



The USAID HIV/AIDS Prevention Program for Central America and Mexico implemented in Partnership with PSI, PASMO and the Institute for Reproductive Health

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## Abbreviations and Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
FBO	Faith-Based Organization
FSW	Female sex workers
GLBTT	Gay, Lesbian, Bisexual Transgender, Transvestites
IRH	Institute for Reproductive Health, Georgetown University
HIV	Human Immunodeficiency Virus
MOH	Ministry of Health
MSM	Men who have sex with men
NGO	Non-governmental organization
PDQ	Partnership Defined Quality
PSI	Population Services International
PASMO	Pan-American Social Marketing Organization
STI	Sexually transmitted infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
VCT	Voluntary Counseling and Testing

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“Stigma is an attribute that is deeply discrediting and results in the reduction of a person or group. The ultimate effect of stigma is the reduction of the life chances of the stigmatized through discriminatory actions.”

(Goffman, 1963)

“Respeto, confidencialidad y buena atención en un ambiente amigable y seguro son parte de tu derecho a la salud.”

(PASMO-IRH slogan)



# **USAID HIV/AIDS Prevention Program for Central America and Mexico in Partnership with PSI, PASMO and Georgetown University/IRH**

## **Executive Summary**

### **Background**

HIV/AIDS has become a global pandemic, with an estimated 33 million people currently living with HIV (UNAIDS, Report on the global HIV/AIDS epidemic 2008). A response to this situation has been to improve access and quality of current Voluntary Counseling and Testing (VCT) services in parts of the world where, despite availability of these services, they are not widely used by the target population women and men 15-49 years of age. VCT services provide information to clients about their HIV status and, for those who test positive for the disease, facilitate appropriate treatment and care. There are benefits too for clients with negative results, as VCT can provide tools and skills to maintain their negative status. Despite these benefits, different barriers exist that prevent people from seeking these VCT services, more often because of the stigma and discrimination associated with getting tested for HIV. This is more evident among populations in situations that make them more vulnerable to stigma and discrimination, such as female sex workers (FSW) and men who have sex with men (MSM). Increasing the use of existing VCT, through improved access to quality services, was the main objective of the USAID HIV/AIDS Prevention Program for Central America and Mexico implemented by Population Services International (PSI), the Pan-American Social Marketing Organization (PASMO) and the Institute for Reproductive Health (IRH) at Georgetown University.

### **IRH's Collaboration**

Through a four-year sub-award from PSI, IRH supported public and NGO efforts in Guatemala, El Salvador, Nicaragua, Panama, Belize, and Mexico to increase utilization of VCT services among vulnerable populations by improving the quality of services. IRH assembled a team of qualified staff centrally and in each of the five intervention countries to carry out the sub-award's main goal. Activities to achieve this goal were completed during the period of January 2006 to September 2009. This report describes the interventions carried out by IRH, and the research that guided their design and implementation. Lessons learned from this experience and recommendations for future actions also are discussed.

### **Formative Research**

A first step in our collaboration with PASMO was the design of a needs assessment involving facility assessments, simulated clients, and consultations with stakeholders. The needs assessment was initially conducted in El Salvador, Guatemala and Nicaragua, and was subsequently adapted for Belize, Mexico and Panama. This research also provided the baseline from which to measure the impact of IRH interventions designed to strengthen provider competency and improve the quality of care they provide patients. Baseline activities consisted of facility assessments, exit interviews with clients, simulated client visits and a consultative process with clients and providers. IRH's work began with mapping visits to each country to meet with key stakeholders and negotiate programmatic priorities and geographic areas of intervention. A rapid assessment of the VCT services provided in each assigned area also was completed. Subsequently, a consultation with providers and clients was conducted to identify quality

indicators and determine which service areas would need improvement and reinforcement. The Partnership Defined Quality (PDQ) methodology developed by Save the Children<sup>i</sup> was adapted and used for this consultative process (Annex 1).

The PDQ was an effective tool for stimulating providers to reflect on their treatment of vulnerable groups. Findings highlighted the social distance between providers and their clients as well as common fears and misconceptions. Results also showed that providers lacked knowledge and skills to serve vulnerable groups. An important outcome of the PDQ process was the development of client and provider defined quality indicators for VCT services. These indicators were then used to guide the development and evaluation of the intervention to improve the performance of VCT providers.



**PDQ Phase IV: Building the Bridge**

All sites assessed in the initial three countries offered free screening and treatment for sexually transmitted infections (STIs), with no specific services for MSM or FSWs. However, these services were being offered without privacy for counseling mostly due to lack of space and by service providers' lack of familiarity with HIV-AIDS national norms and protocols. In El Salvador, for example site assessments revealed few providers had been trained in their use or had access to them. In Nicaragua only half of the providers used national guides and norms for VCT. Furthermore, few facilities in all three countries had personnel who had been trained on issues related to stigma and discrimination. Other shortcomings evidenced through site assessments were a weak referral system for auxiliary services, in particular for HIV positive clients, condom stock outs and limited supervision systems, including lack of supervision forms and use of informed consent.

Based on results of this comprehensive assessment, IRH designed the capacity building strategy for VCT providers that was implemented in Belize, El Salvador, Nicaragua and Panama.

### **Intervention within Public and Private Sector Programs**

A strategy to build provider capacity over time was developed to improve VCT services. The rationale for this strategy relied on: (1) behavioral research that shows training alone is not sufficient to change provider attitude and behaviors; (2) findings from our formative research indicating that programs would not release healthcare providers to participate in extended training events; and (3) empirical evidence that stigma and discrimination stretches beyond the consultation room to involve non-clinical staff. IRH completed an extensive review of existing resources to draw from for training materials and resources from international (UNAIDs, EngenderHealth, Family Health International, etc.) and country programs and local indigenous organizations working in HIV and stigma and discrimination.

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<sup>i</sup> Lovich, et.al. *Partnership Defined Quality: A Tool Book for Community and Health Provider Collaboration for Quality Improvement*. Save the Children, Westport, Connecticut, 2003.

The capacity building strategy comprised several components that led to the certification of providers who completed the necessary steps while evaluating their progress during the process. The certification process entailed:

- Two days of training complemented by a series of seminars to reinforce topics covered in the initial training workshop.
- Educational sessions at their workplace to sensitize all clinic staff about stigma and discrimination.
- Supervisors visited counselors two and four months after initial training to assess skills through the application of a structured checklist, reinforce information, mentor and keep providers engaged.

To help providers strengthen their counseling skills and follow the VCT protocol consistently, IRH developed a simple, comprehensive double-sided-page job aid (Annex 2) that served the dual purpose of a provider checklist for support and self-assessment and a supervision tool. Providers and supervisors found the tool equally useful, as it provides concrete parameters and simple questions to broach sensitive topics that providers generally find embarrassing or difficult to address. Several local programs have adopted it in both public and private sector programs.

The following table shows PSI/PASMO project performance indicators that IRH was responsible for reporting on a quarterly basis. These indicators contributed to the project goal under IRH's sub-agreement of improving the quality of VCT services. As reflected in this table, results exceeded the target goals for in every indicator in El Salvador, and Nicaragua for VCT-related activities as well as Guatemala for FBO activities. For Belize and Panama most indicators were met and exceptions are explained by participant drop-out as well as funding and time limitations to reach the established goal.

While the capacity building strategy was successful in raising provider awareness regarding their own

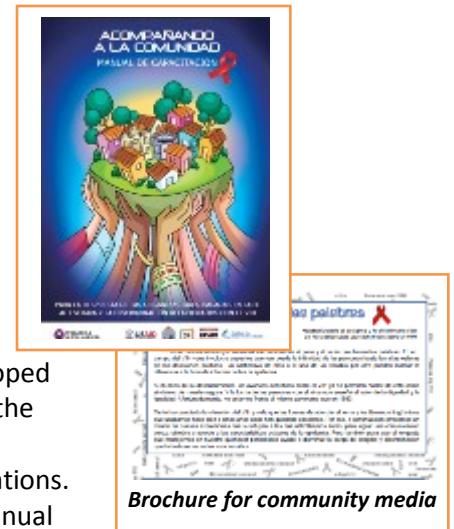
	Indicator 9 Number of service outlets providing counseling and testing according to national and international standards		Indicator 10 Number of individuals who received counseling and testing for HIV and received their test results		Indicator 13 Number of individuals trained in counseling and testing according to national and international standards		Indicator 17 Number of individuals trained in HIV-related stigma and discrimination reduction	
	Actual by Sep. 09	Target	Actual by Sep. 09	Target	Actual by Sep. 09	Target	Actual by Sep. 09	Target
Belize	20	20	N/A	N/A	16	40	114	0
El Salvador	130	50	N/A	N/A	130	100	598	45
Guatemala	N/A	N/A	N/A	N/A	N/A	N/A	42	40
Nicaragua	12	9	N/A	N/A	73	36	96	100
Panamá	18	18	500	N/A	55	36	637	25

attitudes and behaviors toward MSMs and FSWs, further efforts are needed to strengthen their ability to broach sensitive issues with VCT clients.

## Intervention with FBOs and Church Leaders

Parallel to working with MOH and NGO programs to strengthen the quality of VCT services, IRH carried out targeted interventions with Faith-Based Organizations and Churches. The main goal of these initiatives was to strengthen their communication strategies to reflect a human rights and sexual diversity perspective in their messages about HIV and its prevention. IRH efforts with FBOs and Church leaders involved:

- **Tailoring the methodologies and tools developed for the VCT component to the meet FBO needs.** A training manual<sup>ii</sup> was developed and pre-tested, and informational resources designed to sensitize the religious community to the importance of reducing the stigma and discrimination associated with HIV and the most vulnerable populations. Communication tools and a guide to adapt and use the training manual also were developed and disseminated among the participating FBO and church groups.
- **Carrying out workshop and sensitization events at political, institutional and community levels to address stigma and sensitization with a human rights perspective.** With support from PASMO's regional office, a regional workshop was conducted in Antigua, Guatemala with key FBO representatives and religious leaders from Belize, El Salvador, Guatemala, Mexico and Nicaragua, with the goal of increasing their participation in HIV prevention and reducing stigma and discrimination in their communities. In addition, with support from PASMO's local representative, IRH coordinators in each of the five countries conducted sensitization workshops with church leaders to familiarize them with the tools and resources and provide opportunities for hands-on use of the different methodologies. These workshops also involved support for leaders to further articulate their work plans for stigma and discrimination reduction activities within their program and communities.



Brochure for community media

Evaluation efforts for the FBO component of IRH's work were limited to feedback from participants in sensitization sessions and in-depth interviews with leaders for the purpose of collecting information to guide the design and refinement of the training manual and accompanying resources.

## Evaluation and Key Findings

The strategy was evaluated from the perspective of providers, program managers, and clients and involved analysis of: (a) pre and post tests of knowledge; (b) participants' feedback collected from their evaluation of the training interventions; (c) provider follow-up visits; (d) an anonymous online survey of trained providers; (e) post-intervention simulated clients observations, and (f) in-depth interviews with MOH and NGO program personnel, IRH coordinators and community stakeholders.

<sup>ii</sup> The training manual for FBOs was developed in Spanish, in collaboration with Ayuda de la Iglesia Noruega and titled *Acompañando a nuestras comunidades: Manual de capacitación para la respuesta de las OBFs al estigma y la discriminación relacionados con el VIH*.

Results of pre- and post-tests and follow-up visits with service providers showed an increase in providers' knowledge of the VCT protocol and improvements in the quality of services as a result from their participation in the certification process.

The certification process was effectively carried out in a standard manner in all countries, with slight modifications to accommodate local needs. The process was perceived in a positive manner by country representatives and stakeholders. The stakeholders attributed the success of the certification process to the follow up component of the process; this was identified as a novel and distinct aspect of the intervention when compared to other type of training approaches. Data from the surveys (from workshops and online), simulated client observations, follow up visits and interviews suggest that the capacity building strategy was effective in strengthening provider skills. There was significant improvement in provider attitudes towards MSM and FSW and in their knowledge of the VCT process. Privacy and confidentiality improved, as did the quality of counseling (i.e., providers were better able to assess risky behaviors and discuss them with their clients). The results show an improvement in HIV knowledge and counseling skills across all countries. The certification process provided an outlet for providers to reflect on their attitudes and biases towards FSW and MSM; it was revealed in the interviews that many providers struggled with their own beliefs while providing services to these populations. This was an important aspect, as the providers showed what they had learned when they delivered their respective sensitization talks to their coworkers. Finally, the materials developed for the project, in particular the VCT checklist, were highly valued by local authorities and organizations and have already been adopted by a number of programs. In each country, stakeholders mentioned their interest in continuing the capacity building strategy on their own, citing funding as the main obstacle. However, some organizations and agencies indicated that they will continue particular elements of the certification process by using current certified providers as mentors.

## **Lessons Learned**

A number of lessons were identified during the formative research phase and throughout the planning, design, implementation and evaluation of the interventions.

- Stakeholders and providers perceive the value of ongoing capacity building/mentoring strategy, as opposed to one-time training events.
- All intervention countries had comprehensive guidelines and protocols that were share with providers during the training process. However, emphasis on easy-to-use, simple job aids that contribute to agile, effective counseling is critical to ensure protocols are operationalized and actually used in service delivery.
- Programs should continue and foster the active participation of members of vulnerable groups in the planning, implementation, and evaluation of interventions, thereby promoting group empowerment and project ownership.

- Although there are benefits to a regional strategy, it is important to maintain flexibility to adapt to local context and needs.
- Approaching stigma and discrimination through the lens of human rights and sexual diversity is a more effective strategy than focusing on specific vulnerable groups, which may have the unintended effect of further stigmatization.
- Synergy is produced by the passage of legislation guaranteeing human rights and preventing stigma and discrimination at the same time capacity building efforts are underway to address these issues. Our project was implemented at a time when this legislation was enacted or under consideration and the timing for implementing the intervention was right.

## **Recommendations**

This initiative resulted in an effective and popular capacity building strategy to improve the competency of VCT providers and reduce stigma and discrimination. The manual and IE&C materials for addressing stigma and discrimination among FBOs were also valuable products of this collaboration, as evidenced by high demand among organizations to continue work in this area. The results of the formative research, intervention and evaluation provide valuable recommendations for future initiatives to increase the quality and utilization of VCT services and reduce stigma and discrimination. IRH's recommendations below are directed at programs, researchers and donors.

