delivery and pilot design to stimulate demand for VCT	Focus group discussions

Table 3.2 Prevalence of HIV infection in pregnant women (2003) in studied provinces

Whole kingdom 1.30	High prevalence	Low prevalence
North	ChiangMai 2.97	Tak 0.94
Northeast	Udonthani 1.76	Kalasin 0.56
Central	Rayong 3.13	Pratumthani 0.66
South	Trang 1.72	Suratthani 0.64

The researchers visited the study provinces and hospitals (4 hospitals by province; 1 provincial hospital and 3 district hospitals) to observe the VCT and ART delivery systems and to conduct group interviews/ in-depth interviews with key informants including the Provincial Chief Medical Officers, provincial health officers who are responsible for HIV/AIDS program, hospital directors, counsellors, and volunteers from PLWHA groups. This aims to understand the VCT delivery system and the issues of confidentiality, amenities, report system, training support, peer support, network and incentives to provide services.

The site visits were also useful to provide the knowledge for the design of the self-administrative questionnaires.

In addition to qualitative approach, we also conduct self-administered survey questionnaire. The study conducted surveys of VCT delivery at provincial level and hospital level. A workshop was conducted to train the coordinators from provincial health offices to distribute and collect back the filled questionnaire.

The questionnaires for data at provincial level were filled by the officers who responsible for HIV/AIDS at 8 provincial health offices. The questionnaires for data at hospital level were distributed to all hospitals in 8 provinces by the coordinators at the provincial health offices and data were compiled by the counsellors in each hospital.

A total 95 out of 109 hospitals in 8 provinces responded to the questionnaire. **Table 3.3** shows the number of hospitals participated in the survey to the total MOPH hospitals by province. **Table 3.4** shows the distribution of responders by hospital size.

Table 3.3 Number of hospital participated in the survey by province

	Number of hospitals participated / total MOPH hospitals	
	High prevalence	Low prevalence
North	Chiangmai (21/23)	Tak (8/8)
Northeast	Udonthani (18/19)	Kalasin (12/15)
Central	Rayong (6/7)	Pratumthani (8/8)
South	Trang (7/9)	Suratthani (15/20)
Total	52/58	43/51

Table 3.4 Distribution of participating hospitals by bed size

Hospital bed size	Number of participating hospitals	Percent (%)
10	4	4.21%
30	54	56.84%
60	15	15.79%
90	8	8.42%
120	4	4.21%
160	1	1.05%
>300	9	9.47%
Total	95	100.00%

The contents in the survey questionnaires include:

Variables at provincial level

- Geographical variables: region, province;
- Basic statistics on population size and number of districts in the province
- Number of VCT sites (including pre and post counselling and blood sample collection) by type of health facilities;
- Reporting system in the province,
- Training for counsellors in the province
- Needs for increasing of number of counsellors
- Training needs for present counsellors

Variables at hospital level

- Geographical variables: Region, province, district, hospital name, hospital level, hospital size;
- Basic statistics on population size;
- Number of monthly pregnancy who received ANC, pretest-VCT, blood test, and posttest VCT during October 2004-September 2005;
- Number of monthly outpatients who received pretest-VCT, blood test, and posttest VCT during October 2004-September 2005;
- Number of HIV positive tests of pregnant women and outpatients who have HIV test during October 2004-September 2005
- Salary rates and numbers of HIV counsellors in ANC, OPD, and IPD
- Number of pretest/posttest counselling by individual/group in 7-day of prospective data collection in ANC, OPD, and IPD.

- Time spending for pretest/posttest counselling by individual/group in 7-day of prospective data collection ANC, OPD, and IPD.

After the information was compiled, a workshop was arranged in September 2005 to make the focus group discussions for the recommendations for the pilot design.

