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# Executive Summary

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VCT is forms as screening tool and early HIV diagnose to HIV patient that continued by CST care. The successful of VCT is depending on the VCT quality of care in behavior changed of client. This study is as one effort to understanding the problem, both in facility or individual level. The objectives of this study is to learn about quality and factors influencing to VCT care access in Surabaya, while the main objectives is to learn when and where the current target group member get VCT care; what will happen to the target group member after knowing their HIV status; other parties influence in making decision to get VCT; client barrier in getting VCT care; and the way to improve the VCT quality services.

This study is covering the qualitative and quantitative data collection. Target of the study are all VCT facilities in Surabaya, acceptor group and non acceptor VCT of IDU, Transgender, Gay and Sex Worker (direct and indirect). Our team also assesses the quality of VCT care facility by field observation and interviewing the program manager or other senior staff regarding their VCT care institution. Structured In-depth interview done to documenting the characteristic of history, cost, target group, related program, and recruitment strategy in each facility. Beside what VCT care services offered, and how to handle client are also asked through in-depth interview and FGD, to the VCT program staff that consist of manager, field worker, counselor, and cases manager. Staff also asked to explain their perception of client and VCT limitation.

Result finding on each study group are; finding in VCT facility showed that funding support for operational program cost in most of VCT care is still depend to donor agency. Client must not pay for the VCT care given; most of VCT care provider has capability to give one day service; for VCT client with HIV+ status, all VCT facility has capability to guarantee CST care service; there is staff of service that not well understand about standard operational procedure; every VCT facility has gained to run the procedure to keep client confidentiality status; challenges for staff and management are many VCT facility supported by insufficient staff, so that the staff should cover the work load; generally, staffs had trained of VCT, but only a few staff not; VCT facility have risk in running this program if they are not obey to the VCT procedure, they may get complain or pursuit from the client; recommendations their given are to up-grad the facility in order client comfortability; effort to make network with other institution should be more increased; and if there is a problem between the network, there should cover with communication; divided work area of each VCT care service; availability of ARV and reagent are also to be maintained.

Result finding on NGO program in HIV prevention supported by ASA showed that VCT client mainly are come from the high risk group it self; each facility has effort to spread the VCT service program to the target group by the most suitable way with the target condition; VCT care given at no cost/free, even at the start service was not plan for free; VCT client, both negative and positive status are going to have continued service from related NGO; for outreach effort, every NGO are rely on to the outreach worker; support for operational program are come from donor agency. Barrier to recruit a new staff usually is on operational cost, and nevertheless is strong stigma from the community. Another staff challenge in the field is high workload and operational control done by security apparatus. While for recommendation; they recommend to increase the VCT quality by form comprehensive VCT facility in related

NGO, increasing ARV access and number of VCT facility, develop human resources and more attention to the client comfort, and also improving the role of facilitator group they have.

Result finding on VCT acceptor showed that not all participant have same perception about understanding on the way of transmission, and risk of HIV/AIDS transmission; participant get source of information about HIV/AIDS and VCT from NGO, media, health staff, and from their friend; barrier in decision making to have VCT or not, is because they are affraid of the result, afraid of losing job, worries of being discriminate by their friend, worries if other people know their HIV status, and afraid being died as their friend. The outreach worker from NGO is the one who can support participant in decision making to have VCT, or one of their family member, doctor who give treatment to them, their friend, staff from community health center (Puskesmas), beside the decision also base on self motivation and knowledge of the fact that many of their friend suffer from HIV; assessment of the counselor by each participant for their satisfaction or not; regarding the confidentiality, they mentioned that their confidentiality has keep well while other said not; Participants hope that VCT care especially for the confidentiality should be more attention, and so for the comfortable of the VCT room, continually control about patient condition, add number of VCT care provider, exmination result can come out as soon as possible, docter staff not in rush when giving services, and remain free of charge for the service.

As the result from quantitavie study shows that 88.9% locations of VCT services are reachable easily and also the infrastructure are sufficient.

From this study we can learn that, actually, VCT service facility condition very much depend on donor agency as stated by KPAN (76% HIV cost prevention depend to the international donor and 24% from domestic donor) if this situation not changed to opposite condition (76% HIV cost prevention come from domestic donor, 24% from international donor) there will be difficult to reach for VCT sustainability. Beside, means of this VCT activity is very much depend to the outreach worker activity, if there are outreach worker who earn from this kind job, so there are will be VCT client result, but, if there are no fee for the outreach worker so there will be no VCT result. That is why, to optimalized VCT care service in Surabaya, it is not only need to improve the VCT facility, but community condition (especially to the high risk group) to get test in VCT facility (as early as possible are still very difficult) so they can get comprehensive CST treatment, that finally can increasing the quality of life.

In other word, VCT is still suitable to be continued, if the community condition especially to the high risk group it self wish and can afford to come to the VCT facility provided without dependent upon the outreach worker.