- In addition to training VCT providers, it is important to direct sensitization efforts to all clinic/health personnel (waiting room, lab, other health providers and other clinic staff) to effectively address issues of stigma and discrimination in service sites.
- VCT provider training should integrate a rights-based approach in service delivery, particularly to marginalized populations such as MSMs and FSWs. This will ensure that their rights are respected and unfair discrimination is avoided.
- In order to maximize the effectiveness of training initiatives, concerted efforts are required to ensure coordination between Ministries of Health, national training institutions and cooperating and donor agencies.
- The psychological needs of VCT personnel should be addressed as part of the efforts to improve the quality of services. The well-being of service providers is reflected in the quality of the services they offer to clients. Acknowledging work-related stress and giving providers the tools for managing it is a minimal investment that generates significant and long-term positive impact on services.
- Continue to institutionalize and encourage use of the VCT checklist as a tool to help service providers become familiar with a complex or detailed service protocol and use as guidance to address sensitive issues during counseling.

- Disseminate widely the training manual and materials to donor agencies, cooperating agencies, Ministries of Health, training institutions and other organizations so that they can use the manual or elements of the manual in their work.
- Given the significant amount of funds invested into HIV and the large number of actors, it is imperative that donors ensure that cooperating agencies work together with Ministries of Health and other agencies to achieve smooth coordination and avoid duplication of efforts.
- Continue efforts to engage FBOs in HIV activities through distribution of training and IEC materials and continued support to FBO networks in each country.

# I. Introduction

## 1. Background

A response to the global HIV/AIDS epidemic is essential in achieving development goals. Globally, there are an estimated 33 million people living with HIV. While this number has stabilized since 2000, there is still an increase as a result of the on-going number of new infections each year (UNAIDS, Report on the Global HIV/AIDS Epidemic 2008). In the past few years, voluntary counseling and testing (VCT) has become an important component of the global response to HIV/AIDS. It is estimated that from 2004 to 2008, 45 million people, mostly in the developing world, received VCT services with support from PEPFAR. Despite this increase in use of VCT services, VCT remains relatively uncommon worldwide as the proportion of people tested between the ages of 15-49 does not exceed 31% in selected PEPFAR countries (CT in Focus, Vol. III, Issue 1, Feb. 2008).

VCT is an important tool for preventing the spread of HIV. It allows individuals to know their own status and to evaluate their behavior and its consequences. A negative test result offers a critical opportunity to reinforce the importance of safe and risk-reducing behaviors. A person who tests positive can receive referrals to support services, and learn what their HIV status means and what responsibilities they have to themselves and others. Despite the importance of VCT, several obstacles prevent individuals from getting tested; stigma, fear of a positive result, lack of treatment options and concerns about confidentiality are still major barriers to seeking VCT services. Moreover, in many countries the majority of people do not know where they can be tested.

Issues of stigma, privacy and confidentiality have been articulated by vulnerable populations<sup>1</sup>, including men who have sex with men (MSM) and female sex workers (FSW), as barriers to accessing VCT services. The lack of trust in health personnel coupled with the perceived negative attitude of health providers often prevent individuals from getting tested and receiving counseling that can modify behaviors and result in healthy outcomes.

Increasing the use of existing VCT services will require strengthening service delivery quality and improving access to care and support services. Behavior communication change campaigns promoting existing services will fail to sustain increased client-flow unless quality standards are consistently met. Clients who perceive that they are judged by providers, or who do not receive adequate counseling, for example, are not likely to recommend services to their peers.

As part of the “USAID HIV/AIDS Prevention Program for Central America and Mexico Implemented in Partnership with PSI and PASMO”, the Institute for Reproductive Health (IRH) at Georgetown University, through a four-year subagreement from PSI, supported public and NGO efforts in Guatemala, El Salvador, Nicaragua, Panama, Belize, and Mexico to increase utilization of VCT services among

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<sup>1</sup> Vulnerable populations refers to communities facing high risks of HIV infection but are marginalized by society including: men who have sex with men (MSM), transgender, gay, lesbians, sex workers, detained / prison populations, injecting drug users, and migrant populations. As a result of their status, as outside of the mainstream and highly stigmatized, programs rarely reach them with general and they are often excluded, or exclude themselves, from many health & HIV/AIDS services.



vulnerable populations by improving the quality of services. Project activities were initiated in January, 2006 and carried through September, 2009.

## **2. Project Objectives**

The project had two primary objectives:

- 1) Improve the quality of counseling and VCT; and
- 2) Increase access to and increase demand for VCT.

The Institute was responsible for strengthening the quality of VCT services in an effort to increase the use of these services among men that have sex with men (MSM) and female sex workers (FSW). PSI/PASMO was responsible for creating a demand and increasing access to VCT services through behavior change communication (BCC) interventions that promoted healthier behaviors. Activities were complementary since BCC is intended to increase the use of services, while quality services will promote healthier behaviors. Further, satisfied VCT clients will promote services through word of mouth, thus increasing their utilization.

IRH also worked with faith-based organizations (FBOs) to address stigma and discrimination associated to HIV/AIDS and to promote VCT services. Following results from its formative research, IRH developed and tested a capacity building strategy to strengthen and improve the quality of VCT services in study areas.

## II. Formative Research

IRH conducted formative research to develop a shared definition of quality VCT services among stakeholders and identify problems in quality and access, especially for vulnerable groups such as FSW and MSM. Research began with consultations with stakeholders (VCT service providers, FSW and MSM) to define quality VCT services. Once consensus was reached on the key elements of quality, facility assessments were conducted in Guatemala, Nicaragua and El Salvador to identify areas where intervention was needed. These assessments included simulated client visits, structured observation of infrastructure and interviews with providers and clients. This section will present a summary of the methodology and results of the stakeholder consultations and facility assessments. Full reports for each of these components are available for each country in Spanish.

### 1. Consultations with Stakeholders: Defining Quality

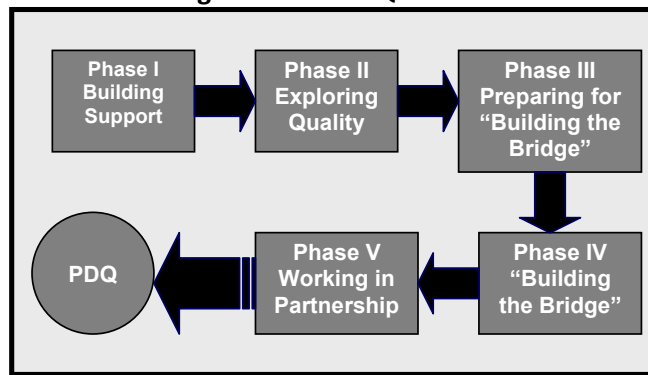
IRH applied the Partnership Defined Quality (PDQ) methodology in El Salvador, Guatemala and Nicaragua to bring together vulnerable populations and providers to develop a shared vision of quality VCT screening services.<sup>2</sup> The PDQ methodology was developed to improve the quality and accessibility of services by involving the community in defining, implementing, and monitoring the quality improvement process.

The PDQ methodology, a participatory approach developed by Save the Children and adapted by IRH to focus on VCT services, helped create a forum for providers and at-risk groups to address negative perceptions and practices about the quality of services. It also served to initiate a sensitization process for providers, which was essential in addressing stigma and discrimination. Most importantly, it involved the target groups in the planning, implementation and evaluation of program activities. Workshops with providers, FSW and MSM created a forum for each group to voice their concerns, needs and priorities regarding quality VCT services. The methodology facilitated open dialogue and consensus-building among people with different perspectives. The PDQ process also was used to help define process indicators and mechanisms to assess progress towards improving client satisfaction, availability of quality services, provider attitudes, utilization of VCT/STI screening services by FSW and MSM, and health seeking behaviors among FSW and MSM.

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<sup>2</sup> Lovich, et al. Partnership Defined Quality: A tool Book for Community and Health Provider Collaboration for Quality Improvement. Save the Children, Westport, Connecticut, 2003.

**Figure 1: The PDQ Process**



#### *Phase I – Building Support*

A first step in building support for improving VCT and STI screening involved explaining the purpose and the benefits of the quality improvement process, as well as the partnership approach. By providing a focused explanation of the purpose of PDQ to different stakeholders, IRH helped develop the initial interest and support needed for service improvement.

#### *Phase II – Exploring Quality*

Workshops were conducted separately with health providers and target groups to continue to build interest in, and ownership of, the quality improvement process; explore views on quality, their perceptions of the obstacles to quality health care and counseling; and mobilize a core group of providers and community members to remain involved in the partnership process. At the end of each meeting with target groups and health providers, there was an opportunity for reflection and analysis of the issues discussed. Representatives from each group were also selected by their peers to present the perspective of the vulnerable groups and the provider perspective at the “Building the Bridge” session.

#### *Phase III – Preparing for “Building the Bridge”*

In preparation for the next phase of the process, “Building the Bridge”, representatives from the FSW and MSM groups met to review information and establish a common voice. Representatives from the provider groups also held a similar meeting. During these separate sessions, participants categorized information, integrated it for presentation, analyzed the gaps, and identified possible ways to bridge differences between providers and the community.

#### *Phase IV – “Building the Bridge”*

During phase IV, the groups had to bridge gaps in language, culture and perspective and dialogue about quality. Once they developed a shared vision they could begin to work as a team. This process, which occurred during a half-day workshop with health providers and representatives of the target groups selected earlier, became the launching pad for the ongoing quality improvement initiative. It provided an understanding of the needs and perspectives of quality among vulnerable groups and health providers, fostered mutual respect between these groups, and integrated their perspectives into a shared vision of quality.

Across the three countries, the providers' perspectives on quality were not that different from that of the FSW and MSM, and the identified problems were also similar. Thus reaching consensus on a common vision was achieved without much controversy.

**Table 1. Participants in PDQ Process by Country**

	<b>Sites</b>	<b>MSM</b>	<b>FSW</b>	<b>Providers</b>
<b>El Salvador</b>	2	56	23	61
<b>Nicaragua</b>	3	50	40	43
<b>Guatemala</b>	4	12	39	23
<b>Total</b>	<b>9</b>	<b>118</b>	<b>102</b>	<b>127</b>

A summary of the shared visions of quality services appears in the table below:

**Table 2. Shared Vision of Good VCT Services – Indicators of Quality**

<b>Category</b>	<b>Indicator</b>
<b>Facility, equipment and supplies</b>	
Physical environment	<ul style="list-style-type: none"> <li>• Cleanliness</li> <li>• Large attractive waiting areas with sufficient seating</li> <li>• Private consultation rooms with doors, lights and good ventilation</li> <li>• Clean bathrooms (with water)</li> </ul>
Supplies and medicines	<ul style="list-style-type: none"> <li>• Test kits</li> <li>• Medicines (especially for treating STIs)</li> <li>• Variety of condoms (available without a consult)</li> <li>• ARVs</li> <li>• Lubricants (available without a consult)</li> </ul>
<b>Personnel</b>	
Interpersonal relations	<ul style="list-style-type: none"> <li>• Good treatment by providers <ul style="list-style-type: none"> <li>○ Ethical and fair</li> <li>○ Friendly and respectful</li> <li>○ Motivated and dynamic</li> </ul> </li> <li>• Good attention by providers <ul style="list-style-type: none"> <li>○ Follow counseling norms</li> <li>○ Eliminate interruptions</li> <li>○ Confidentiality</li> <li>○ Punctuality</li> </ul> </li> </ul>
Training/Knowledge	<ul style="list-style-type: none"> <li>• Training on quality</li> <li>• Understanding of sexual diversity</li> <li>• Psychologist available</li> </ul>
<b>Services, systems and procedures</b>	
Availability of services	<ul style="list-style-type: none"> <li>• Pre and post test counseling</li> <li>• Counseling for PLWHA and their partners</li> </ul>

	<ul style="list-style-type: none"> <li>• Counseling on STI</li> <li>• Counseling on self-esteem</li> <li>• Individual, rather than group consultations</li> <li>• Services for underage FSW</li> <li>• Family planning services</li> <li>• Integral care for referrals to non-STI/VCT services</li> </ul>
Accessibility to services	<ul style="list-style-type: none"> <li>• Accessible locations</li> <li>• Security guards at facilities</li> <li>• Accessible hours of operation</li> <li>• Free HIV tests</li> </ul>
Access to supplies and medicines	<ul style="list-style-type: none"> <li>• Condom dispensers</li> </ul>
Timeliness/Time-related	<ul style="list-style-type: none"> <li>• Short waiting time for consultations</li> <li>• More time for individual counseling</li> <li>• Timely receipt of test results</li> <li>• Same day appointments</li> </ul>
Referral network	<ul style="list-style-type: none"> <li>• Referral for other services</li> </ul>
Awareness of norms and procedures	<ul style="list-style-type: none"> <li>• Knowledge and application of the laws on HIV/AIDS</li> <li>• Knowledge and respect for human rights</li> </ul>
Access to IEC materials	<ul style="list-style-type: none"> <li>• Posters promoting getting tested</li> <li>• Access to information on NGO services</li> <li>• Educational materials on HIV/AIDS/STI</li> <li>• Videos on prevention in waiting areas</li> </ul>

In addition to a clear vision of good quality services, the PDQ process helped to identify areas where improvements were needed. Among the findings, priority areas identified included discriminatory attitudes and behaviors, systems and infrastructure and counseling, some of which were possible to address by this project.

#### *Findings from the PDQ Process*

Discriminatory Attitudes: Providers and other personnel discriminate against MSM because of sexual orientation and FSW because of their line of work (discrimination includes inappropriate comments and gestures and unfair practices such as making clients wait longer for services). At the same time, MSM and FSW do not feel empowered to request quality services. This is more pronounced among FSW. Their participation in the meetings was limited because of their work schedule, fear of speaking out, limited knowledge regarding rights, and limited understanding of the concept of quality. Also of concern is that other users of health services discriminate against MSM and FSW in the waiting room.

Systems and Infrastructure: Ensuring adequate systems and infrastructure in public sector systems is always a challenge. Many concerns were identified during the PDQ process such as cleanliness, availability of condoms, lubricants and tests, delay in providing test results, weak referral systems, and lack of privacy, were outside the scope of this project. The capacity building strategy developed and tested during this project, however, did address the following areas:

- Many providers have not been trained in counseling and lack knowledge of existing VCT norms and protocols.
- Job aids to support VCT services are not available.

- Existing service delivery norms and patient flow do not allow enough time for adequate counseling (most allow 15-20 minutes).
- Providers have high workloads and do not have support to prevent burnout.
- Comprehensive health services are not offered to MSM and FSW (e.g. family planning for FSW).