In order to better understand the factors determine lost to follow-up, this study conducted 4 focus group discussions with counsellors from 8 provinces to assess the factors of lost follow-up cases from the providers' perspectives. The focus group discussions were conducted in September 2005 in Bangkok. Some respondents were notified to observe the number of lost follow-up cases in their facilities to be discussed in the focus group discussions. The issues were discussed included how the counsellors use the peer support for the HIV infections with CD4>200, the proportion of lost follow-up cases among HIV infections with CD4>200, the socio-economic characteristics of the lost follow-up cases, the important factors of counsellors to stop following up the HIV positive patients to accept the test for CD4

IV. Results

1. Service availability

VCT services in Thailand have evolved from VCT in Sexual Transmission Disease (STD) clinic in provincial health offices and VCT in the PMTCT program to the VCT for general patients alongside to the ART clinic development. The services have gradually expanded to the target groups in community and school (with or without HIV testing). Since 1991, the Ministry of Public Health has established the anonymous clinics for general patients in all public health hospitals throughout the country (Guntamala and Duangchant, 2002). Data from the survey in 2005 in 8 provinces confirmed the country-wide coverage of the VCT services that the percentage of districts with at least one operational counselling and testing site was 100. However, the name of the unit and the service systems varied from site to site depending on the perception on the community openness of the VCT manager of each hospital and the limitation of staff capacity.

Table 4.1 shows the number of VCT sites and distributions among sample provinces. The number of adult populations (15-60 years) per VCT site varied from 10,489 to 61,990 adult populations per site.

In Chiangmai, a particular high prevalence province, health centers were strengthened to provide pretest/posttest counselling and take blood sample, and many private clinics also provided VCT services. However, there is no systematic record on the private VCT site in all sample provinces. The numbers provided in the table were best estimated by the provincial health officers.

Table 4.1 Number of VCT sites and distributions in sample provinces

Province code	Population 15-60	Number of districts	Total VCT sites	VCT availability (populations/VCT sites)	Regional / General hospitals	Community hospital	Health centers	Other public facilities	Private clinic/hospitals
13	557,906	7	9	61,990	1	7	0	1	1 clinic
21	385,723	6	7	55,103	1	6	0	0	0
50	1,174,734	22	112	10,489	1	22	81	8	More than 6 clinics
63	390,308	8	10	39,031	2	6	0	1	1 hospital
41	1,055,859	20	21	50,279	1	18	0	3	0
46	717,105	14	15	47,807	1	13	0	0	1 hospital
84	615,270	19	23	26,751	2	18	0	2	1 hospital
92	382,627	9	9	42,514	1	8	0	1	0

Note: Data from the self-administrative questionnaires by the provincial health officers who were responsible for VCT or HIV/AIDS program in 8 provinces

2. Modes of VCT services

VCT services provided in the MOPH hospitals were frequently performed in antenatal care clinics (ANC clinics), Out-patient Department (OPD), and Inpatient Department (IPD). The service modes can be categorized by type and need of the VCT client as:

1. antenatal care clients,
2. symptomatic patients referred by medical doctor,
3. walked in patients,
4. pre-operative patients,
5. Drug treatment attendees.

Table 4.2 shows the models of VCT in practice. For antenatal care clients, the program for prevention of mother to child transmission was well established and nation wide scaled up since 2001. Counselling services were provided in conjunction with family counselling and pregnant women counselling. The information provided in a group of pregnant women was the common practice for pre-test counselling, followed by the individual post-test counselling for seropositives and seronegatives.

In some hospitals with a small number of antenatal care clients per day, the individual pre-test counselling was performed. The couples counselling services were rarely performed. The common reason of the pregnant women to deny for the couple counselling was "fear for separation and not ready to be independent" (Interviews of counselors, 2005).

For referred patients to test from other medical departments and walked-in patients, the individual pre-test and post-test counselling were the common practice, while most of the pre-operative patients and the drug treatment attendees were ignored to be informed and asked for consent before HIV/AIDS screening. The individual post-test counselling was provided for those found HIV positive.

Counselling services were also provided in conjunction with other services such as sexual transmitted infection (STI), and TB medication program counselling. In some provincial health offices, anonymous clinics were still good performed while the task was gradually transferred to the hospital in each district.

Table 4.2 Modes of VCT services in public hospitals in sample provinces, Thailand

	Group information, group counselling	Pre-test counselling	Post-test counselling
1. Antenatal care clients	√ (opt-out)	Some hospitals √ Individual	√ Individual
2. Symptomatic patients referred by physician		√ Individual	√ Individual
3. Walked in patients		√ Individual	√ Individual
4. Surgical patients (if HIV+)			√ Individual
5. Drug treatment attendees (if HIV+)			√ Individual

Note: Common practice (not all cases), reported by counsellors in sample hospitals (Interviews, 2005)

3. Characteristics of VCT services

At the ANC, the counselling for HIV test was integrated into other prenatal cares for pregnant women who come at the first time by group counselling. The post-test counselling was usually provided at the next visit of the appointment for prenatal care.

