African Development Bank

THE DEVELOPMENT OF HARMONIZED MINIMUM STANDARDS FOR GUIDANCE ON HIV TESTING AND COUNSELLING AND PREVENTION OF MOTHER-TO-CHILD TRANSMISSION OF HIV IN THE SADC REGION

HTC COUNTRY REPORT

MAURITIUS

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ABBREVIATIONS

AHC	Area Health Centre
AIDS	Acquired Immune Deficiency Syndrome
AfDB	African Development Bank
ART	Antiretroviral therapy
BCC	Behaviour Change Communication
CICT	Client Initiated Counselling and Testing
CT, C&T	Counselling and Testing
CSW	Commercial Sex Workers
DHS	Demographic and Health Survey
HIV	Human Immunodeficiency Virus
HSRC	South African Human Sciences Research Council
IDU	Injecting Drug Users
MARP	Most-At-Risk Population
M&E	Monitoring and Evaluation
MOHQL	Ministry of Health and Quality of Life
MS	Member State
NAC	National AIDS Council
NACP	National AIDS Control Programme
NDCCI	National Day Care Centre for the Immuno-suppressed
NEP	Needle Exchange Program
NGO	Non Governmental Organisation
PEP	Post-exposure Prophylaxis
PFP	Project Focal Person
PICT, PITC	Provider Initiated Counselling and Testing
PLWHA	People Living with HIV and AIDS
PMTCT	Prevention of Mother to Child Transmission (of HIV)
PSS	Psychosocial Support
SADC	Southern African Development Community
SAHARA	Social Aspects of HIV/AIDS Research Alliance
STI	Sexually Transmitted Infections
SWOT	Strengths, Weaknesses, Opportunities and Threats analysis
TAC	Technical AIDS Committee
TOT	Training of Trainers
TB	Tuberculosis
UN	United Nations
UNAIDS	United Nations Joint Programme on AIDS
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

ACKNOWLEDGEMENTS

This report is based on information and support from many sources. Our thanks to the SADC secretariat for commissioning this project, and for supporting all its various phases. Thanks also to the various partners and the Mauritian National authorities and officials who contributed to the design and successful implementation of the field work. Our gratitude also to the HTC project focal person for Mauritius, Mr. Ramnarain Radhakeesoon, National AIDS Secretariat, for the substantial efforts he invested in conducting field work. This analysis was carried out by Prof John Seager (Monitoring and Evaluation Expert for the project) and Dr Njeri Wabiri (Project Director).

1. INTRODUCTION

1.1 HIV/AIDS and HTC in Mauritius

According to the Republic of Mauritius UNGASS report (2008)[1], based on 2007 sentinel surveillance data provided by the Ministry of Health and Quality of Life (MOHQL), the total cumulative HIV/AIDS cases for Mauritius amount to 3258, of whom 3107 are residents. Among the residents detected as positive, 2574 are male and 533 female, resulting in a male to female sex ratio of 5:1[2] . Death among residents registered as HIV/AIDS cases, cumulatively as from 1987 to November 2007 amounts to 217 (214 adults and 3 children) thus leaving 2890 (2410 males and 480 females) people living with the virus at present. The HIV/AIDS epidemic in Mauritius is said to be "concentrated" with estimated adult (15-49 years) prevalence of 1.8%[1] and estimated rate of infection among the IDUs ranging from 30% to 60%.

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HIV Testing and Counselling services have been extended to all 5 health regions in order to encourage HIV testing among the population in general. Three centres are operational in the district of Port-Louis where there is a higher concentration of most at risk population (MARP). According to Medical Statistics, 43,246 people were tested for HIV in 2007.

1.2 Aim and Objectives of the Consultancy

The main aim of this consultancy is to develop regional harmonized minimum standards for HTC policies, protocols and guidelines in the SADC region.

To achieve this, project team of the Social Aspects of HIV/AIDS Research Alliance (SAHARA) – see Appendix 1 -- is reviewing and analysing policies, protocols and guidelines for HTC in each SADC member state (MS), in collaboration with the HTC project focal person in the MS.