Counseling: One aspect to improve upon with an intervention was providers counseling skills given that:

- Counseling is often not provided after testing and fails to effectively assess risk.
- Sufficient, easy-to-understand information is not provided.
- Appropriate IEC materials for MSM/FSW are lacking.

### *Lessons Learned from the PDQ Process*

The experience with the PDQ demonstrated that consulting service providers, MSM and FSW groups to improve VCT and STI screening services created a safe forum for clients and health providers to voice their concerns regarding quality VCT services. Moreover, involvement in the consultation process increased awareness of program initiatives among MSM and FSW communities and health providers and involved them in quality improvement efforts.

Building relationships between health providers and the communities they serve was key first step before developing and launching an intervention to address quality of care issues. This consultative process should be viewed as an integral component of the intervention and not regarded as a preparatory step of the program.

The PDQ methodology proved an ideal tool for addressing negative perceptions and practices between providers and vulnerable groups and to begin the process of sensitizing stakeholders to existing stigma and discrimination. During the process we found that providers were more inclined to collaborate with vulnerable groups than anticipated. It is worthwhile to note that some vulnerable groups are less empowered than others, affecting participation and commitment. Special attention to bringing these groups to an optimal level of participation is necessary in the early phases of the consultation process.

An important outcome of the PDQ process was the development of client and provider defined quality indicators for VCT services. These indicators were then used to guide the development and evaluation of the intervention to improve the performance of VCT providers, by building their counseling skills and ensuring that every VCT client of affiliated clinics receives non-judgmental, confidential, personalized risk reduction counseling.

A copy of the full report of the PDQ process followed by IRH is included as Annex 1.

## **2. Facility Assessments and Simulated Client Visits: Assessing Quality of Care**

Facility assessments were conducted in MOH and NGO facilities which provide VCT services in Nicaragua, El Salvador and Guatemala. The purpose of the assessments was to: 1) identify the needs of VCT service providers; 2) evaluate the access, availability and quality of VCT services; and 3) identify opportunities for improvement. The assessments included site observations, simulated client visits, and interviews with providers and clients. The key results of each of the three countries are presented below. Complete reports for each country are available in Spanish.

**Table 3. Facility Assessment: No. of Facilities, Simulated Client Visits and Exit Interviews by Country**

	<b>El Salvador</b>	<b>Nicaragua</b>	<b>Guatemala</b>
Local sites	Sonsonate, La Libertad, San Salvador, Usulután, La Paz, San Miguel, La Unión	Managua, Chinandega, Leon, Masaya, Bluefields	Guatemala, Santa Rosa, El Progreso, Jutiapa
Number of facilities visited for assessment	50	21	18
- NGOs	14	10	5
- MOH	37	11	13
Number of facilities with simulated client visits	32	16	-
Number of simulated client visits	102	51	-
Number of client exit interviews	302	239	-

*Site Observations*

The research protocol and instruments used for the different needs assessment components were approved by the Georgetown University Internal Review Board (IRB) and the Ministry of Health in each country. Instruments are included in Annex 11.

Interviews/Observations: A sample of facilities representative of the range of service delivery points and regions included in the project catchment areas in each country (Table 3) was selected. Interviewers visited each facility, completed an observation check list, interviewed VCT providers, and when feasible, conducted exit interviews with clients who had received an HIV test during their visit. Experienced interviewers were recruited through participating organizations and received a three-day training which included an introduction to HIV and VCT services, interviewing techniques, how to complete the interview and observation forms and practice in the field.

The results show that VCT services were available in almost all the MOH facilities and most of the NGO sites. In all three countries, public sector VCT services are available free of charge. Most sites assessed in the three countries also offered screening and treatment for sexually transmitted infections (STIs), with no specific services for MSM or FSWs. Overall, there seemed to be a lack of VCT and STI support materials and training. In Nicaragua and Guatemala educational materials were rarely available and in El Salvador those materials that were available were used infrequently. Another concern in all countries was the lack of privacy for counseling, primarily due to lack of space.

With regards to norms and protocols for VCT services, norms and protocols were available in most MOH facilities in El Salvador, but not all providers had been trained in their use or had access to them. In Nicaragua, only half of the providers used national guides and norms for VCT. Furthermore, few facilities in all three countries had personnel who had been trained on stigma and discrimination, even though in Guatemala discrimination against clients from vulnerable groups was identified as a problem, especially among support staff.

Another shortcoming identified included a weak referral system for additional client needs, in particular for HIV positive clients. In Nicaragua, an informal telephone referral system is in place, with public

sector providers generally referring to NGOs for social support. In El Salvador, however, it is the NGOs that conduct community outreach and refer individuals to the MOH or to private labs for testing.

Other issues identified were condom stock outs and limited supervision systems, including lack of supervision tools and use of informed consent forms.

Simulated clients were sent to clinics to ascertain how FSW and MSM who requested HIV testing were treated by providers. The simulated clients played one of three pre-defined roles: female sex worker, heterosexual man with occasional sexual relations with other men, or self-identified homosexual. Individuals who would be credible and comfortable playing each role were selected with help from participating organizations. Simulated clients were trained to visit the health center and request an HIV test; playing the role they were given. They were trained to offer no information other than that which the provider elicited, and to carefully mark the presence or absence of each indicator on the check list immediately upon leaving the facility.

Structured checklists were developed with yes or no questions to facilitate data collection. Simulated clients were asked, for example, “Did the provider offer you condoms during the visit?” Simulated clients received a one-week training which included practice in the field. Providers were advised several months in advance that they would be visited during the year by simulated clients to assess their services, and their written consent was obtained. Only providers who gave consent were visited.

Over 100 simulated client visits were conducted in El Salvador and 51 in Nicaragua, in addition, 302 exit interviews with actual clients were conducted in El Salvador. Simulated client visits were not conducted in Guatemala. The results indicate the need for improvements provider counseling skills and the way providers treat MSM and FSW.

In El Salvador, there was an overall positive assessment. Virtually all of the respondents considered the clinic environment comfortable, clean and organized. Results from the facility assessment in El Salvador suggest that, in general, good quality, respectful VCT services are provided to clients.

Discrimination in varying degrees toward FSW and MSM was identified in both countries. In Nicaragua, an important issue was discriminatory treatment by the health center security guard and cleaning staff; less than half of the simulated clients reported that they were treated with respect. Simulated clients also felt they were being discriminated against by how long or where they were made to wait to see a provider. In El Salvador, most clients wait an average of two hours for services, and some wait as long as three hours. In Nicaragua, FSW reported that they were made to wait separately from other clients.

There was also a need for improvements in some of the basic principles of counseling, such as privacy and confidentiality. In El Salvador, clients did not rank privacy and confidentiality as high, with 38% of the simulated clients saying they were not satisfied because their counseling was interrupted or because others could see or hear them. The results suggested that the privacy of services needed improvement by reducing interruptions during counseling and reminding reception staff not to state loudly the purpose of the visit.

In general, providers felt constrained working in a resource-scarce environment and perceived little support from the Ministry of Health. Perhaps their biggest concern is pressure to provide a variety of services to as many patients as possible with limited time and resources.



- *“Me siento limitada en cuanto a dar una calidad (en la atención), hay demasiados pacientes, no tenemos suficiente tiempo, no le brindamos el espacio al paciente, eso afecta la calidad.”*
- *“Trabajamos con las uñas, quieren calidad pero nos demandan cantidad.”*
- *“A nosotros nos miden con números, no tenemos tiempo para la consejería, tenemos que hacer PAP, muestras, poner vacunas, atender niños y muchas otras cosas. Estamos concentrados en muchos trabajos no solo en uno, si solo fuera consejería fuera muy lindo.”*

In both countries, providers failed to explore specific risk behaviors and missed the opportunity to help clients to formulate a prevention plan. In Nicaragua, only one-third of the heterosexual simulated clients and half of the other simulated clients reported discussion on this topic during counseling. In El Salvador, even when providers knew that clients have a history of STIs, they failed to probe about current symptoms. Risk behaviors were not discussed consistently during counseling, according to 50% of the actual and 21% of the simulated clients in El Salvador. Furthermore, counselors failed to explore aspects of sexuality such as type of sex and number of partners.

Another area for improvement in both countries is the integration of family planning services, which are rarely offered to female sex workers. In Nicaragua, less than half of the female sex workers reported that providers offered them family planning. Similarly, violence, a key risk factor for HIV among FSW, was also discussed infrequently. Other issues that surfaced included verifying that clients had the knowledge and skills needed for correct and consistent condom use and simply allowing clients the opportunity to ask questions. However, a limiting factor may be the time available for counseling.

### *Conclusion and Recommendations*

The information provided by the needs assessment guided the design of a capacity building strategy for VCT providers emphasizing the reduction of stigma and discrimination for VCT providers. Some of the assessment findings that informed the strategy included:

- Evidence of provider discrimination based on sexual orientation and commercial sex activity
- Lack of knowledge of the legal framework that protects individuals' rights to quality HIV-related services and the norms and protocols for offering them
- Lack of privacy and confidentiality in VCT services
- Inability to adequately assess client's risk of infection during client counseling
- Limited ability to offer quality counseling due to insufficient time and heavy workloads
- Lack of support and information for counselors on how to handle work-related stress

The results from all three countries suggested the need to recognize those staff that do offer good quality care, while increasing their knowledge and application of HIV laws and norms through training and support materials. Training needed to be competency based, with a focus on sexual diversity and gender to better prepare providers to reduce risk behaviors through behavior change and skills

development during counseling. Resources such as anatomical models, self-evaluation check lists and counseling guides would be useful. In addition, it was important to ensure the availability of condoms and lubricants.

# III. Intervention

## 1. Capacity building strategy

Results from IRH’s formative research and an extensive review of literature and existing training resources, were used to design a capacity building intervention in support of PSI/PASMO’s project objective of improving the quality of VCT services in designated geographical locations. This in turn was expected to improve acceptance by and interest from clients, in particular men who have sex with men (MSMs)—including transgender, transvestites and bisexuals—and female sex workers (FSWs).

PSI’s mandate under this project included the increased utilization of voluntary counseling and testing (VCT) services among key populations. These populations, which are exposed to situations that make them highly vulnerable to HIV infection, experience stigma and discrimination on a number of levels, with evidence of discrimination based on sexual orientation and commercial sex activity. To address these inequalities in access and treatment through raising awareness, promotion, and empowerment of their clients, IRH designed an intervention directed at healthcare providers.

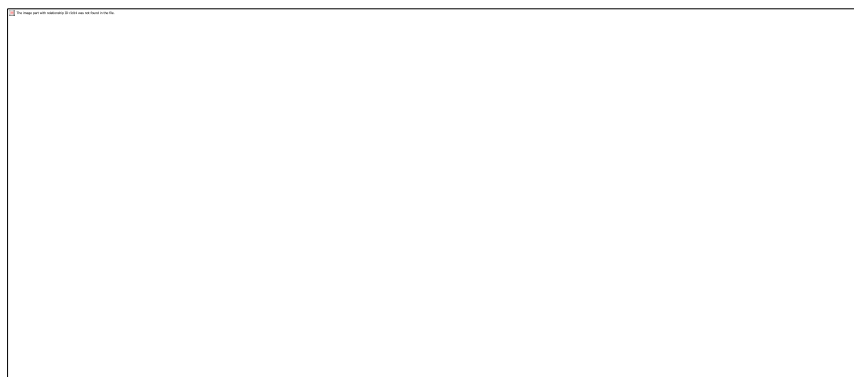
The intervention to strengthen provider’s competence in VCT service provision was based on research that shows that training by itself is not sufficient to bring about changes in provider attitudes and behaviors that will result in improved services. It also takes account of the reality that healthcare providers often are not released from work to participate in extended training events. A four-stage certification process combining training, sensitization of clinic staff by trained providers, follow-up visits and focused seminars was thus developed. The process takes four months and participants follow the

activities sequentially in order to achieve certification. The process starts with two days of training, followed by a practicum in which trainees conduct a sensitization session about VCT at their workplace. During months two and four, IRH personnel visited each trained counselor to reinforce key information and assess

skills through the application of a structured checklist. The last step involved attending at least two continuing education sessions where topics covered in the initial training were reinforced. Figure 1 describes the four stages of the certification process, the time involved in each stage and the tools that support the learning in each of the stages.

The strategy also entailed improving the provider and their clinic colleagues’ attitudes toward MSM and FSW groups. Another important reason to use a certification approach that entails several steps was to sustain provider participation and encouragement amidst working conditions that often limits their

**Figure 2: Certification Card for Trainees**



**A full view of the Certification Process illustration is found in the Appendices section.**

ability to provide quality services. The certification process was assumed to offer enough value to encourage providers' active participation and multiple opportunities for reinforcement.

The VCT certification process offered participants:

- A variety of training experiences including participatory, hands-on, on-the-job activities
- Materials, tools and resources
- On-going visits, individualized feedback and support
- Reinforcement that focuses on what providers need
- Knowledge that can be built on and reinforced over time
- Affirmation and strengthening of skills
- Accountability and motivation to perform

### *The Training Workshop*

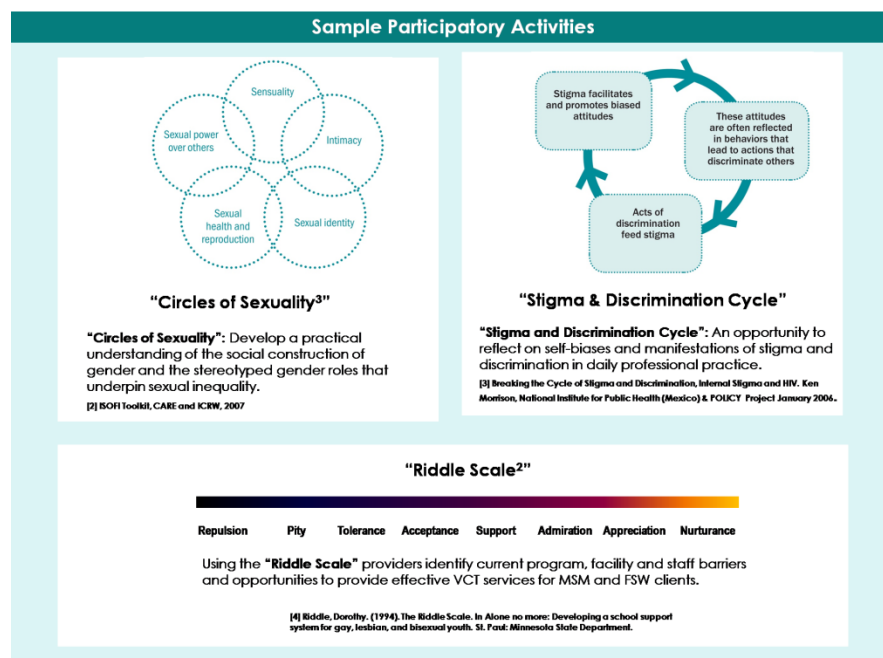
The two day training workshop includes learning activities that combine basic theory with practical applications. The curriculum aim is to update providers on the norms and procedures for HIV/AIDS in their countries, standardize their knowledge about VCT, strengthen counseling skills, and sensitize providers to stigma and discrimination in services. The workshop provides the normative and technical framework to sensitize providers about the VCT process as well as the stigma that exists in their worksites, opportunities for reflection on their attitudes and behaviors and hands-on experimentation. It seeks to offer participants a safe environment for sharing their experiences and for learning to cope with the stresses of their work.