For general patients, there were several ways of the management of VCT clinics. It can be categorized as one-stop service, integrated into general OPD services; and extended clinic.

A. One stop service model

The Counselling clinics were specially established as a center to provide VCT, and usually provided in conjunction with HIV/AIDS treatment, and/or treatment for sexual transmitted infection (STI), and/or other psycho-social counselling services such as drug abuse. Clients

could directly contact the center for anonymous testing or be referred from the OPD. Each hospital had at least a counselling room with privacy. After the pre-test counselling, the patients were asked to sign a consent message of acceptance for blood testing and made an appointment for the results, usually 3-7 days. A counsellor gave a reason for delaying the results that "*this is to let the patients to prepare their mind before facing with the results*" (Interview: a counsellor at Ban Khai Hospital, Rayong province, 2005). However, client could request the result at the same day for the test for pre-employment. Counseling contents and testing results in this kind of clinic were usually recorded in a log book with identification number instead of the client name.

This model was found in many community hospitals at large size (Ban Kai Hospital in Rayong Province, Kamalasai Hospital, Kalasin; Nong wou Sao Hospital, Udonthani, Karnjanadit Hospital in Suratthani Province) and general/regional hospitals (Udonthani Hospital)

B. Integrated to general services model

Apart from the counselling clinic, in some hospitals the counselling services were allocated to the well-trained nurses at OPD, IPD and Primary care unit (providing ante-natal care) because of the increasing number of VCT cases and the limited capacity of the counseling clinics. The departments provided counseling at any privacy area or a privacy room which was provided for multipurpose.

The cases with HIV positive result were usually referred to receive the counselling on the ARV program and to be followed up by the counselling clinic. It was observed that there were infrequent records and information compiled for the VCT activities provided in this kind of service model. Exceptionally in some long experienced hospital, the VCT or HIV/AIDS program managers produced a record form and information system that facilitated the continuity care for HIV/AIDS patients where the confidentiality was also guaranteed.

This model was found in many community hospitals at small and medium size (Ban Dung Hospital and Kumpawapee Hospital in Udonthani, Kuchinarai Hospital in Kalasin, Punping Hospital in Suratthani) and some general hospitals.

C. Extended clinic model

Extended clinic was usually established to supplement the office-hour clinic in hospital. An evening clinic established outside the Udonthani Hospital was managed as a private clinic in an urban community area. Service hours were from 5 to 8 pm; however, it closed at the weekend. The name "Friend" was used for the clinic title to avoid stigma.

The numbers of hospital staff trained for counselling for VCT were vary ranged from 1 person to more than 5 persons in each department depending on each hospital policy.

Table 4.3 shows the number of trained counsellors at ANC, OPD, and IPD in MoPH hospitals in 2005.

Table 4.3 Number of trained counsellors at ANC, OPD, IPD in MOPH hospitals, 2005

Staff at ANC	hospitals	Percent	Staff at OPD	hospitals	Percent	Staff at IPD	hospitals	Percent
1	20	25.97	1	15	17.44	1	16	25.81
2	17	22.08	2	22	25.58	2	20	32.26
3	18	23.38	3	16	18.6	3	7	11.29
4	14	18.18	4	11	12.79	4	2	3.23
5-11	8	10.39	5	14	16.28	5	2	3.23
			6-26	8	9.29	6-26	15	24.18
Total	77	100	Total	86	100	Total	62	100

4. Services for special and vulnerable groups

There were VCT services at the workplace of sex workers either free of charge or some fee introduced. For young people, some hospitals scheduled a proactive health education in schools and informed the VCT services availability to students in secondary and vocational school.

5. HIV testing methods

The screening test was used and confirmed with the ELISA test with the time interval of 90 minutes between taking blood and results. Some hospitals used 3 tests to confirm the HIV positive results. The Elisa was used as a standard test and the rapid test and the GPA test were used to confirm the positive case.

6. Service record and quality control

In each province, two hospitals were invited to attend the pilot program on quality control of AIDS care; hence, there was record form for case follow-up including the counselling contents (Punping Hospital, Surathani). However, the counseling contents were rarely recorded in many hospitals.

