INTEGRATING HIV COUNSELING AND TESTING INTO NUTRITIONAL CARE

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Goal

The overall aim of the Malawi programme was to mainstream HIV into the care of severely malnourished children in order to improve care for children exposed or infected with HIV.

The initial point prevalence study demonstrated a high rate of uptake of HIV testing: >90% by carers for children with severe acute malnutrition, following counseling by specially trained nurses. The uptake rate by carers for personal testing, at >70%, was also higher than anticipated. Both findings counter earlier perceptions that families would be reluctant to participate in testing programmes. During the course of the point prevalence study, ART programmes for adults were beginning to roll out and were increasingly well established in regional centres by the second period of testing. Support services, including home-based care, nutrition supplements, PMTCT programmes and cotrimoxazole prophylaxis were becoming more widely available, along with community awareness that case identification was the key to programme access. It is likely that all these factors along with the opportunity to talk privately with trained counsellors who were not normally resident in the local community contributed to the high uptake rates.

Following the results of the study, the ACF International Network has promoted HIV counseling and testing (HCT) and referral to HIV care as an integral part of the NRU/SC care package, with the objective to improve care for HIV infected malnourished children. This has been done in conjunction with the NAC from 2004-2006.

Activities

To increase knowledge and awareness of HIV amongst NRU staff, training sessions were conducted on HIV-related topics to enable them to refer patients to the most appropriate facilities. The sessions covered the basics of HIV, transmission, the link between HIV and malnutrition, and treatment and services available such as prevention of mother to child transmission, home-based care, antiretroviral therapy and family planning services. The training stressed the importance of referral to these services and the benefits that could be provided. Staff members from each of the 48 NRU supported by the ACF International Network, attended the training. District health officers and district AIDS coordinators were also invited. Refresher trainings on HIV and nutrition were conducted.

For some NRU, even where HCT services are available, factors like distance, time and financial constraints can delay or hinder uptake. Even where HCT is available on the same site but not in the actual unit, referrals will be lost between people agreeing to be tested and actually attending for testing. Therefore, the ACF International Network facilitated full HCT training for staff members of selected NRU where access to testing was more limited, to develop their capacity to implement HCT in the NRU. Trainers of Malawi AIDS Care and Resource Organisation (MACRO) facilitated this training which, in accordance with MOH regulations, lasted 4-5 weeks. Some of the staff identified for training did not reach the level of education required by the MOH to be full counsellors and these participants were trained as HCT motivators.

Although several NRU now have staff members qualified to perform HCT, this has not resulted in HCT taking place within all NRU. This is due to several factors, including lack of provision of test kits and increasing availability of HCT services within the healthcare facility (external to the NRU). Although the trained counsellors do not actually perform HIV testing in these NRU, they still play a valuable role, acting as motivators for HIV testing.