The specific objectives are to:

- identify and assess policies, procedures and frameworks on HTC, and come up with best practices in implementation of HTC policies;
- conduct field visits to engage in policy dialogue with policy makers and other stakeholders (including discussions of implementation strategies and challenges, opportunities and lessons learnt, gather views of the service users/providers);
- review gender issues and consider how men and women are involved in HTC; and
- review and analyse proposed minimum standards for HTC policies.

2. METHODOLOGY

The HTC project focal person (PFP) in Mauritius was tasked with three key responsibilities:

2.1: Identify policies, procedures and frameworks on HTC

2.2: Participate in the assessment of the policies, procedures and frameworks on HTC

2.3: Facilitate dialogues and stakeholder consultations on policies relating to HTC, including policy discussions on the development and implementation of policies, procedures and frameworks on HTC in the country.

[1] Republic of Mauritius, 2008. Country progress report: Declaration of commitment of the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS.

[2] AIDS Unit, M.O.H & QL, Sentinel Surveillance

A field guide, consisting of relevant tools and instructions for each of the tasks, was provided to the PFP by the SAHARA project team, and included tables for data collection and key questions to guide policy discussions with key HTC stakeholders in the country. The field guide was implemented in Botswana in collaboration with the SADC Secretariat. Lessons learnt were used to enrich fieldwork in the other MS.

Policy discussions, facilitated by the PFP, were held with various key stakeholders in the country, including:

- government official(s) responsible for HTC policies, protocols and guidelines;
- civil society official(s) dealing with HTC policies, protocols and guidelines;
- representative(s) of international organizations involved in HTC;
- representative(s) of private or informal sector involved in HTC policies, protocols and guidelines; and
- others as appropriate.

The policy discussions were scheduled at the convenience of the respondents, and conducted in the community or at an office where there was an undisturbed atmosphere. The PFP received direction and guidance from the SAHARA project team on how to conduct policy discussions. Selected respondents were invited by letter or email to participate in the discussions, and included officials from the national AIDS council and national AIDS coordination programmes, HTC programme and administrative staff, primary stakeholders (such as technical partners, donors and implementing agencies), and civil society.

3. FINDINGS

3.1 SWOT analysis of HTC in Mauritius

An analysis of collected data revealed the following strengths, weaknesses, opportunities and threats regarding HTC programming in Mauritius (see details in Appendices 2, 3, 4, 5and 6)

STRENGTHS	WEAKNESSES
• Strong political commitment to HIV and AIDS response • HIV and AIDS Act (2006) • Guidelines available(2008) • Rapid testing available (for outreach and MARPs) • Routine test results in 3-5 days • Good access (<10 km for all) • Testing service 5½ days a week • Mobile clinics (caravane de santé) –new innovative approach • Counselling hotline (09h00-22h00, 7 days)	• Inadequate space in existing AHC (being addressed) • Lack of sufficient trained staff (training ongoing) • Lack of transport for blood specimens • Inadequate M&E • Poor NGO Coordination
OPPORTUNITIES	**THREATS**
• All AHC staff being trained in CT • Scale-up Mobile clinics (caravane de santé) • Use of private doctors in service delivery	• Changing nature of epidemic – concentrated to generalised

3.2 Assessment of HTC policies in Mauritius

Mauritius has an HIV and AIDS Act passed in 2006. HTC models/approaches include Pre/post test counselling (Rapid Test Elisa & Western Blot) Group pre test, Provider-initiated CT, outreach/NEP CT and a few home-based CT. Only Medical /Nursing Officers and NGOs Trained Members are allowed to do CT. The goal is to have HTC in all Area Health Centres.

According to the Mauritius UNGASS report (2008), opt out method is used for HIV testing of pregnant women and there is almost no refusal of the HIV test as a part of the standard care package for ANC and best estimates from doctors are that 94-98% of pregnant women are tested for HIV.