7. Linkages to ART delivery

In the case who know themselves as HIV+ and have CD4 cells less than 200 cells or pass the criteria of the NAPHA program were voluntary recruited to the ART program. Almost all MoPH hospitals were able to provide ARV treatment. The ARV clinics usually are held once a month or twice a month depending on the number of patients who received ARV at the hospitals. Many hospitals also provide space for Day care clinics which allow the PLWA groups to work and be socialized with their peer.

8. Service utilization and return rate

A hospital survey was conducted for monthly records in the fiscal year 2005 and 95 out of 109 hospitals in the 8 provinces responded to the questionnaire.

The total ANC case per annual (2005) in 95 MOPH hospitals was 54,351 cases with an average 466 cases per a community hospital and 1,589 cases per general/regional hospital. 99.10% of the pregnant women who visit ANC clinics have got the HIV test while 98.71% received pretest counselling for HIV test. 95.80% out of the test returned for the results and received the post-test counselling.

However, the return rate at large hospital (more than 90 beds) was 5% lower than the return rate of smaller hospitals (P value <0.05). **Table 4.4** shows the coverage of counseling and HIV test of the pregnant women who visited ANC clinics and return rate.

Table 4.4 Coverage of VCT and return rate of ANC patients in the fiscal year 2005

	Observations (hospitals)	Mean	Std.Dev	Note
Coverage of pretest counselling (%)	95	98.71%	3.29%	
at community hospitals (10-60 beds)	73	99.70%	1.90%	
at medium size hospital (90-160 beds)	13	99.17%	2.65%	
at large hospital (300-806 beds)	9	96.36%	4.82%	* P <.05
Coverage of HIV test (%)	95	99.10%	2.87%	
at community hospitals (10-60 beds)	73	99.7%	2.1%	
at medium size hospital (90-160 beds)	13	99.0%	2.6%	
at large hospital (300-806 beds)	9	98.0%	4.2%	
Return rate for post-test counselling (%)	95	95.80%	8.58%	
at community hospitals (10-60 beds)	73	98.45%	5.44%	* P <.05
at medium size hospital (90-160 beds)	13	93.17%	9.93%	
at large hospital (300-806 beds)	9	92.57%	11.44%	

Note: data from the hospital survey in 8 provinces

Table 4.5 shows the percent of positive test by province. The average percent of the positive test was 1.21% and the distribution by province has a similar pattern of the Sero-sentinel surveillance in 2004 except the positive rate in Udonthani of which the hospital survey was lower than the rate of the sentinel surveillance in 2004.

Table 4.5 the Pretest counselling for HIV and the rate of positive test by province, fiscal year 2005

Province co	Obs. (hospitals)	Number of pregnant (cases)	Number of pre-test counselling (cases)	% of pregnant women received pre-test counselling	Number of blood test (cases)	% of pregnant women received HIV test	HIV Positive rate	
							Mean	Std. Dev.
13	8	5,583	5,583	100%	5,582	100%	0.91%	0.43%
21	6	6,819	6,572	96%	6,819	100%	2.13%	0.67%
41	18	11,028	11,025	100%	11,023	100%	0.90%	0.43%
46	12	4,691	4,691	100%	4,682	100%	1.00%	0.91%
50	21	9,544	9,386	98%	9,370	98%	1.41%	0.93%
63	8	3,337	3,337	100%	3,337	100%	1.20%	0.40%
84	15	8,707	8,430	97%	8,422	97%	0.94%	0.53%
92	7	4,642	4,626	100%	4,625	100%	1.23%	0.44%
Total	95	54,351	53,650	99%	53,860	99%	1.21%	0.73%

Note: data from the hospital survey in 8 provinces

Only 84 hospitals completed the data on the services provided by the out-patient department. An average HIV test per year at OPD was 1,502.29 per a hospital (SD 1,109.35, range from 27 – 3,827 cases) with an average of 1,113 cases per an OPD at a community hospital and 2,297 cases per an OPD at a regional/general hospital. The proportion of HIV test per general patients at OPD was 5.84 per 1,000 OPD cases (SD 6.41) while the rate of patients who received pre-test counselling was 5.73 per 1,000 OPD cases. The number of HIV test at an OPD is related to the level of the hospital (p value <0.01) and the number of patient at the OPD (p value <0.01). The rate of HIV test per OPD patients in Chiang Mai province was remarkable higher than the rate of other provinces (p value <0.01).