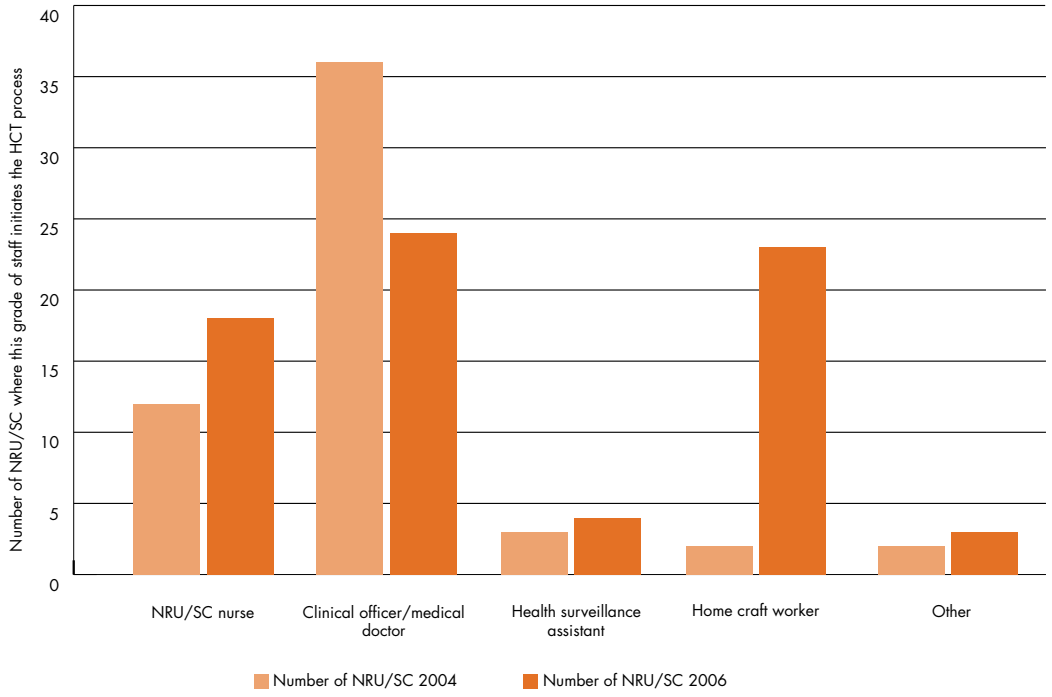
Uptake evaluation

Between September 2005 and February 2007 48 NRU and SC were evaluated to examine the uptake of counseling and testing as an integrated part of nutrition care.

The overall uptake of HCT amongst children admitted for inpatient care of SAM increased from around 30% to around 50% between 2005 and 2007, with considerable variations between NRU/SC. Those with specialised staff members trained in HCT, had the best uptake, offering and providing the service on admission. In those centres with a low uptake, HTC was not always easily available, for example when only offered by busy medical staff or in centres with particular staff shortage.

In many NRU/SC human resources are limited and more often than not, home craft workers (HCW), health surveillance assistants (HSA) and nurses have the most patient contact. Widening the range of health professionals able to initiate the offer of HCT is therefore important; this was previously felt to be a role for a clinical officer or medical doctor. Today in the NRU/SC, a higher number of nurses, HSAs, and HCWs are initiating the offer of HCT in comparison to 2004. This is shown in figure 2.

Figure 2 Staff initiating HCT in NRU and SCs 2004 & 2006



The national HIV policy in Malawi aims at routine testing for all patients from high risk groups including malnourished children. Nevertheless, rates of HIV testing of the children admitted to NRU remain below 50%. Results of a follow up evaluation done by the ACF International Network in August 2006 show that HCT is routinely done in only 28 out of 48 NRU. This is encouraging, but there is still a large proportion of NRU where referral is done on the basis of the clinical condition or doctor's/ carer's suspicions of HIV infection rather than as routine procedure. When we look at social research conducted to look at stigma and perceptions of care, it will be apparent why this is not appropriate and in fact adds to the continuing challenge of HIV-related stigma. Many staff said they would like more training on HCT, perhaps reflecting that staff members are still uncomfortable with referral for HCT and the skills required to discuss and offer testing. In general, there is also a high turnover of staff in the NRU, itself a possible consequence of the population impact of HIV. Ongoing training and support is therefore needed.

Service implications

HCT services are becoming more available and accessible to children admitted to NRU. In the near future, the increasing availability of ART for children, and access to infant HIV testing methods are likely to amplify this trend.

As HIV treatment services for children develop, routine access to HCT in all NRU, with adequate supplies of test materials and well-trained staff, would ensure that children receive timely and appropriate clinical interventions. There should be a strong move in international guidelines towards promotion of routine paediatric HIV testing, including that of infants, where it can result in access to effective HIV services. In each context, guidelines need to be adapted locally to address the complex social and holistic needs of affected children and their families with the provision of integrated clinical care programmes linking therapeutic feeding and community based therapeutic care programmes with HIV treatment programmes.