Although the training objectives and manual are the same in all countries, IRH relied on and distributed to participants the existing VCT counseling materials developed locally, such as norms, guidelines and protocols. Participants also received the tools and information for completing the remaining three steps.

The training approach used was participatory and relied on well-tested methodologies to explore and address issues of stigma and discrimination. Three exercises drawn from existing resources were particularly powerful in "bringing-home-the message" about internal and external stigma. For example, providers expressed surprised when realizing about discrepancies between their self-perception of neutrality and results of their position within the "Riddle Scale".

Figure 3 depicts activities addressing stigma and discrimination and sexual diversity, two main topics covered throughout the four components of the certification process and highlighted in the VCT provider job aid.

**Figure 3. Sample Participatory Activities**



### *Practicum – All-site Sensitization Sessions*

Each trainee is expected to conduct a VCT sensitization session at their worksite, within one month following training, using materials and lesson plans received at the training. This gives trainees an opportunity to share and teach others what they have learned and in the process internalize the information. It also helps them become agents for change in their healthcare setting, and ensures that key information is shared with administrative staff. IRH coordinators in each country attended these sessions provide the trainee support as needed and observe, assessed and offer feedback to the trainee. Sample lesson plans were developed and used by trainees to adapt and prepare their own sensitization sessions.

### *Follow-up visits*

Two follow-up visits for each provider are scheduled during months two and four after the training workshop. At each visit, providers are observed and assessed as they conduct a simulated counseling session and then they are provided feedback on the session. They are also given an opportunity to talk about their experience applying the information and skills gained in training. The follow-up visits provide an opportunity to identify gaps in competency and understanding, which can be built into the final session. Use of the VCT checklist by the provider also is observed/evaluated during these support visits. Follow-up visits were conducted in Belize, El Salvador, Nicaragua and Panama.

### *Seminars*

Short seminars on topics related to core competencies in VCT counseling were offered at convenient times outside the providers work schedule. These seminars address topics and concerns which cannot be addressed or addressed adequately in training. IRH developed four different seminars from which providers could choose to participate in two. The topics of the seminars included: Sexuality and Sexual

Diversity; Stigma and Discrimination; Counseling for Special Populations, including youth; Provider Self-Care and Stress Management. Having different options proved useful to country coordinators who were able to offer trainees a range of options from which to choose and their preferences varied from site to site.

Completion of all training requirements entitled providers to receive certification attesting to their successful completion of the training. A certificate from the Georgetown University was handed to all 273 participants who completed the process. Certificates of accomplishment also were issued to coordinators locally in recognition for their support and contributions to the project.

#### *Implementation of the intervention*

Prior to implementing the capacity building intervention, IRH pilot tested a draft of the training manual in Guatemala with 30 VCT counselors and program managers from the MOH, the Instituto Guatemalteco de Seguridad Social (IGSS), APROFAM, and NGOs working with key populations that were the focus of this project. A second iteration of the manual also was pre-tested in El Salvador with MOH authorities and in Nicaragua with participants' feedback was collected and analyzed and post-test scores tabulated. In general, participants felt that the length and the content were adequate and the materials distributed valuable for their work. The review of the HIV/AIDS national norms and the overview plus hands-on of VCT counseling process and procedures were the participants two more highly rated topics in the workshop.

**Table 4. Participants' feedback during the training pre-testing sessions**

No. de Pregunta	Porcentaje por calificación			
	1- Muy Bien, 2- Bien, 3 - Mas o menos & 4 - Mal			
	1	2	3	4
1. Actualizarse en las bases científicas del VIH y SIDA	73%	23%	5%	-
2. Afianzar principios de la consejería en general	86%	9%	5%	-
3. Conocer el proceso de la consejería en la CPV enfocada en grupos de MTS y HSH	73%	27%	0%	-
4. Actualizar conocimientos sobre el algoritmo de la CPV	73%	23%	5%	-
5. Desarrollar las habilidades para brindar una consejería individualizada	73%	23%	5%	-
6. Actualizarse sobre la norma nacional (Decreto 27-2000)	68%	32%	0%	-
7. Sentirse capaz de usar las herramientas recibidas en el taller para dar atención en VIH/SIDA a grupos de MTS y HSH	73%	27%	0%	-
8. Aprender que es la estigma y discriminación y como afecta la calidad de los servicios de CPV	77%	18%	5%	-
9. Recibir la información necesaria para poder transmitir a los usuarios información básica sobre el VIH/SIDA	86%	14%	0%	-
10. Los facilitadores conocen el tema	82%	18%	0%	-

11. Los facilitadores emplearon un estilo efectivo de presentación	77%	18%	5%	-
12. El contenido fue relevante para los objetivos	73%	18%	9%	-
13. Los métodos de enseñanza fueron efectivos	59%	32%	9%	-
14. El material que se repartió en hojas aparte fue útil	86%	9%	5%	-
15. Las herramientas de consejería/ material de apoyo fueron útiles	91%	5%	5%	-
	<b>Adecuado</b>	<b>Muy Corto</b>	<b>Muy Largo</b>	
16. El lapso de tiempo programado para este taller fue:	64%	32%	5%	-

Two-hundred and seventy-three service providers (an amount above the 212 provider goal set for IRH's project component) followed the four-month VCT certification process and were certified. In addition, over 700 providers were trained during the initial two-day workshop and over half of these received at least one follow-up visit. The number of providers participating in continuing education seminars also exceeded the initial target.

**Table 5. Providers Who Completed Phases of the Certification Process**

	El Salvador	Panama	Belize	Nicaragua	Total
<b>Target Goal (Providers to be Certified)</b>	100	36	40	36	<b>212</b>
<b>Total Providers Certified</b>	130	55	16	72	<b>273</b>
<b>Phases Completed by all participants (target goal and beyond)</b>					
<b>Training Workshop (2 days)</b>	575	65	26*	91	757
<b>Delivered Sensitization Sessions at their clinic</b>	33%	91%	62%	79%	
	188	59	16	72	335
<b>Attended at least 1 Seminar</b>	16%	100%	100%	77%	
	92	65	26	70	260
<b>Attended at least 2 Seminars</b>	16%	92%	100%	88%	
	92	60	26	80	261
<b>Received 1<sup>st</sup> Follow up Visit</b>	47%	95%	62%	80%	
	272	62	16	73	423
<b>Received 2<sup>nd</sup> Follow up Visit</b>	11%	85%	62%	79%	
	65	55	16	72	208
<b>Total Certified</b>	23%	85%	62%	79%	
	130	55	16	72	<b>273</b>

\*Belize participants were trained by the CAPACITY Project at the University of Belize.

To help providers strengthen their counseling skills and follow the VCT protocol consistently, IRH developed a simple yet comprehensive double-sided job aid that served the dual purpose of a checklist for support and self-assessment and supervision tool (see Annex 2). Providers and supervisors found the tool equally useful and various local programs have adopted it in both public and private sector programs.

The implementation of the capacity building strategy in four countries followed the same process and relied on the same materials and guidance. However, the process offered enough flexibility to accommodate provider's knowledge and preferences. For example, in Belize, service providers who had recently received a training equivalent to the IRH-designed training workshop completed the remaining three steps (seminars sensitization practicum and follow-up visits). Another example refers to the choice of seminars providers selected to attend which varied from one country to the next.

The process was perceived in a positive manner by country representatives and stakeholders. The stakeholders attributed the success of the certification process to the follow up components of the process. In an anonymous opinion survey, providers reported on the benefits of their certification and that it was effective in strengthening providers VCT skills.

The strategy was evaluated from the perspective of providers, program managers as well as clients and involved data analysis of: (a) provider follow-up visits, pre and post tests and participants' feedback collected from their evaluation of the training interventions and an anonymous opinion survey; (b) post-intervention simulated clients observations; and (c) in-depth interviews with MOH and NGO program personnel, IRH coordinators and community stakeholders. Results of the evaluation are described in section V.

#### *Table of indicators*

The table of indicators (Table 6) presents PSI indicators which this project's work contributed to. The indicators were reported to PSI/PASMO quarterly as participants completed the certification process. In most cases the indicators were met or exceeded. Some exceptions were due in part to participant drop out as well as funding and time limitations.



**Table 6. Table of indicators**

	Indicator 9 Number of service outlets providing counseling and testing according to national and international standards <sup>3</sup>		Indicator 10 Number of individuals who received counseling and testing for HIV and received their test results		Indicator 13 Number of individuals trained in counseling and testing according to national and international standards <sup>4</sup>		Indicator 17 Number of individuals trained in HIV-related stigma and discrimination reduction <sup>5</sup>	
	Actual by Sep. 09	Target	Actual by Sep. 09	Target	Actual by Sep. 09	Target	Actual by Sep. 09	Target
Belize	20	20	N/A	N/A	16	40	114	0
El Salvador	130	50	N/A	N/A	130	100	598	45
Guatemala	N/A	N/A	N/A	N/A	N/A	N/A	42	40
Nicaragua	12	9	N/A	N/A	73	36	96	100
Panamá	18	18	500	N/A	55	36	637	25

<sup>3</sup> These numbers represent sites where training and at least one follow up visit of at least one provider has been completed this quarter. It is not cumulative.

<sup>4</sup> These numbers represent providers who are trained and have completed the certification process.

<sup>5</sup> These numbers represent the participants that attend sensitization talks given by trained providers as part of the certification process and FBO members who participate in a workshop. The target indicators were set low.

## IV. Evaluation Methodology

IRH developed a comprehensive plan to evaluate the capacity building and FBO strategies of the project that included analysis of data from pre- and post-tests, participant evaluations, and provider follow-up visits. In addition, simulated client visits, an on-line survey and interviews with country coordinators and community stakeholders (MOH, FBOs, etc.) were conducted.

### 1. Service Statistics

The certification process was documented by keeping track in each country of the number of providers who completed the initial two-day training; provided a sensitization training for other colleagues in their health center; participated in one, two or three seminars coordinated by IRH on various topics; and received one or two follow-up visits by an IRH country coordinator. This information was obtained through attendance sheets for the training, sensitization sessions and seminars, and checklists for the follow-up visits.

### 2. Pre-post test results from training

Pre- and post-tests were applied to assess provider knowledge of VCT services. After the training, the providers took the post-test and these results were compared during the evaluation phase.

### 3. Data from follow-up visits with trained providers

As part of the certification process, providers received follow-up visits from an IRH coordinator to assess the application of the skills they learned, and to support them in their efforts to provide better quality VCT services. The follow-up visit checklist asked providers about the language they used with patients, how they assessed risky behaviors during counseling, empathy towards patients and privacy issues.

Once providers completed the certification process they were asked to evaluate the training using a brief participant evaluation form. The participant evaluation asked about the usefulness of the training and instruments, expectations for the certification process and benefits of their participation in the process.

### 4. On-line survey of training participants

An anonymous on-line survey was completed by 50 service providers who completed the capacity building certification process. Responses to this survey helped measure changes in four aspects:

- Provider awareness of self stigma and discrimination toward FSWs and MSM within the context of VCT counseling;
- Provider level of comfort with sexually diverse clients, assessing clients risk, and inquiring about sexual practices
- Following best practices in VCT counseling and self-care/stress management
- Value of the certification process and use of the VCT checklist in counseling

## **5. Simulated client visits**

Simulated client methodology is becoming increasingly popular to measure the quality of health care services. Using this methodology, trained simulated clients requested an HIV test from service delivery sites included in the project. Simulated clients are not real clients; rather they are men and women trained to play the role of a client. In most cases, however, the provider will believe that he/she is providing services to a real client. Immediately after the visit, the simulated client completes a checklist, which measures provider behavior and attitudes, as experienced in an actual counseling session by the client. Providers at participating clinics were explained the procedure and signed informed consents accepting a possible visit by a simulated client a few months before the visits began.

The simulated clients were given a pre-determined profile about life circumstances and reproductive health history, so that simulated clients with the same profile can be compared across clinics. Three simulated client profiles were developed: 1) a female sex worker, 2) homosexual man; and 3) a man who identifies himself as heterosexual but occasionally has sex with men. Simulated clients were recruited with assistance from partner organizations working with MSM and FSWs, because it was found to be too difficult for others to play these particular roles. Checklists were developed to reflect appropriate responses for each profile, and contained a number of behavioral items and a column to register whether or not the behavior was observed.

In El Salvador, 51 simulated client visits were conducted before and after completion of the certification process. In Nicaragua, 39 simulated client visits were conducted at the end of the training process.

## **6. Stakeholder interviews**

Stakeholder interviews consisted of non-client stakeholders who were involved in various stages of the certification process. These included representatives of government agencies (such as Ministries of Health), non-governmental organizations and Universities. Participants for the interviews were identified by the respective IRH country representatives in El Salvador, Panama, Belize and Nicaragua.

Fourteen persons were identified, and were invited by email to participate in a phone interview. Of the ten persons that showed interest, we were able to successfully conduct nine interviews between July and September. There were two interview guides used in this process, one that was identical to the country representatives' interview guide, and one for non-client stakeholders. The country representative guide focused on details of the different activities in the certification process, such as the seminars and the follow-up visits. This interview guide was used with respondents who actively participated in some stage of the certification process. The other interview guide was designed for individuals who could provide feedback on the process, as well as their opinion regarding possible continuity of these activities after the end of PASMO. In general, the two semi-structured interview guides collected feedback and recommendations. All but the Belize interviews were conducted in Spanish. The stakeholder interviews were conducted between July and August 2009.