The return rate of OPD case for post-test counselling was at an average of 79.1% (SD 26.90%). The return rate at regional/general hospitals (more than 300 beds) was dramatically

low (45.77 %) while community hospitals (10-60 beds) could follow up almost all cases for post-test counselling (97.9%) (p value <.001).

Table 4.6 shows the coverage of counseling and HIV test of the general patient who visited OPD and the return rate. **Table 4.7** shows the percent of positive test by province.

The average percentage of positive test was 9.29% and the distribution by province was not similar to the pattern of the Sero-sentinel surveillance for pregnant in 2004.

Table 4.6 VCT for patients at Out-patient department

	Observations (hospitals)	Mean	Std.Dev	Note
Pretest counselling per 1000 OP cases (cases)	84	5.73	6.48	
· at community hospitals (10-60 beds)	63	5.29	5.64	
· at medium size hospital (90-160 beds)	12	8.85	10.08	
· at large hospital (300-806 beds)	9	4.92	5.47	
HIV test per 1,000 OP cases (cases)	84	5.84	6.41	
· at community hospitals (10-60 beds)	63	5.37	5.72	
· at medium size hospital (90-160 beds)	12	8.03	9.65	
· at large hospital (300-806 beds)	9	5.50	5.74	
Return rate for post-test counselling at OPD (%)	84	79.1%	26.9%	Different by size among three groups of hospitals
· at community hospitals (10-60 beds)	63	97.9%	5.7%	
· at medium size hospital (90-160 beds)	12	90.4%	6.7%	Different from smaller hospitals P<.05
· at large hospital (300-806 beds)	9	45.8%	21.8%	different from smaller hospitals P<.001

Table 4.7 Pre-test counselling at Out-patient department and rate of positive test

Province code	Obs. (hospitals)	Number of OPD (cases)	Number of pre-test counselling (cases)	Pre-test counselling rate (cases per 1,000 OP)	Number of blood test (cases)	HIV test rate (cases per 1,000 OP)	HIV Positive rate (%)	
							Mean	Std. Dev.
13	7	623,936	2,355	3.77	2,348	3.76	14.10%	5.13%
21	6	780,954	5,000	6.40	4,398	5.63	15.21%	4.31%
41	17	1,412,209	5,169	3.66	5,125	3.63	11.26%	9.25%
46	10	785,598	3,653	4.65	3,785	4.82	9.43%	13.56%
50	17	1,519,112	18,771	12.36	20,527	13.51	6.86%	2.62%
63	8	627,532	2,933	4.67	2,894	4.61	6.19%	5.03%
84	13	1,387,805	3,010	2.17	2,996	2.16	16.19%	7.38%
92	6	673,251	3,856	5.73	3,546	5.27	6.57%	6.66%
Total	84	7,810,397	44,747	5.73	45,619	5.84	9.29%	6.96%

9. Cost and sustainability

The hospital charge of a HIV test is about 150-200 Baht and was exempted for the 30 Baht card holders. The 30 Baht scheme pays all MoPH hospital by per capita budget for the whole services in the benefit package including the VCT. However, people have to pay if they cannot meet the terms of the 30 Baht Scheme.

The hospital charge of a CD4 test is 200-270 Baht and was exempted for the people who are eligible for the ART. In some hospitals, for example in Punping Hospital, the ART program got funding from the Supamitr Foundation of Thailand and coordinated other government support for the clients such as seeding money for career or education scholarship from the Ministry of Social Development and the Local Administration. However, this is a rare case.

Information from Sikao Hospital, reported that the material cost for the HIV test were 60, 60, and 110 Baht for the ELISA, GPA, and Rapid test. The hospital survey calculating the labor cost of counseling found that the labor cost of an individual counseling was about 41-59 Baht per case and the labor cost of group counselling was 12 Baht per case with an average 7 persons per session. The average time per individual session was 20-29 minutes and the average time per group session was 41 minutes. **Table 4.8** shows the details of labor cost by type of counseling and **Table 4.9** shows the monthly income of counsellors in MoPH Hospitals.