There is good referral system encompassing condoms distribution, NEP, Detox centre and NDCCI. The Act promotes more aggressive campaign. Private doctors/clinics should be motivated to offer this service.

3.3 HTC policy gaps in Mauritius

- Partner's notification

3.4 HTC situation analysis in Mauritius

According to the Mauritius UNGASS report (2008), based on a 2004 Knowledge, Attitudes, Beliefs & Behaviours survey:

Percentage of women and men aged 15 – 49 who received an HIV test in the last 12 months and who know their results		Percentage of most-at–risk populations who received an HIV test in the last 12 months and who know their results	
15 19 yrs	0	CSW	15 /50 = 30%
20-24 yrs	8 /307 = 2.6%	MSM	8/50 = 16%
25-29 yrs	29 /1319 = 2.2%	IDU	5 /50 = 10%
Total	37 /2000 = 1.8%		

3.5 HTC approaches Mauritius

- Rapid Test, ELISA & Western Blot
- Pre/post test counselling
- Group pre test
- Provider-initiated
- Outreach Needle Exchange Programme CT for IDU
- A few home-based CT
- Mobile clinic (caravane de santé)

3.6 HTC policy discussion: Success, Challenges, Best practice views of stakeholders

A summary report on the policy discussions is provided in Appendix 6

4. RECOMMENDATIONS FOR MINIMUM STANDARDS

Issues of concern in the Mauritian situation include:

4.1 Age of Consent in testing

Especially for minors (refer to section 7.5 of HIV Act 2006 “A person may undertake a test on a minor without the consent of his legal administrator or guardian where the minor makes a written request for such test and that person is satisfied the minor understands the nature of his request.")

4.2 Training of providers

Capacity building is required

4.3 Accreditation of HTC sites

In order to ensure quality services

4.8 Referrals

There is a need to harmonize this aspect so as not to lose clients between the VCT and the Day Care Centre.

APPENDICES

APPENDIX 1: SAHARA PROJECT TEAM

NAME	TITLE
Dr. Vincent Agu	Team Leader
Prof. Karl Peltzer	PMTCT Expert
Prof. John Seager	Monitoring and Evaluation Expert
Prof. Geoffrey Setswe	HTC Expert
Dr. Njeri Wabiri	Project Director
Ms. Mercy Banyini	Researcher

APPENDIX 2: ASSESSMENT OF HTC POLICIES, PROTOCOLS AND GUIDELINES

	Yes, No, N/A and Additional comments
Is HTC policy available?	Y (HIV&AIDS ACT 2006)
Has HTC policy been approved? Indicate year	HIV&AIDS ACT 2006
Are there HTC guidelines? (indicate the year of the operational guidelines)	Y 2008 (Dr.Catherine Gaud)
When were the guidelines published?	2008
Please list the stakeholders involved in the consultation process for developing HTC policy?	Line Ministries, PLWHIVA,NGOs,Private Sector
Are policies/guidelines easily available?	Y
Is there an HTC implementation plan?	Y
Which CT methods/approaches are used?	Pre/post test counselling (Rapid Test, ELISA & Western Blot) Group pre test, Provider-initiated CT, outreach/NEP CT. A few home-based CT
Which types of staff do the counselling?	Med/Nursing Officer, Trained members of NGOs
Other relevant documents	

Comment [JRS1]: Please supply a copy or full reference

APPENDIX 3: HTC indicators

Please provide the extent of the following HTC indicators in your country (in numbers or Percentage, specify the year and the source of information

Indicator	MAU
HIV testing and counselling	43,246 yr2007 Medical statistics
Retesting at a later stage	*
HIV pre-test counselling	*
Post-HIV test counselling	*
Male involvement in HTC	* mostly male
Involvement of PLHIV or PLWHA	*