The four Country Representatives were also interviewed by phone, using a semi-structure interview guide developed for the country representatives. Nicaragua, El Salvador and Panama interviews were conducted in Spanish; and the Belize interview was conducted in English. The interviews were carried out between June and July 2009.

## V. Results

Evaluation of the capacity building strategy designed for this project addressed four main questions: 1) Was the certification process feasible and acceptable?; 2) Was the strategy effective in strengthening provider VCT knowledge and skills?; 3) Was it effective in raising provider awareness of generalized and personal stigma and discrimination toward MSM and FSWs while offering VCT services?; and 4) Did implementation partners take steps to integrate this approach into their program? Data were collected through stakeholder interviews, pre- and post- training tests, an on-line survey with training participants, structured observations during follow up visits and simulated client visits.

### **1) Is the certification process feasible and acceptable?**

The feasibility and acceptability of the capacity building process was assessed through analysis of training statistics and stakeholder interviews and from each of the four countries.

#### *Service Statistics*

The goal of this project was to improve the quality and utilization of VCT services among vulnerable populations. Based on the formative research discussed in the previous section, IRH selected a capacity building strategy to achieve this goal. The objective established for this project was to train a total of 212 providers in Nicaragua, El Salvador, Belize and Panama. By the end of the project, 273 providers were certified, substantially exceeding this goal (see table 5 in section III). It is important to note that the significance of this achievement goes far beyond the number of providers participating in a one-time training. In fact, 757 providers participated in the initial two-day workshop. The providers certified during this project not only participated in the training workshop but also delivered sensitization sessions at their clinic, attended at least one continuing education seminar and received at least one follow-up mentoring visit. As a result, certified providers have acquired the knowledge needed to provide VCT services to these populations, and have also received reinforcement through certification activities to reduce stigma and discrimination and become change agents among their colleagues.

An important issue to address is whether this intensive capacity building process is feasible and acceptable, and thus appropriate for replication and scale up. Table 5 in section III shows that the goals set for providers certified during the project were met fully in El Salvador, Panama and Nicaragua and partially in Belize. Due to high demand for the training in the first three mentioned countries, IRH responded to requests from the MOH to train a larger number of providers. The cost of the additional trainings was covered by the MOH. In El Salvador in particular, local organizations, in addition to the MOH, funded their training beyond the funding for activities under the PASMO project. While provider certification goals were exceeded in three of the four intervention countries, many more providers who attended the initial training workshop didn't complete all the phases of the certification process. Neither IRH nor local organizations were able to fund the full certification process beyond the initial two days of training. Funds to conduct the seminars and follow-up visits with all providers who participate in the initial training were not available.

## *Stakeholder Interviews*

The feasibility and acceptability of the process was explored from the different perspectives of IRH country representatives and local stakeholders. Country representatives focused on the approaches they used to maximize participation and retention. In El Salvador, the certification process was in high demand and by the end of the program, 575 providers participated, 130 of whom were certified due to time and financial limitations. The principal recommendation in El Salvador was that the initial two-day provider workshop should be longer. The seminars were scheduled according to the preferences of the providers, in some countries they were conducted on weekdays and in others on weekends.

Approximately 20 individuals participated in each seminar; most of the country representatives were satisfied with the size of the group, although one suggested reducing the number if there is only one facilitator. On the other hand, another representative mentioned that the group size could be larger (up to 25 participants) if there was a co-facilitator. The country representatives also provided guidance and feedback to participants in the conduct of the sensitization sessions in their respective clinics.

All countries, with the exception of El Salvador, planned the dates for the follow-up interviews ahead of time with participants. In El Salvador, the visits were conducted during on site observations, without prior notice. Three out of the four representatives suggested that the follow up visits be done in the month following the first seminar, to provide immediate reinforcement to providers after the initial training. The representatives commented that it was important to emphasize that the purpose of the follow up visits was not to evaluate the providers, but to provide them support and point out areas for improvement to meet certification standards. Most of the stakeholders identified the follow up process as a critical element of the certification process. They cited this element of the capacity building strategy as the primary reason they would like to continue this effort. According to the stakeholders, the providers liked the process, and have increased their knowledge and skills. On the other hand, the country representatives considered the seminars as key to the success of the capacity building strategy.

Flexibility while implementing the capacity building strategy ensured its feasibility. For example, there was an initial concern in Belize that this process would duplicate the efforts of the Capacity Project which was conducting a week-long training with the University of Belize on HIV/AIDS counseling. After a comparison of the IRH and Capacity Project curricula, overlap of content was identified. As a result, rather than conducting separate trainings, the certification process including the sensitization talks, seminars and follow up visits were offered to participants who completed the Capacity Project training. Of the 50 VCT providers who completed the Capacity Project training, 33 went on to enroll in the IRH certification process, and 16 were certified.

In Nicaragua, the certification process was described as “nice”, “eye-catching” and “innovative”. The process was carried out in three areas (Bluefields, Masaya and Chinandega); a fourth area decided not to participate because of other HIV-related programs going on at the time. Ninety-one providers were trained in the initial workshop and 73 were certified by the end of the project. The primary reasons for desertion were that the process took too much time and job transfer.

In Panama the certification process was accepted, although the country coordinator noted that providers were not used to a training which required not only individual follow up, but in which planned activities actually took place. According to stakeholders, the new capacity building training had to overcome some barriers, but was accepted by participants and has motivated a change in educational methodology in HIV training. Participants in Belize expressed satisfaction with the methodology as they

seldom have the opportunity to learn and discuss issues in an informal, relaxed venue like the seminars. After these seminars, the participants reported changes in their attitudes and behaviors. Participants also responded positively to the sensitization sessions given by colleagues, feeling it was an important element of the capacity building process. The provision of an environment conducive to interaction and open discussion was key to the success of the sensitization sessions.

In Panama, stakeholders and country representatives reported that participating providers made an effort to find additional information on stigma and discrimination, specifically related to their target populations. Participants who were enrolled in the certification process showed a commitment to improving their services, volunteering counseling services at free VCT campaigns during the course of the project, and since the end of the project advocating to the National AIDS Program for other providers to become certified.

## 2) Was the capacity building strategy effective in strengthening the knowledge and skills of VCT providers?

Effectiveness of the capacity building strategy was measured through the results of the pre-post test, an on-line survey, follow up visits and simulated client visits.

### *Pre-post Test*

**Table 7. Provider Knowledge Before and After Training Workshops in Panama and El Salvador**

Question	N	Correct answer in Pretest	Correct Answer in Posttest
What conditions someone to get infected with HIV?*	226	84.5%	92.9%
What is involved in pre-test counseling?*	229	79.5%	93.4%
Support and follow up resources to minimize risk should be offered to:*	224	79.5%	90.2%
AIDS is:*	225	80.9%	96.4%
HIV is:*	223	85.2%	97.3%
If the health care provider comes into contact with client's blood/body fluids while examining him/her, the provider must:*	217	53.5%	78.8%
Universal precautions to avoid blood (or other bodily fluids) related infections in clinics and hospitals apply to:*	224	78.1%	98.2%

\*significant change in answers (McNemar,  $p < .05$ )

Participants in the certification process were given a test measuring general knowledge and attitudes related to counseling and HIV before and after the initial workshop. There was a significant improvement in all knowledge indicators after participating in the workshop (Table 7). The results presented in Table 8 demonstrate significant improvements as well in the majority of items measuring provider attitudes toward MSM and FSW (*I would mind working with a gay person*) and the importance of counseling (*What's important is that someone gets tested, even if they don't get counseling*). The

results suggest that providers now view counseling as an integral element of HIV testing which must be provided even in the case of a negative result.

**Table 8. Provider Attitudes Before and After Training Workshops in Panama and El Salvador**

Item in Evaluation	N	Said Yes in Baseline	Said Yes in Endline
I would mind working with a gay person*	267	9.4%	2.2%
Gay medical staff is as competent as heterosexual staff	244	93%	90.6%
FSW are indifferent to their health care and don't listen to recommendations*	230	24.3%	10.4%
Discrimination is something that is in the mind of people with low self esteem*	258	58.5%	40.7%
What's important is that someone gets tested, even if they don't get counseling*	265	32.1%	7.5%
Only MSM and FSW are vulnerable to HIV*	278	6.5%	2.2%
Counseling should only be practiced with vulnerable groups	276	3.6%	2.9%
Giving counseling after the test is only important if it's a positive result*	245	9.6%	3.3%
According to the law in case of a positive result, it's obligatory to inform the partner	253	47.4%	50.2%
The law establishes that only trained personnel can give counseling	247	50.2%	56.3%
Every person who engages in sex work, is liable to be obliged to get an HIV test*	263	23.6%	11.0%
In my country, the HIV epidemic continues to affect only people who are older than 25 years old*	263	11.0%	2.7%
Vulnerability (to HIV) is lower to housewives that are faithful to their husbands*	265	17.0%	5.3%
While a person continues doing sex work, health care personnel cannot help to lower their risk	273	55.7%	59.0%

\*Significant at the  $p < .05$  level, McNemar Test

### *On-line Opinion Survey*

Participants in the initial workshop in all four countries who provided their e-mail address were invited to complete an anonymous online survey to measure the effect of the certification process on their attitudes and practices.

The results suggest that respondents felt that the certification process improved their ability to provide VCT to MSM and FSW. For example, 92% of respondents reported changes in their counseling practices as a result of the certification process. They also reported improved understanding of sexual diversity in the context of VCT services. In terms of their degree of comfort providing VCT, 67% of respondents reported that they feel comfortable evaluating HIV risk among MSM and FSW. One goal of the certification process was to increase the ability of providers to manage stress; Sixty-three percent of respondents reported that they handle stress better since participating in the training.

**Table 9. VCT Providers Self-Reported Changes in Attitudes and Practices after Certification**

<b>Attitudes</b> that point to changes in stigma and discrimination levels	
Believe HIV testing should <u>not</u> only be for FSWs and MSM	100%
Reported being more interested in inviting DSWs and MSM to the clinic for testing	79%
Believe FSW should not be coerced to get tested	69%
<b>Comfort level</b> discussing sexual practices and other sensitive topics when assessing clients risk, including FSWs and MSM	
I feel very comfortable	67%
I feel somewhat comfortable	33%
<b>Self-Care Practices</b> As a result of my participation in the training and seminars, now I:	
Can handle stress much better	63%
Can handle my stress somewhat better	31%
Don't see differences in how I handle my stress level	0%
I don't experience work-related stress	3%
I don't remember discussing stress management at the training/seminars	3%

As reflected in the Table 10, over 75% of providers reported improvements as a result of the certification process in evaluating risk practices, identifying risk reduction practices, providing test information and ensuring confidentiality. This self-reported information.

**Table 10. Differences reported by providers after completing the certification process**

	Reported Significant Difference	Reported Some Difference	Reported No Difference
Assessing client risk	75%	25%	0%
Helping clients identify risk-reduction measures	75%	19%	6%
Securing client's confidentiality	79%	21%	0%
Offering VCT-related information	83%	17%	0%



Of particular interest is the finding that 77% of trained providers found the VCT checklist very useful with 21% reporting they found it useful. About 80% reported using the check list while counseling, however, during follow-up visits it was found that less than 60% were actually using it at the time the visit took place. However, the self-reported information is consistent with the results of the stakeholder interviews which suggested that the counseling checklist was one of the most valued elements of the certification strategy.

### *Stakeholder Interviews*

The qualitative data from the stakeholders suggest that the providers learned how to evaluate themselves, and thus continue to improve their skills over time. In addition, the stakeholders remarked that the follow up activities included in the certification strengthened provider skills, especially in terms of sensitivity towards vulnerable groups, and updated provider knowledge. The seminars pulled together the information and tied it together with actual counseling practices. Although burnout was seen as an important topic by providers in Belize and El Salvador, it was the least interesting topic among providers in Nicaragua.

### *Follow-up visits*

Observations recorded during the follow up visits also provide relevant information on the ability of the providers to offer VCT counseling. Table 11 presents the results of the two follow up visits conducted with providers in Panama, Nicaragua and El Salvador. The results suggest significant improvements in privacy and confidentiality (*Conducted Counseling in private space 88.3% at first visit, 92.2% at second visits\*; Guaranteed client's confidentiality 77.8% at first visit, 86.3% at second visit\**) and inquiring about condom use (*Inquired about condom use 93.4% at first visit, 98.4% at second visit\**). Providers also showed significant improvement from visit one to visit two in explaining the window period to clients, how the result might affect the partner relationship, and identifying the client's need for support resources. Providers also improved in overall counseling skills. Overall the quality observed during the second follow up visit was good (over 65% score). Areas needing further improvement after the second visit include: inquiring about drug use and previous test results and addressing partner issues such as condom negotiation; exploring support needs and emotional state; and offering materials and referrals.