Hence, the price of HIV test in public hospitals might not recover the cost of counseling and laboratory test. Many counsellors complained that there is no incentive for counsellors when the scaling ART was launched. Most of supports from the central management were the laboratory chemical liquids. The 30 Baht scheme even ignored to include the labor cost of the counselling into the per-capita budget.

Table 4.8 The 7-day diary record of workloads of counsellors in MoPH hospitals, 2005

	Observations (hospitals)	number of cases	persons / session	Minutes /case	Std. Dev.	Baht /case*	Std. Dev
ANC Group counselling	25	18.67	7.18	5.70	4.45	11.52	8.99
ANC pretest counselling	57	10.30	1	21.27	11.25	43.00	22.74
ANC posttest counselling	57	10.93	1	20.47	13.72	41.38	27.74
OP pretest counselling	79	10.33	1	23.55	10.58	46.41	20.85
OP posttest counselling	71	9.07	1	23.92	11.53	47.14	22.73
IP pretest counselling	48	3.38	1	25.12	11.72	51.61	24.08
IP posttest counselling	43	2.81	1	28.72	14.41	59.01	29.61

Note: Price per minute is calculated from the average monthly income of the counsellors grouped by department and divided by 22 days and 7 hours per day

Table 4.9 Monthly income of counsellors at ANC, OPD and IPD at MoPH hospitals, 2005

	Observations (hospitals)	Mean	Std. Dev.	Min	Max
Counsellors at ANC clinics					
Monthly salary	51	17,250	4,442	8,580	28,940
Additional income	51	1,432	1,876	0	6,750
Total income per month	51	18,682	5,181	8,580	32,440
Counsellors at OP Department					
Monthly salary	51	16,239	3,716	10,000	25,000
Additional income	51	1,973	1,979	0	6,000
Total income per month	51	18,211	4,312	10,500	25,968
Counsellors at IP Department					
Monthly salary	51	16,148	3,964	7,260	26,650
Additional income	51	2,837	2,341	0	7,500
Total income per month	51	18,986	4,519	7,260	30,150

Note: No statistical different among three departments

10. Factors for people returning for the test results

At the pre-counselling visit, the counsellors normally exchange the telephone number with the patients for following up the results and an appointment for receiving the results usually be scheduled in the next 3 or 7 days. In general, all hospitals don't follow the people who did not return for the test results at this stage. Many reasons were provided such as the patient might not be ready to confront with the result and the proactive approach would be harm to the patient in the context of stigmatization.

In the case who know themselves as HIV+ after the post-test counselling, the patient will have an appointment for CD4 test which usually scheduled once a month. The patients who have CD4 cells less than 200 cells or pass the criteria of the NAPHA program should be consulted to enter the ART. The patients who have CD4 cells more than 200 will be followed with the CD4 test in the next 3 months and 6 months for the case who have CD4 cells between 200-350 and more than 350, respectively.

Counsellors from community hospitals reported that they followed the HIV+ patients who did not show up on the appointment day by phone (Focus group discussion, all groups) or post (Group III), and followed by home visit by peer (all groups). Many hospitals provided space for volunteers from people living with AIDS (PLWA) to work with the hospital staff. The well-trained volunteers had a schedule to visit HIV+ patients who made consent of acceptance for peer visit.

The counsellors from some general/regional hospitals admitted that the hospital didn't follow up the patients for CD4 results because the patients stayed in other districts (Group II). However, the information on the sites providing CD4 test and the criteria for ART were provided to the patients and the patients were convinced to get back to the hospitals when their CD4 cells lower to less than 200 or they get any opportunity infection (Group II).

The proportion of lost follow-up cases among HIV infections with CD4>200 was averaged at 5-10%, and could be dramatically high at 50% in the South of Thailand (Group III).

The socio-economic characteristics of the lost follow-up cases which are common in all regions are poor or migrant workers or earning on a daily basis. In the South, migrant workers such as

fishermen, they moved to their home town after getting sick, then they were lost follow-up (Group III).

The focus group discussions summarized 3 main factors of the lost follow-up for CD4 test from the demand side as below:

- Migration – patients move frequently between new working place and home town
- Non-disclosure – patients are afraid to be observed as HIV+ on the appointment day
- CD4 cost – patients have to shoulder the cost of CD4 test while they are not eligible for the NAPHA program

Though some hospitals had a follow-up system, the important factors of counsellors to stop following up the HIV positive patients to accept the test for CD4 were the lack of the budget and the limited number of hospital staff. Supporting fund from NGOs can be found only in some hospitals with active and long experienced staff.