APPENDIX 4: SUMMARY OF HTC IMPLEMENTATION CHALLENGES IN MAURITIUS

Implementation Challenges	Yes, No, N/A Additional comments
Inadequate financial resources, which are often narrowly	Good govt. commitment- increase in budget of Response to HIV/AIDS (Global Fund R8 got)

earmarked by donors	
Inadequate human resources; problems with lay counsellors	
Poor partner and sectoral coordination and donor support resulting in verticalisation of programmes and poor implementation of national policies	Poor NGO participation
Stigma and discrimination	HIV & AIDS ACT 2006,Civil Status Act amended; but still a long way to go,lot of campaign to do
Inadequate support for infant feeding which remains a complex issue, requiring further research	No problem in infant feeding supply & feeding counseling
Unequal emphasis on the needs of women, their children, partners and families, and insufficient follow up within a continuum of care and assurance of adequate care, treatment and diagnosis of exposed infants	Follow up problem from the patient.HIV+ bus fare refunded when attending for treatment. Good care, treatment/diagnosis of exposed infants
Insufficient integration of HTC services and insufficient linkages with other health and social services;	From 2nd Feb another 10 AHC will provide HTC Services. Constraints: Lack of space, staff, transport
The need to decentralize implementation and service delivery, and focus on developing and strengthening of community structures and systems to include HTC;	Mobile Clinic (Caravan de Santé)
Programme monitoring, recording and reporting	Need Capacity building and Human Resource (Training in progress)
Quality assurance and impact assessment;	Continuous training, >need to be done to track poor compliance
Inadequate efforts to ensure male engagement in HTC;	NO. > campaign to sensitize population involvement in HTC
Impact of gender inequality and of gender-based violence	NA – More research on this subject is required
Lack of capacity to cost plans	Need >training& capacity building
Slow scale-up of provider-initiated testing and counselling services, where appropriate, and the limited creation of demand for these services.	!0 new HTC in operation from this month (a total of 26 Area Health Centres is operational in February & 1st week of March. Scaling up included in GFTAM proposal)
Other: Please include other challenges not covered above	

APPENDIX 5: HTC IMPLEMENTATION NEEDS IN MAURITIUS

Implementation Needs	Yes, No, N/A Additional comments
Need to speed up development of HTC policies and guidelines	
Need to improve M & E (HTC indicators, registers)	Y
Need to improve C & T (quality)	Y
Appropriate use of lay counsellors in the health care setting	Y
Improve integration of HTC into AIDS treatment and care activities	Y
Effective communication on HTC	Y
Improve community support for HTC	Y
Strengthen quality assurance for HTC services	Y

Best practice/models in HTC	Y
Other: Please include any other needs not captured in the table	

APPENDIX 6: SUMMARY OF DIFFERENT POLICY DISCUSSIONS

Please tell me about the Country's HTC programme, what has been its great achievements or strengths, and where you think it could be improved?"

- Testing was available since 1988. By 1999/2000, 5 Regional VCT units came up.
- Full ANC coverage in all ANC clinics.
- HTC is Free, Anonymous, maintain Confidentiality, good Referral system – Condoms distribution, NEP, Detox centre, NDCCI.
- 10 new HTC is operational from this month and more to come so as to have HTC in all Area Health Centre.
- More aggressive campaign.
- Private doctors/clinics should be motivated to offer this service.

What are the gaps in HTC policies? Give examples.

- Partner's notification

What are the HTC implementation challenges?

Lack of space in existing AHC structure, problem of trained staff & transport for blood transportation which will be tackled soon

Describe the characteristics of HTC service users?

General population but mainly IDUs & also those having risky sexual behaviours are on the increase.

Which groups of people does the CT service mainly target? What is the age and gender of the clients who used your counselling and testing services during the past year?

- Open to the population at large though a lot of promotion is done during sessions with youth in-school and out-of-school settings – Age range is between 17 – 30 yrs

HIV Counselling & Testing (CT) Services

Is HIV testing done on site? If YES, is rapid HIV testing available with clients being given their HIV test result on the day of testing? If NO, how long do clients have to wait for a HIV test result? ___5___ days

- Rapid Testing is available, especially in outreach sessions with MARPs.