**Table 11. Observations of Counseling During Two Follow-up Visits in Panama, Nicaragua and El Salvador**

	Observation	N	Observed in 1 <sup>st</sup> Follow up Visit (marked as yes)	Observed in 2 <sup>nd</sup> Follow up Visit (marked as yes)
General Observations	Conducted counseling in private space*	128	88.3%	92.2%
	Guaranteed client's confidentiality*	117	77.8%	86.3%
	Greets the client and presents him/herself	129	79.8%	82.9%
	Inquired about reason for visit	124	92.7%	91.9%
	Explored client's knowledge	123	82.1%	83.7%
	Used counseling checklist	123	70.7%	74.0%
	Explored client's needs	124	80.6%	78.2%
	Assessed client's risk	119	94.1%	94.1%
	Motivated/allowed client express him/herself*	129	91.5%	86.0%
	Inquired about previous STIs	103	65.0%	67.0%
	Inquired about sexual practices	104	79.8%	77.9%
	Inquired about number of partners	115	75.7%	73.0%
	Inquired about condom use*	122	93.4%	98.4%

	Inquired about drug use	104	35.6%	32.7%
	Inquired about previous test results	101	62.4%	60.4%
	Checked correct condom use	117	76.9%	77.8%
	Discussed condom negotiation	105	54.3%	57.1%
	Helped client establish prevention plan	106	89.6%	89.6%
	Verified client's comprehension	127	79.5%	78.7%
	Explained the process of testing	122	96.7%	96.7%
	Explained meaning of positive result	115	98.3%	99.1%
	Explained meaning of negative result	109	84.4%	84.4%
	Explained implication of results for partner*	100	30.0%	38.0%
	Explained window period*	116	69.0%	79.3%
	Explored client's support needs	109	60.6%	60.6%
	Gave client time to analyze the information	125	92.8%	92.8%
	Motivated client to involve partner	110	70.9%	70.9%
	Discussed informed consent with client	117	84.6%	84.6%
	Motivated client to return for follow up	109	95.4%	96.3%
	Provided support materials	111	36.9%	36.9%
	Motivated client to consult SIDATEL (hotline) <sup>6</sup>	97	15.5%	15.5%
Observations when result negative	Evaluated client's emotional state	71	38.0%	38.0%
	Discussed negative result clearly	69	92.8%	94.2%
	Reinforced information	70	72.9%	72.9%
	Verified client's comprehension	70	82.9%	82.9%
	Motivated client to express him/herself	70	64.3%	64.3%
	Identified client's need for support services*	70	48.6%	72.9%
	Offered referrals	70	54.3%	52.9%
Observations when result positive	Evaluated client's emotional state	11	36.4%	36.4%
	Asked client if he/she is prepared	11	54.5%	54.5%
	Explained the result clearly	11	100%	100%
	Gave client time to 'take in' his/her result	11	72.7%	72.7%
	Summarized things to do and follow up	11	100%	100%
	Explained importance of HAART	11	90.9%	90.9%
	Discussed implications for family and partner	11	100%	100%
	Identified client's need for support resources	11	90.9%	90.9%
	Offered referrals	11	100%	100%
Counseling Skills	Used appropriate language	133	100%	100%
	Summarized things to do and follow up	113	80.5%	82.3%
	Reinforced/offered information	131	75.6%	78.6%
	Motivated the client to express him/herself	132	86.4%	86.4%
	Inquired and evaluates risky situations	121	86.8%	90.9%
	Answered client's questions	132	93.9%	94.7%
	Accepted client's decisions	130	97.7%	97.7%
	Showed empathy with problems	133	99.2%	99.2%

\*Significant at the  $p < .05$  level, McNemar Test

Due to time constraints only one follow-up visit was conducted in Belize (Table 12). Results were generally quite high (over 80%), with only a few exceptions, such as use of the counseling checklist, identifying the need for support services and offering referrals.

<sup>6</sup> Only relevant in El Salvador.

**Table 12. Observations of Counseling During One Follow-up Visit in Belize only**

	Observation	N	Belize
General Observations in visit	Conducted counseling in private space	10	90.0%
	Guaranteed client's confidentiality*	10	100%
	Greets the client and presents him/herself	10	100%
	Inquired about reason for visit	10	100%
	Explored client's knowledge	10	60.0%
	Used counseling checklist	10	40.0%
	Explored client's needs	10	100%
	Assessed client's risk	10	100%
	Motivated/allowed client express him/herself*	9	100%
	Inquired about previous STIs	10	100%
	Inquired about sexual practices	10	80.0%
	Inquired about number of partners	10	100%
	Inquired about condom use*	9	100%
	Inquired about drug use	10	100%
	Inquired about previous test results	10	90.0%
	Checked correct condom use	10	100%
	Discussed condom negotiation	10	70.0%
	Helped client establish prevention plan	10	88.8%
	Verified client's comprehension	10	100%
	Explained the process of testing	10	100%
	Explained meaning of positive result	10	100%
	Explained meaning of negative result	10	90.0%
	Explained implication of results for partner*	10	100%
	Explained window period*	10	70.0%
	Explored client's support needs	10	100%
	Gave client time to analyze the information	10	90.0%
	Motivated client to involve partner	10	90.0%
	Discussed informed consent with client	10	100%
	Motivated client to return for follow up	10	50.0%
	Provided support materials	10	90.0%
Observations when result negative	Evaluated client's emotional state	7	28.6%
	Discussed negative result clearly	7	100%
	Reinforced information	7	100%
	Verified client's comprehension	7	100%
	Motivated client to express him/herself	7	100%
	Identified client's need for support services*	7	71.4%
	Offered referrals	7	71.4%
Observations when result positive	Evaluated client's emotional state	3	0%
	Asked client if he/she is prepared	3	0%
	Explained the result clearly	3	100%
	Gave client time to 'take in' his/her result	3	100%
	Summarized things to do and follow up	3	100%
	Explained importance of HAART	3	100%
	Discussed implications for family and partner	3	100%
	Identified client's need for support resources	3	100.0%
	Offered referrals	3	100%

Counseling Skills	Used appropriate language	10	100%
	Summarized things to do and follow up	10	100%
	Reinforced/offered information	10	100%
	Motivated the client to express him/herself	10	100%
	Inquired and evaluates risky situations	10	100%
	Answered client's questions	10	100%
	Accepted client's decisions	10	100.0%
	Showed empathy with problems	10	100.0%

### *Simulated Client Visits*

Simulated client visits were made to the clinics with trained providers in El Salvador before and after implementation of the capacity building strategy. Table 13 presents a comparison of key baseline and endline results in El Salvador, including indicators related to confidentiality, knowledge, risk assessment, information about testing and risk reduction planning. Increases were seen in almost all of the indicators, with significant improvements in the counseling and risk assessment among vulnerable groups – the area prioritized in the capacity building strategy.

**Table 13. Comparison of Baseline and Endline Indicators in El Salvador Simulated Client Data**

	Observation	N	Baseline	Endline
<b>Confidentiality</b>	Counseling was done in private*	51	74.5%	51.0%
	Provider discussed confidentiality	51	43.1%	52.9%
<b>Knowledge</b>	Provider asked about your HIV/AIDS knowledge	50	34.0%	52.0%
	Provider asked where you heard about HIV/AIDS	51	29.4%	80.8%
	Provider explained what is HIV	50	68.8%	76.0%
	Provider explained what is AIDS	51	58.8%	78.4%
	Provider explained how to be protected against HIV*	51	68.6%	92.2%
<b>Perception of risk</b>	Provider asked if you have had a STI*	51	11.8%	43.1%
	Provider asked if you had treatment	51	23.5%	31.4%
	Provider asked about sexual partners in the last 6 months*	51	37.3%	68.6%
	Provider asked if you if were tested before*	51	31.4%	52.9%
	Provider asked if your partner was tested	51	0%	43.1%
	Provider asked about your sexual practices*	50	20.0%	58.0%
	Provider asked about condom use during sex*	51	29.4%	78.4%
	Provider asked about alcohol/drug use*	51	27.5%	66.7%
<b>Provider gives information about the HIV test</b>	Provider explained how HIV testing is done*	51	31.4%	70.6%
	Provider explained that there are no bodily defenses	51	45.1%	68.6%
	Provider explained what a positive result means	51	58.8%	47.1%
	Provider explained that you might be rejected*	50	6.0%	32.0%
	Provider explained the importance of including your partner	51	0.0%	35.3%
<b>Provider discusses risk reduction plan</b>	Provider recommended condom use for STI/HIV prevention	51	74.5%	80.4%
	Provider explained how to use condoms	51	19.6%	31.4%
	Provider demonstrated correct condom use	51	19.6%	21.6%

\*Significant at the  $p < .05$  level, McNemar Test

Significant increases were seen in the areas of risk assessment (previous STIs, number of sexual partners, and type of sexual practices, including condom use) and explanation of the HIV test. For example, discussion of sexual partners during the last six months increased from 37% to 69%, asking about condom use increased from 29% to 78%, and exploration of risky sexual practices increased from

20% to 58%. The substantial improvement in the areas related to risks of vulnerable groups suggests that the capacity building strategy improved provider behavior regarding exploration of counseling vulnerable groups. The entire results from El Salvador (Table 14) further suggest that improvement is needed in the following areas: asking clients if they have any questions, privacy and confidentiality, previous history of STIs, discussion of partner issues, explanation of how to use condoms and lubricants and obtaining signed consent for the test.

**Table 14. Simulated Client Visits in El Salvador Before and After Capacity Building Intervention**

	Item	N	Baseline	Endline
General observations	There were available chairs for you to sit	51	92.2%	96.1%
	They made you wait more than other clients	51	5.9%	7.8%
	There were bathrooms for clients*	50	92.0%	100.0%
	You were allowed to use the bathrooms	47	97.9%	93.6%
	Bathroom was clean	47	68.1%	70.2%
	Bathroom had flowing water*	46	89.1%	73.9%
	Clinic floors were clean	50	82.0%	88.9%
	Receptionist treated you with respect	48	97.9%	93.8%
	You were called when it was your turn*	51	88.2%	100%
	They asked the reason for your visit in a loud voice	51	51.0%	13.7%
	Other clinic staff treated you with respect (security guard)*	23	95.7%	100%
	Other clinic staff treated you with respect (pharmacists)	14	92.9%	100%
	Other clinic staff treated you with respect (custodial)	17	94.1%	100%
	The provider treated you with respect	50	96.0%	90.0%
Communication Skills	Provider was judgmental	51	13.7%	11.8%
	Provider treated you with kindness	51	96.1%	86.3%
	Provider asked if you had questions*	49	40.8%	59.2%
	Provider answered your questions/doubts*	51	74.5%	72.5%
	Provider listened to you carefully*	50	78.0%	90.0%
	Provider used language that you understood	50	90.8%	94.0%
Observations During Counseling	Counseling was done in private	51	74.5%	51.0%
	Someone else listened to what you talked about	51	29.4%	35.3%
	Someone else entered the room without asking first	51	29.4%	43.1%
	Other people were observing	51	33.3%	25.3%
	Provider greeted you or replied to your greeting	51	96.1%	96.1%
	Provider congratulated you on your decision to come for testing*	51	23.5%	52.9%
	Provider promised you confidentiality*	51	43.1%	52.9%
	Provider asked you reasons for getting tested	51	100%	92.2%
	Provider asked what was your profession*	50	44.0%	82.0%
	Provider asked if you were tested before	51	31.4%	52.9%
	Provider asked if you have kids*	51	17.6%	88.2%
	Provider asked if you have a stable partner	50	48.0%	72.0%
	Provider asked about sexual partners in the last 6 months	51	37.3%	68.6%
	Provider asked if your partner was tested	51	0%	43.1%
	Provider asked about sexual relations practices	50	20.0%	58.0%
	Provider asked about condom use in sexual relations	51	29.4%	78.4%
	Provider asked about alcohol/drug use	51	27.5%	66.7%
	Provider asked if you have had a STI	51	11.8%	43.1%
	Provider asked if you had treatment	51	23.5%	31.4%
	Provider asked if you have recurrent secretions or itching	50	14.0%	28.0%
	Provider asked if you experience violence during sex	51	3.9%	33.3%

HIV/AIDS Information	Provider asked about your HIV/AIDS knowledge*	50	34.0%	52.0%
	Provider asked where you heard about HIV/AIDS*	51	29.4%	80.8%
	Provider explained what HIV is	50	68.8%	76.0%
	Provider explained what AIDS is	51	58.8%	78.4%
	Provider explained how be protected against HIV	51	68.6%	92.2%
Explanation of Testing	Provider explained how HIV testing is done	51	31.4%	70.6%
	Provider explained that there are no bodily defenses	51	45.1%	68.6%
	Provider explained what a positive result means	51	58.8%	47.1%
	Provider explained what a negative result means	N/A	N/A	N/A
	Provider explained that you might be rejected	50	6.0%	32.0%
	Provider explained the importance of including your partner*	51	0.0%	35.3%
	Provider recommended condom use for STI/HIV prevention*	51	74.5%	80.4%
	Provider explained how to use condoms	51	19.6%	31.4%
	Provider demonstrated correct condom use	51	19.6%	21.6%
	Provider talked about lubricant use	50	12.0%	18.0%
Closing and Follow up	Provider asked about emotional support you can count on*	50	16.0%	40.0%
	Provider helped you establish a prevention plan to reduce HIV risk	50	32.0%	74.0%
	Provider motivated you to continue with your healthy behaviors	50	48.0%	76.0%
	Provider offered referral information for other health services*	50	80%	82.0%
	Provider gave you educational material	51	27.5%	49.0%
	Provider gave you condoms	51	25.5%	82.4%
	Provider gave you lubricants*	51	2.0%	0%
	Provider asked you if you wanted to get tested	51	76.5%	100%
	Provider offered you testing that same day	51	58.8%	82.4%
	Provider asked you to sign a consent form*	51	41.2%	35.3%
	Provider gave you a new appointment	46	73.9%	93.5%

\*Significant at the  $p < .05$  level, McNemar Test

Simulated client visits were conducted in Nicaragua and El Salvador after the provider certification process was completed. The results presented in Table 15 suggest relatively good quality services, with the exception of support levels, privacy and confidentiality, exploration of sexual behavior and STIs, and use of condoms and lubricants.