11. Perception on VCT and factors determining quality of counselling

A self-administrative questionnaire on the perceptions of counsellors on VCT was disseminated to the counsellors who attended the focus group workshop in September 2005. Most of counsellors in hospitals knew well on the counselling activities; however, only five from 28 responders raised the issues of voluntary and confidentiality when they were asked about activities in VCT. Only one respondent expressed clearly about the process of voluntary acceptance for HIV test and another one respondent rose about the confidentiality. Another three respondents used the term of the protection of 'Human Rights' which can be assumed to be the right to have HIV test and the right to keep confidential.

The responders perceived the benefit of VCT as education for patients' health and self care, early recruitment of ART, disease control, mental preparation of clients, good communication and client satisfaction and cooperation, ensuring the decision is on voluntary basis and human right protection, and reducing government expenses from the curative care, respectively.

Table 4.10 shows the number of responders raised each type of the benefit of VCT.

Table 4.10 Benefit of VCT perceived by counselors

Type of benefit of VCT	Number of responders (out of 28)
Education for patients' health and self care	17
Early recruitment of ART	13
Disease control	11
Mental preparation of clients	8
Good communication and Client satisfaction and cooperation	3
Ensuring the decision is on voluntary basis and human right protection	2
Reducing government expenses	1

Counsellors individually perceived about quality in VCT in different ways. Outcomes on a client of a quality VCT in their perspectives include good self recognition, client's satisfaction and trust, understanding AIDS, cooperation in self care, better sex behavior, controllable of the opportunistic infection. Good processes of VCT delivery in their perspectives include accessibility, good follow up system, good CGs process (Good counselling system), patient center approach, confidentiality, and choice or rights to make decision. For the management for VCT clinic, they suggested these elements:

- Having a main responsibility person with team members
- Number of team members and the maximum workload per counsellor should be 3 case per day

- Well trained counsellors with knowledge, maturity, and good mentality
- Having standard of practice
- Having record system and follow up system
- Having a private space for counselling with a good atmosphere
- Having evaluation of performance to improve quality of services by clients
- Having human resource development plan
- Hospital director and administrative committee pay high attention on this service

Table 4.11 shows the list of last training courses attended by the counsellors in 8 provinces. There are many course organizers include Department of Disease Control, Department of Mental Health, and Thai Red Cross. Moreover, some hospitals arranged their internal training on counselling for their new staff.

Table 4.11 List of the last training courses attended by 27 counsellors from 8 provinces

Year BE	AD	Title of training course	Number of respondents
2535	1992	Counselling for HIV/AIDS patients	1
2537	1994	TOT Counselling	1
2542	1999	Counselling for patient at the end of life	1
2545	2002	Pretest-posttest counselling for HIV testing	1
2545	2002	Counselling for ART program	1
2546	2003	Group counselling	1
2546	2003	Advance counselling with integrated approach	1
2546	2003	Basic Counselling for HIV/AIDS patients	3
2547	2004	Basic Counselling	1
2547	2004	Counselling for ART program	1
2547	2004	Counselling for post-delivery mother and family living with AIDS	1
2548	2005	Voluntary Counselling and Testing for HIV	3
2548	2005	Counselling to encourage 'Self disclosure'	6
2548	2005	Counselling for ART program	5
			27

Note: Course organizers include Department of Disease Control, Department of Mental Health, and Thai Red Cross.

The focus group discussions indicated the problems in the existing VCT services as follows:

- Hospital directors and management committees did not pay adequate attention to the VCT works.
- There were too many workloads while there was less incentive to the counsellors.
- The counselling room was inappropriate for privacy.
- The time interval between taking blood for CD4 test and results was too long and might affect the acceptance to have CD4 test in public hospital and would lost the follow-up.