Number of days the client has to wait varies from 3-5 days depending on the region where the test has been carried out. Only one National Reference laboratory available in Mauritius

Are you familiar with the CT methods/approaches used in the country?

Do you use traditional one-one-one HTC, or is CT part of a prevention of mother-to-child transmission (PMTCT) programme, Provider-initiated CT, Group counselling (pre-test), Couples

counselling, Family counselling, Partner counselling (partners of HIV-positive people), Home-based CT or any other method of CT?

All those methods/approaches are available in Mauritius. Recently, the MOH has started a mobile clinic (Caravane de santé) – going into the community to provide a series of services (NCD, nutrition, dental services and HIV Counselling & testing)

Which types of staff do the counselling?
Is it Health workers, Professional counsellors (registered with the country's professional health authority) or Lay counsellors.

It is stipulated in the HIV/AIDS Act only a medical Officer, a Nursing Officer and a Registered Member of an NGO trained in counselling can carry out the counselling.

Do you know of HTC policies in this country?
How closely do the HTC policies, protocols and guidelines match practice?

Very closely as it is well detailed in the HIV/AIDS Act, moreover there are continuous training/workshop/seminars among the staff.

Where are HIV Counselling & Testing (CT) services provided in this country?
Is it nationally (all provinces), provincially (services spread throughout one or more provinces in the country), district (services spread throughout a health district or a municipality) or local (services spread over an area smaller than a health district or municipality)?

Across the island. One VCT centre in each of the 5 health regions, and one at the Day Care Centre. As mentioned above, recently access to HTC has been extended by making it possible to do the test in 10 AHCs & the remaining 15 AHCs by the end of this year. The mobile clinic (Caravane de santé) – going into the community to provide a series of services (NCD, nutrition, dental services and HIV Counselling & testing). The latter was introduced recently by the new Minister of Health & QL. It shows the political will & commitment to HIV/AIDS response. The services are within the reach of the population, i.e. less than 10 km.

Service Load
How many HIV counselling sessions were conducted (across all service delivery points combined) in the past year?_____ Difficult to get (M&E tools being finalised
How many HIV tests were done (across all CT service delivery points combined) in the past year? 43,246 in 2007

Hours of Operation of HIV Counselling & Testing (CT) Services
How many days per week are counselling and testing services available at service delivery points in this country?

6 Days per week
VCT & AHC 9 am – 4 pm (Monday to Friday)
9 am – noon (Saturday)
Community Testing 1 pm – 6 pm
+ a hot line services for counselling and information - 9 am – 10 pm (7 days a week including holidays)

What are the service delivery points for providing HIV Counselling & Testing (CT) in this country?

Is it HTC clinics, hospitals, community health centres, clinics, (stand-alone) counselling and testing facilities or other fixed HTC service points? What is the approximate number of service delivery points in urban/rural areas?

As a small island all health service points are at walking distance & equally dispersed in Rural/Urban areas.
7 VCT centres
20 AHC
142 PMTCT point + 1 community testing across the island and 2 NEP Caravan

What are the strategies to promote HTC uptake in the country?

- Training of AHC Staff in C&T
- Media campaign to promote testing
- Hotline services

In your view what issues should proposed minimum standards for HTC in SADC critically consider under each of the following themes?

a) Age of Consent in testing

Specially for minors consider this part (refer to section 7.5 of HIV Act 2006 "A person may undertake a test on a minor without the consent of his legal administrator or guardian where the minor makes a written request for such test and that person is satisfied the minor understands the nature of his request.")

b) Standards for service provision
No response

c) Training of providers

Capacity building

d) Accreditation of HTC sites

To ensure quality services

e) Quality assurance of HTC services
No response

f) Monitoring and evaluation of HTC policies
No response

g) Comprehensive HTC approaches
No response

h) Referral system

A need to harmonize this aspect so as not to lose a client between the VCT and the Day Care