**Table 15. Results of Endline Simulated Client Visits in Nicaragua and El Salvador**

General observations	Item	N	Nicaragua and El Salvador
	There were available chairs for you to sit	90	100%
	They made you wait more than other clients	89	15.8%
	There were bathrooms for clients*	84	84.8%
	You were allowed to use the bathrooms	75	88.5%
	Bathroom was clean	75	65.4%
	Bathroom had flowing water*	73	52.0%
	Clinic floors were clean	87	75.7%
	Receptionist treated you with respect	79	86.2%
	You were called when it was your turn*	79	92.9%
	They asked the reason for your visit in a loud voice	78	14.8%
	Other clinic staff treated you with respect (security guard)*	49	77.8%
	Other clinic staff treated you with respect (pharmacists)	43	71.4%
	Other clinic staff treated you with respect (custodial)	46	100%
	Other clinic staff treated you with respect (PF personnel)	26	0%

Communication Skills	The provider treated you with respect	90	97.4%
	Provider was judgmental	89	13.2%
	Provider treated you with kindness	90	94.9%
	Provider asked if you had questions*	90	84.6%
	Provider answered your questions/doubts*	88	94.6%
	Provider listened to you carefully*	90	100%
	Provider used language that you understood	90	100%
	Provider used support materials	90	44.7%
Observations During Counseling	Counseling was done in private	90	69.2%
	Someone else listened to what you talked about	90	38.5%
	Someone else entered the room without asking first	90	35.9%
	Other people were observing	90	35.9%
	Provider greeted you or replied to your greeting	89	86.8%
	Provider congratulated you on your decision to come for testing*	90	79.5%
	Provider promised you confidentiality*	90	84.6%
	Provider asked you reasons for getting tested	90	87.2%
	Provider asked what was your profession*	90	64.1%
	Provider asked if you were tested before	90	59.0%
	Provider asked about previous test results	89	50.0%
	Provider asked if you have kids*	90	61.5%
	Provider asked if you have a stable partner	90	82.1%
	Provider asked about sexual partners in the last 6 months	90	71.8%
	Provider asked if your partner was tested	90	46.2%
	Provider asked about sexual relations practices	90	46.2%
	Provider asked about condom use in sexual relations	90	84.6%
	Provider asked about alcohol/drug use	90	76.9%
	Provider asked if you have had a STI	90	59.0%
	Provider asked if you had treatment	90	43.6%
	Provider asked if you have recurrent secretions or itching	90	43.6%
	Provider asked if you experience violence during sex	90	35.9%
HIV/AIDS Information	Provider asked about your HIV/AIDS knowledge*	90	82.1%
	Provider asked where you heard about HIV/AIDS*	90	82.1%
	Provider explained what HIV is	90	89.7%
	Provider explained what AIDS is	90	87.2%
	Provider explained how be protected against HIV	90	94.9%
Explanation of Testing	Provider explained how HIV testing is done	90	76.9%
	Provider explained that there are no bodily defenses	90	71.8%
	Provider explained window period	90	82.1%
	Provider explained you can transmit the virus if you are positive	90	69.2%
	Provider explained what a positive result means	90	38.5%
	Provider explained what a negative result means	90	43.6%
	Provider explained that you might be rejected	90	51.3%
	Provider explained the importance of including your partner*	90	79.5%
Prevention Plan	Provider asked if you could change your sexual practices and avoid a STI	90	69.2%
	Provider recommended condom use for STI/HIV prevention*	90	97.4%
	Provider explained how to use condoms	90	48.7%
	Provider demonstrated correct condom use	90	33.3%
	Provider talked about lubricant use	90	33.3%
Closing and Follow-up	Provider asked about emotional support you can count on*	90	61.5%
	Provider helped you establish a prevention plan to reduce HIV risk	90	76.9%
	Provider motivated you to continue with your healthy behaviors	90	82.1%



Provider offered referral information for other health services*	90	2.6%
Provider gave you educational material	90	53.8%
Provider gave you condoms	90	71.8%
Provider gave you lubricants*	90	12.8%
Provider asked you if you wanted to get tested	90	97.4%
Provider offered you testing that same day	90	94.9%
Provider asked you to sign a consent form*	90	94.9%
Provider gave you a new appointment	90	100%
Provider asked if you use condom with clients (for FSWs)	35	92.3%

\*Significant at the  $p < .05$  level, Chi Square Test

In summary, data from stakeholder interviews, follow up and simulated client visits suggest significant improvements of provider knowledge and counseling skills after completion of the certification process. The follow up process which provides ongoing support, motivation and reinforcement distinguishes this approach from other training programs used by the Ministry of Health. The certification process provided a continuing learning experience for providers.

### 3) Was the capacity building strategy effective in raising provider's awareness of generalized and personal stigma and discrimination toward MSM and FSWs while offering VCT services?

According to the results of the interviews with stakeholders and country representatives, the topics related to stigma and discrimination in the seminars and sensitization talks, were the most interesting to providers. The discussion of these topics allowed providers to reflect on their experiences in order to serve members of vulnerable groups. The results presented earlier in Table 8 suggest improvements in the attitudes of providers toward MSM and FSW after participating in the certification process. Notable improvements were observed in attitudes toward gay colleagues (*I would mind working with a gay person -- 9% at baseline, 2% at endline<sup>7</sup>*) and a broader perception of HIV risk (*Only MSM and FSW are vulnerable to HIV -- 6.5% at baseline, 2.2% at endline\**). In terms of human rights, it is also noteworthy that the percentage of providers who believed that people who engage in sex work should be obligated to undergo testing reduced from 24% at baseline to 11% at endline).

An unexpected result of the certification process was that it encouraged authorities to prioritize issues of stigma and discrimination. The country representatives suggested that this project opened new spaces to discuss these topics.

Providers were eager to conduct all-staff sensitization sessions in their clinics because they were aware that personnel such as the security guards and clerical personnel sometimes discriminated against members of vulnerable groups. HIV laws help to strengthen these efforts and according to the stakeholder, although there is still a long way to go, treatment of FSW and MSM has improved. New laws, such as the one in El Salvador combating homophobia, contribute to efforts to legitimize discussion of these topics. On the other hand, in countries like Belize and Panama, MSM are invisible to health services as their sexual practices are deemed illegal. In this case, the awareness of stigma and discrimination is limited. Stakeholders feel that continuing to certify providers using this approach may ameliorate this situation.

<sup>7</sup> \*Significant at the  $p < .05$  level in McNemar test.



Stakeholders explained that some certified providers struggle with their personal and religious beliefs when offering services to FSW and MSM. This can be seen in the results of the follow up visits. Some providers do not address all of the items in the verification list, perhaps due to discomfort discussing the specific sexual practices of their clients. For example, according to the results of the simulated client visits, only 52% of the providers asked clients about the type of sexual relations they engage in, and few explained how to use a condom (39%) or discussed lubricant use (26%). Stakeholders mentioned the need to provide FSW and MSM clients ways to report perceived wrongdoing, such as establishing confidential complaint procedures.

Related to this point is the perceived lack of educational materials for FSW and MSM among stakeholders. In most cases, this is due to lack of resources, but may also be a result of the perceived invisibility of MSM that seeking testing.

The country representatives suggested that the clinic sensitization talks given by the newly trained providers should take place more than once in each site, due to the frequent personnel rotation. They suggested that these talks provide the opportunity for other staff to raise awareness of discriminatory actions. For example, the Belize country report states that some participants were very vocal in their rejection of MSM during sensitization sessions, but the session allowed them to explore the source of their stigma and the importance of remaining objective in fulfilling their responsibilities as health providers. The follow up visits also provide an opportunity for country representatives to identify problem areas, and emphasize these in the seminars, if needed. The providers also commented that the inclusion of FSW and MSM in the certification approach sets it apart from other training initiatives.

The interviews with the stakeholders suggested a common belief that civil society is moving towards improvements in human rights, and therefore these efforts to increase awareness of discrimination are very welcome. Local organizations are addressing these issues in various ways and view the continuing education of providers as complementary.

#### **4) Are implementation partners taking steps to integrate this approach into their program?**

Local organizations are integrating the lessons learned through the certification process into their own programs. According to the stakeholders interviewed, most of the Ministries of Health in all four countries would like to expand this process on a larger scale. In order to accomplish this, they plan to use already certified providers to spread the knowledge and skills to the providers in other areas who have not yet been certified. Stakeholders suggest that this will be relatively easy in El Salvador and Panama where the capacity building strategy fits into new government mandates to address stigma and discrimination. In El Salvador, the Ministry of Health has institutionalized the materials from the certification process into their trainings, and covered the costs of training workshops and seminars in order to reach a larger number of providers than originally planned. Despite recent challenges due to the H1N1 epidemic, the Ministry of Health of Nicaragua has emphasized the expansion of this effort to other cities.

Materials such as the verification list have been adopted by some of the Ministries of Health, formally integrating them into their program or informally photocopying the tools in mass testing events. Some stakeholders mentioned that they are considering replacing their own materials with the certification materials. In Nicaragua, the verification list was distributed to participants during events on National

AIDS Day in December 2008. The main aspect the MOH is implementing, or starting to implement in other health areas, is standardization of counseling components. This is demonstrated by the fact that in Panama and El Salvador, counselors certified by this strategy were utilized for testing during their respective “National Testing Days”. Since most of the certified providers work for the Ministry of Health, they have been applying what they have learned to different spaces in the MOH. One example of this is that during the governmental transition in Panama, one of the newly certified providers attained an executive position in the Ministry, and has expressed support for future certification activities to the local heads of HIV/AIDS in the different cities. The National AIDS Program in Panama has indicated that they would like to continue certifying additional providers. Certified providers provide a valuable resource, according to stakeholders, that they can deploy in future training. Although not as formal as the seminars, some stakeholders feel that the providers will share their new skills with their coworkers, to the benefit of all. As managers and agency directors, they intend to provide the space to make that happen.

Regarding the question of to what extent organizations might continue this capacity building strategy on their own; stakeholders agree that this depends on available resources. As a result, they have taken a ‘cafeteria approach’, integrating components of the program on their own. One example, is continued follow up by monitoring and evaluating certified personnel. Although most of participating organizations and agencies have the personnel resources to continue these activities, they feel that additional support will be welcome to continue these efforts; especially in the case of small organizations, which have only a few certified VCT providers. This is not the case with clinics supported by the Ministry of Health, which have certified a large number of providers. In addition, some of these NGOs feel that they can contribute to broad utilization of these tools by training other organizations. Another element of the strategy that some consider feasible to continue, especially the MOH, is to repeat the most popular seminars. For example, a stakeholder in Belize mentioned that they planned to emphasize burnout and self care, along with stigma and discrimination.

Evaluation and follow up of certified providers and others is another aspect that might be continued. Through the indicators established during the development and implementation of the certification process, program managers feel that they can now measure quality in counseling. One stakeholder suggested continuing application of the simulated client methodology to evaluate services through a standardized method. Finally, many of the stakeholders mentioned the need for continuing education through educational materials. They felt that their current materials do not address the diversity of HIV infection, an aspect that should be remedied.

Some smaller-scale institutionalization of the project’s work includes the continuation of working groups formed during the life of the project. For example, the IRH country coordinator in Nicaragua coordinated with other USAID funded projects such as PASMO, NicaSalud, Capacity, Garantía de Calidad, Deliver and PRONICASS to form the HIV Technical Group to share experiences, methodologies and interventions. With the end of IRH’s work in Nicaragua, PASMO has taken over coordination of this group. The University of Panama continues to coordinate free testing through their VCT campaign during which many certified providers volunteered their counseling services. Services with the armed services and the national police have been established with a number of providers in their clinics certified. Although no particular organization in Belize will be taking over the certification process, several plan to integrate pieces of the process into their work. PAHO, the Belize Family Life Association and the Ministry of Health have discussed providing sensitization sessions for their staff to improve services for sexually diverse groups.

## VI. Lessons Learned

### Lessons Learned

A number of lessons were identified during the formative research phase and throughout the planning, design, implementation and evaluation of the interventions.

- Stakeholders and providers perceive the value of ongoing capacity building/mentoring strategy, as opposed to one-time training events.
- All intervention countries had comprehensive guidelines and protocols that were share with providers during the training process. However, emphasis on easy-to-use, simple job aids that contribute to agile, effective counseling is critical to ensure protocols are operationalized and actually used in service delivery.
- Programs should continue and foster the active participation of members of vulnerable groups in the planning, implementation, and evaluation of interventions, thereby promoting group empowerment and project ownership.
- Although there are benefits to a regional strategy, it is important to maintain flexibility to adapt to local context and needs.
- Approaching stigma and discrimination through the lens of human rights and sexual diversity is a more effective strategy than focusing on specific vulnerable groups, which may have the unintended effect of further stigmatization.
- Synergy is produced by the passage of legislation guaranteeing human rights and preventing stigma and discrimination at the same time capacity building efforts are underway to address these issues. Our project was implemented at a time when this legislation was enacted or under consideration and the timing for implementing the intervention was right.

## VII. Recommendations

This initiative resulted in an effective and popular capacity building strategy to improve the competency of VCT providers and reduce stigma and discrimination. The manual and IE&C materials for addressing stigma and discrimination among FBOs were also valuable products of this collaboration, as evidenced by high demand among organizations to continue work in this area. The results of the formative research, intervention and evaluation provide valuable recommendations for future initiatives to increase the quality and utilization of VCT services and reduce stigma and discrimination.

### Recommendations derived from interventions with public and private sector programs

- In addition to training VCT providers, it is important to direct sensitization efforts to all clinic/health personnel (waiting room, lab, other health providers and other clinic staff).
- VCT provider training should integrate a rights-based approach in service delivery, particularly to marginalized populations such as MSMs and FSWs. This will ensure that their rights are respected and unfair discrimination is avoided.
- In order to maximize the effectiveness of training initiatives, concerted efforts are required to ensure coordination between Ministries of Health, national training institutions and cooperating and donor agencies.
- The psychological needs of VCT personnel should be addressed as part of the efforts to improve the quality of services.
- Continue to institutionalize and encourage use of the VCT checklist as a tool to help service providers become familiar with a complex or detailed service protocol and use as guidance to address sensitive issues during counseling.
- Disseminate widely the training manual and materials to donor agencies, cooperating agencies, Ministries of Health, training institutions and other organizations so that they can use the manual or elements of the manual in their work.

### Recommendations derived from interventions with FBOS

- Continue efforts to engage FBOs in HIV activities through distribution of training and IEC and materials and continued support to FBO networks in each country.

## VIII. Faith Based Component

Many churches and faith-based groups have responded to the AIDS epidemic with compassion and empathy, but also with limited knowledge and resources to guide their support. Churches of different faiths have been providing their congregants with emotional support for all their hardships, including illness, but many feel they have a role and obligation beyond this type of spiritual support. Many Faith-based Organizations (FBOs) express an interest in working in the area of HIV/AIDS prevention but lack the skills and resources to approach the issue with their congregations and communities. In addition, there remains a need for these influential groups to organize themselves to put forward a joint response to how they can best offer support to HIV/AIDS prevention in their communities. Work with FBOs was an essential element of IRH's efforts within this project to address stigma and discrimination associated with MSM and FSWs and to promote VCT services.

### *FBO Regional Conference (2006)*

In 2006, PASMO and IRH collaborated to host a regional FBO conference in Guatemala City. IRH country coordinators invited key FBO and religious leaders from their countries (Belize, El Salvador, Guatemala, Nicaragua and Panama) to participate. The goal was to create a dialogue among churches and FBOs to discuss their roles in the fight against HIV/AIDS by reducing related stigma and discrimination towards PLWHA and others and to help develop partnerships for their efforts within their countries. The specific objectives of this conference were to:

- Motivate FBOs to take "moral" responsibility by advocating to diminish stigma and discrimination within their churches and organizations;
- Explore the different strategies FBOs can use to combat stigma and discrimination within their communities; and
- Strengthen the capacity of church and FBO leaders to coordinate activities within their organizations and among civil society to identify and reduce stigma and discrimination.

In the end the conference brought about interesting results, most notably:

- Training and orientation on stigma and discrimination at a religious level for FBO leaders is needed;
- Little information is available on HIV/AIDS for churches and FBOs;
- It is important to work directly with religious community leaders or outreach personnel on these issues; and
- Churches need help preparing a public response to the situation of HIV/AIDS in their community.