12. Suggested models for VCT activation

The focus group discussions suggested target groups for VCT activation are

- Sex workers
- Migrant workers
- Young workers in industrial units
- Adolescents both in school and outside school
- Drug users
- Pre-marriage couple

The focus group discussions suggested strategies to activate the VCT including:

- Campaign for VCT and Education on VCT and HIV/AIDS
- Incentives for VCT such as fee exemption, free condom
- Group education and counselling at secondary / vocational school and opt-in pre-test counselling - requires budget for going out to school, which are rarely supported by hospital director)
- Activities to change teachers' attitude in counselling
- To establish peer groups of PHA – requires budget support for group activities and require jobs for PHA earnings

V. Discussions and recommendations

1. Capacity and quality of the VCT service systems

VCT services were distributed to all community hospitals and were introduced in health centers in some provinces; however, there was no official record of VCT sites in private sector. Moreover, there was no information on the linkage of the HIV test in private sector and the recruitment to the ART delivery in the government sector. The private clinic could be useful as a gate to the government's ART program for the patients in need.

Group information for pre-test counselling was practical with a large number of patients who were tested with the same reason, while the test without consent in the pre-operative patients and the drug treatment attendees were becoming unacceptable by the counsellors. Some of them have put their efforts to motivate the consent procedure; however, there was no explicit attention from doctors and hospital directors.

In the light of increasing number of the VCT clients, the integrated model seems to be more appropriate for the hospitals that have limited number of the full-time responsible counsellors; however, the record and information systems that facilitate the continuity care for HIV/AIDS patients should be developed. The Kuchinarai Hospital in Kalasin is a good example that developed the information system of VCT and HIV tested patients where the confidentiality was also guaranteed. Private-typed clinic also facilitates the flexibility in access by the HIV patients.

Services for special and vulnerable groups were available as incidental programs in some hospitals which have active managers of AIDS or Social programs. This is because of the national policy after the Universal Coverage Scheme directed the public providers to integrate the VCT service to the general services without a clear direction for the special and vulnerable groups. Moreover, there is no attention from many hospital directors to implement this kind of program. In addition, the teachers' attitude is a barrier to introduce the safe-sex education and information on VCT in the secondary and vocational schools.

Most of VCT were not recorded; hence, the quality of VCT was difficult to be evaluated. This study suggests a quantitative index which is the return rate for HIV test results. The study provides based-line data of the return rate at 97.9%, 90.4, and 45.8% for the hospital with the

number of bed of up-to 60, 90-160, and more than 300 beds, respectively. Other qualitative indexes of VCT services that should be considered are the patient center approach, confidentiality, and choice or rights to make decision. The outcomes of the counselling for HIV patients could be measured by the good self recognition and disclosure to family, better safe-sex behaviors, the controllable of the opportunistic infections, etc.

For the management of VCT clinic, a main responsible person should be identified and should be supported by the hospital administrative team to introduce the confidentiality and continuity of VCT services for the clients. All nurses at all patients' contact points should be trained for a basic counselling for HIV/AIDS. A private space with good ventilation should be provided for counselling activities. A systemic record system and follow-up system should be developed in all hospitals.

2. Models and incentives for VCT activation

The following recommendations are key messages to the national HIV/AIDS program managers, ART/VCT providers at micro-level and other concerned agencies and NGO.

1. It is required a national policy to emphasize the quality of VCT that the VCT should includes three components: 1) HIV counselling, 2) Voluntary testing and, 3) Confidentiality. This is to ensure that the scaling of VCT services would not jeopardize the patient's right.
2. Integrating the VCT services into the general services is suggested and the service system should be designed for the continuity and confidentiality of services. However, special activities should be provided to reach these special target groups:
 - Sex workers
 - Migrant workers
 - Young workers in industrial units
 - Adolescents both in school and outside school
 - Drug users
 - Pre-marriage couple
3. The activities to activate the VCT including:
 - Campaign for VCT and education on VCT and HIV/AIDS
 - Incentives for VCT such as fee exemption, free condom
 - Group education and counselling at secondary / vocational school and opt-in pre-test counselling
 - Activities to change teachers' attitude in counselling
 - To establish peer groups of PHA
4. It is required a budget from the national health insurance schemes to cover the full cost of VCT, not just only for the material cost. Then the hospitals should consider allocating the budget for going out to school and providing incentives for health staff who works in this area. Additionally, matching NGOs and health staff to work together would provide incentives for the creative programs whereby the resources channeled through the NGOs are rich in this era.
5. The private-linkage system for the services including the VCT and the laboratory test should be prepared and introduced subsequently. This would rapidly increase the VCT capacity to be available when the policy to activate the VCT is launched.

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