While great progress was achieved during the conference, there was more work to be done and another conference was recommended to develop concrete action plans to achieve the objectives set out, specifically, developing resources to guide FBOs and developing country plans to ensure anti-stigma and discrimination activities were included in the churches efforts. The need to develop these action plans was addressed in each country with IRH coordinators facilitating the process with local partner organizations.

### *FBO Regional Workshop (2008)*

Two years later, in 2008, IRH and PASMO brought together representatives from 21 FBOs from the same countries to a regional workshop held in Antigua. The goal this time was to identify negative attitudes and beliefs related to gender sexual diversity and human rights, and develop strategies and activities that FBOs and other religious groups could integrate in their involvement with communities to improve attitudes.

To better equip FBOs working in this field, IRH designed a faith-based component to the VCT counseling manual. The topics addressed by this component include stigma and discrimination, gender, culture, sexuality, diversity and human rights using teachings from religious text, such as the Bible. The creation of a manual like this was seen as a strategy to develop a unified approach by FBOs in response to HIV/AIDS related stigma and discrimination. A presentation of the initial version of the future FBO manual was shared with all the participants.

As part of the workshop, FBOs from each country were asked to develop a country plan using objectives for integrating anti-stigma and discrimination activities. The purpose of these country plans was to:

- Strengthen FBO outreach capacity through communication strategies which optimize public HIV messages focusing on human rights and sexual diversity;
- Develop methodologies that could be included in existing FBO HIV trainings addressing stigma and discrimination, human rights and sexual diversity; and
- Develop and implement effective interventions to reduce stigma and discrimination related to HIV/AIDS and sexual diversity at the political, institutional and community levels.

After participating in the presentation on the components of a potential FBO manual and working in groups to brainstorm activities to help reduce stigma and discrimination, participants expressed a need for skills to provide their congregants and their communities with resources and information on HIV/AIDS, as well as a better understanding of how their faith should respond to these issues. These needs and concerns were documented to ensure that the revised manual include these important issues.

### *Training manual for FBOs*

After the FBO workshop, IRH/Guatemala, in collaboration with the Norwegian Church Aid (NCA), assumed the task of producing a training manual and facilitator's guide for FBOs and religious leaders to use with their communities. The manual would be loosely based on the VCT manual developed earlier and the presentation developed by the FBO workshop facilitators on a religious response to HIV/AIDS prevention and understanding sexual diversity. The manual was titled "*Acompañando a nuestras comunidades: Manual de capacitación para la respuesta de las organizaciones basadas en la fe al estigma y discriminación relacionados con el VIH*" (Accompanying our communities: Training manual for faith-based organization's response to stigma and discrimination related to HIV). A full copy of the final version of the manual is found in Annex 4.

The objective of the manual is to strengthen the skills and competency of facilitators from FBOs, whether they be religious leaders or community outreach personnel, on four key issues related to reducing stigma and discrimination, which serve as the chapters of the manual: 1) Exploring Gender, Culture and Religion; 2) Sexuality; 3) Stigma and Discrimination; and 4) Sexual Diversity and Human Rights.

In the opening chapter, participants explore the role of religion in society and culture and how it affects people's views, behaviors and attitudes towards others. This chapter emphasizes the importance of understanding the impact of this role and its potential responsibility in creating stereotypes and discrimination. The first chapter also introduces participants to the differences between gender and sex. The second chapter, aims to help participants understand sexuality as an integral concept and explore the links between gender and sexuality, as well as, teaching them how to think about how and why it is important to integrate sexuality in their work.

The third chapter introduces participants to stigma, discrimination and gives examples of its manifestations, as well as, discussing its impact and examining participants own attitudes towards individuals who they consider different from themselves. This third chapter ends by exploring ways in which FBO can work in a discrimination-free environment. The fourth and final chapter helps participants identify the attitudes and prejudices that some people face when they try to participate in their church and analyzes the current barriers that exist at churches and FBOs, which deny access to much-needed guidance about HIV/AIDS.

### *Implementation of FBO curriculum*

Leaders from FBOs and religious groups in El Salvador, Guatemala, Nicaragua and Panama were initially invited to participate in a workshop in their respective countries to test the draft manual. Feedback from the different countries was incorporated in the final version of the manual, which takes between two hours and three hours to implement, depending on the size of the group and the depth of the discussion.

### Belize

In Belize, unlike other countries, one FBO – Hand in Hand Ministries (HHM) – took the lead in following through on the objectives set out during the original FBO conference in 2006. While IRH did not yet have a country coordinator for Belize in 2006, HHM actively participated in this conference along with the Association of Evangelical Churches and joined in again in 2008 along with St. Peter's Anglican School and the Council of Churches' Committee on a Faith-based Response to HIV (COMFORTH). During these meetings, participants committed to working with the IRH in their country to strengthen the faith based response to HIV using a unified approach.

These FBOs expressed a need to address three key issues in order to continue this work in their country: 1) the absence of a national plan for FBOs; 2) the lack of expertise in facilitating sessions on stigma and discrimination; and 3) the need for the sustainability of capacity building initiatives. The goals of this project helped address some, but not all of these issues. Primarily, while a national plan for FBOs was being conceptualized, FBOs were given an opportunity to meet and work on one component of this plan – their approach to a serious dilemma in their community, HIV/AIDS. FBOs were also given the opportunity to participate in the VCT certification program, including the sessions on stigma and discrimination before the FBO manual was developed. HHM staff participated and went on to conduct sessions on stigma and discrimination for other staff.

Hand in Hand Ministries, along with other FBOs, then implemented the FBO manual when it was made available and began looking for opportunities to incorporate its messages into their activities. The director of the National AIDS Commission Secretariat became involved in the process and stressed the

importance of getting all FBOs on board. Follow up meetings with the trained FBOs were held, but it was agreed that more time and resources need to be dedicated to these efforts.

### El Salvador

El Salvador has had the greatest number of FBOs involved in the beginning and throughout this process. During the FBO conference of 2006, it counted with the participation of the Red de Cristianos Unidos contra del Sida, Catholic Relief Services (CRS), Equipo contra el Sida, Ministerio Internacional Leon de Juda, Iglesia de Dios en El Salvador, Iglesia Espiritual de VIDA and Iglesia. Later, in the 2008 workshop, others joined, including: Iglesia Luterana, Tabernaculo de Avivamiento Internacional, Caritas El Salvador and Visional Mundial El Salvador.

The primary strategy in El Salvador was to join the National Group of Faith Based Organizations Working for the Prevention of HIV. IRH held meetings with this group to discuss the role of the church in bringing about action for HIV prevention and the spiritual needs among all groups. Strategies to include FBOs in joint activities with the Ministry of Health (MOH) were also discussed and implemented to.

The IRH country coordinator in El Salvador met with FBOs that had participated in the two meetings to begin working on the proposed interventions of the work plan. The churches and FBOs first conducted sensitization sessions with parish clinics and spiritual leaders. Subsequently, the IRH coordinator presented a work plan at the local level which included a training for leaders and a sensitization session for parishioners. Some of the activities in this workplan included:

- A sensitization session on stigma and discrimination and sexual diversity with community personnel for CRS;
- A VCT training with pastors and their wives for Tabernáculo de Avivamento;
- A training with social workers and support groups for people with HIV for CARITAS;
- A training with the pastoral team and representatives from seven other churches conducted by ELIM Church, with IRH's support;
- Forums to discuss sexual diversity, the church's stance on HIV, updates on anti-retroviral treatments, existing stigma and discrimination in the community, and children orphaned by HIV; and
- Follow-up sessions with CARITAS and CRS.

Other activities in El Salvador included working with FBO leaders to promote activities and messages to reduce stigma and discrimination towards MSM and FSW seeking HIV counseling, update statements and national statistics related to HIV, and learn what VCT services the Ministry of Health (MOH) and Non-Government Organizations (NGOs) are already providing in order to have information available to make referrals.

The final phase of FBO activities in El Salvador, as in other countries, was the implementation of the FBO manual. The initial testing of the manual was done with representatives of FBOs in San Salvador and members of the Lutheran Church. The training was then held with participants from parish clinics and leaders of FBOs.



## Guatemala

In Guatemala, the main focus of all activities under this project was related to working with FBOs. Furthermore, Guatemala hosted both FBO regional meetings took on the task of developing the training manual and facilitator's guide for FBO leaders, in collaboration with NCA.

The country strategy for Guatemala had five key components:

1. An internal communication plan, which involves different decision-makers within churches and FBOs.
2. An external communication plan for providing information and communication materials to disseminate messages to the public.
3. A training for religious leaders to help them identify and develop key messages on HIV/AIDS issues
4. A training for FBO leaders on stigma and discrimination, using the FBO manual, which would later be replicated by the participants.
5. An advocacy plan that targets the community, institutions and policy makers. (Due to time constraints the advocacy portion of the strategy was not implemented).

Guatemala's internal and external communication plans allowed IRH to work with different actors in FBO and churches, including its leaders, but also outreach and community personnel. The plans help identify the individuals to participate in the trainings and the better explore their roles within their organization.

In Guatemala, FBO leaders participated in a two-part training titled "How to be effective in our communication with media outlets". As part of this training, participants learned about working with print media, as well as, television and radio media. Specifically, participants were given resources and guidance on how to write press releases and give interviews, among other activities. All the activities relayed important messages about the church's role against stigma and discrimination.

The final activities in Guatemala were the trainings on stigma and discrimination using the FBO manual. These activities, held in December after a few sensitization sessions, were well accepted by participants and allowed IRH to further test the manual and how it can be used better as a training guide. At the end of the trainings, participants seemed dedicated to continuing these efforts within their organizations, including conducting trainings themselves. It was recommended that follow-up support be given to these activities.

## Nicaragua

In Nicaragua, the principal activities related to working with FBOs to help reduce stigma and discrimination were: participation of FBOs in the meetings held in Guatemala, validate the FBO manual and training FBO leaders using the tested manual. The religious groups involved in the FBO activities in Nicaragua were:

1. Iglesia Luterana
2. Iglesia Metropolitana
3. CARITAS Nicaragua
4. Accion Medica Cristiana
5. Vicariato Apostolico de Bluefields

These first four groups were involved since the 2006 conference, where as the others joined in during the 2008 workshop and afterwards. Unfortunately, there existed division among some of the FBO groups in Nicaragua, which delayed a coordinated effort from developing in- country earlier. The division arose due to lack of consensus their stance on HIV/AIDS issues. However, after some delays, the FBOs were able to carry on the proposed activities in their country.

As was the case in other countries, some FBO members participated in the VCT certification process. In Nicaragua, the Vicariato Apostólico de Bluefields delegated two people to participate. FBO personnel learned a great deal from the VCT training, especially how they could support a member of their church at the time of their diagnosis, how to help manage that time, and how to use the church as a source of support.

The Lutheran and Metropolitan Community Churches assisted with the validation of the manual for FBOs. There were 17 participants in the training, including pastors and community leaders.

### Panama

IRH began activities in Panama in early 2008, and the collaboration with FBOs began immediately after the workshop in Antigua. In general, working with religious groups in Panama posed a challenge because of the resistance to the topic of HIV/AIDS and its links to sexuality and moral behavior. Religious groups have been very vocal opposing passage of national sexual and reproductive rights legislation. However, support from participants at the Antigua workshop helped move forward coordination meetings to develop a work plan and objectives for in-country activities.

Participating organizations in Panama included Red Defensoria de Derechos Humanos PVVS, Casa Hogar San Jose de Malambo, Hogar el Buen Samaritano, and the secretariat of the Ecumenical Institute. Through their efforts, they formed a network of FBOs committed to work on HIV/AIDS issues. The objectives of the network were to develop and execute integrated programs to increase awareness and understanding of HIV prevention among the general population. This group is also interested in promoting HIV prevention through responsible behavior.

FBO leaders in Panama coordinated activities with the National HIV/AIDS Program. The Program had an existing partnership with PASCA-USAID, which with their own funds will be able to continue the work that IRH has started. One of the activities coordinated with the Program was sensitization sessions with participants from different churches. In the first session, 37 people participated and discussed the HIV/AIDS situation in Panama and relayed their commitment to the cause. Twenty-five people participated in a second session which focused on HIV/AIDS, stigma and discrimination and the country work plan.

FBO representatives then went on to participate in the training on stigma and discrimination. The IRH country coordinator first reviewed the manual with the help of FBOs. In addition to the manual, a few leaflets were developed on HIV/AIDS, stigma and discrimination and resilience and HIV. Other FBOs have used materials from Consejo Episcopal Latinoamericano (CELAM) and UNAIDS to distribute in parishes who assign a member to be part of the Pastoral.

### Mexico

At the end of September 2009, a training for FBOs was held in Mexico City, Mexico with assistance from PSI Mexico. Due to the funding challenges presented to the project in the beginning of its final year, the

development of the manual for FBOs was delayed until July 2009. As a result of this delay, scheduling conflicts did not permit this activity to take place earlier than September. This training was facilitated by IRH's country coordinator from Nicaragua. Eleven participants from four FBOs and PSI participated in the one-day training. During this training the IRH country coordinator from Nicaragua shared with the group the manual developed by IRH and explained the purpose and objectives of the manual. Due to limited time, the training only covered the stigma and discrimination section.

The training activities related to stigma and discrimination included identifying stigmatizing and discriminatory attitudes and behaviors, measuring the impact, mobilizing and looking at testimonials of people living with HIV. A questionnaire regarding knowledge and perception was distributed at the beginning and the end of the day. Analysis of the responses to the questionnaires showed little change from the beginning of the day to the end, but demonstrated that the group had a strong existing knowledge and awareness of their perceptions. Participants showed interest in the issues discussed and were each given a manual to take back to their organizations for future use.

## IX. Annexes<sup>8</sup>

1. [PDQ Final Report](#)
2. [VCT Checklist](#)
3. [Voluntary Counseling and Testing Manual](#)
4. [Manual for Faith Based Organizations](#)
5. [Belize Country Report](#)
6. [El Salvador Country Report](#)
7. [Nicaragua Country Report](#)
8. [Panama Country Report](#)
9. [Guatemala Country Report on FBO Activities](#)
10. [Mexico Report on one FBO Training Activity](#)
11. [Data Collection Instruments](#)

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<sup>8</sup> For electronic versions of this report, please refer to additional attachments for annexes.