THE REPUBLIC OF UGANDA

Uganda National Policy Implementation Guidelines for HIV Voluntary Counselling and Testing Services

Ministry of Health

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Contents

Abbreviations

AIC	AIDS Information Centre
AIDS	acquired immune deficiency syndrome
ANC	antenatal care
ART	antiretroviral therapy
ARV	antiretroviral drug
CORP	community-owned resource person
CPHL	Central Public Health Laboratory
DDHS	district director of health services
ELISA	enzyme-linked immuno-sorbent assay
FP	family planning
HIV	human immunodeficiency virus
JCRC	Joint Clinical Research Centre
M&E	monitoring and evaluation
MoH	Ministry of Health
NACWOLA	National Community of Women Living with AIDS
NGO	non-governmental organization
NHRL	national health reference laboratory
PHA	people living with HIV/AIDS
PMTCT	prevention of mother-to-child transmission [of HIV]
PTC	post-test clubs
STD	sexually transmitted disease
TB	tuberculosis
UVRI	Uganda Virus Research Institute
VCT	voluntary counselling and testing

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Foreword

Voluntary counselling and testing (VCT) is a major lynchpin in HIV/AIDS prevention and care strategies. Persons, their spouses and sexual partners are better equipped to make appropriate HIV prevention decisions if they know their HIV status. Couples about to be married can use VCT to know their HIV status before deciding on marriage. VCT can enable pregnant women to learn their HIV status and seek services to help prevent mother-to-child transmission of HIV. Women of reproductive age who go for counselling before pregnancy can make informed decisions about becoming pregnant, based on knowing their HIV status. VCT lets people who are infected learn their HIV status early enough to receive adequate care and support. Early care and psychosocial support may enable them to live a longer and better quality of life with HIV.

Uganda has had much success in HIV prevention and care. But more needs to be done and VCT is central to this. Uganda is a model for VCT service delivery. Many partners, both present and emerging, are doing an excellent job of providing high-quality VCT. The government of Uganda now aims to place high-quality VCT service within the reach of every Ugandan. As we go to scale, however, we need national guidance and quality assurance. We need to clarify such issues as who should receive VCT, who should deliver it, and when and how they should deliver it.

Many countries and international agencies look to Uganda as a showcase of good HIV/AIDS programming. It has thus become increasingly necessary for the government to systematically outline policies and guidelines upon which our programmes are based.

The government believes in an open and participatory approach to HIV/AIDS policy development and programming. Guided by this principle the Ministry of Health, having been mandated to develop national VCT policy guidelines, decided to involve a wide base of stakeholders. In the process the ministry thus involved scientists, counsellors, medical and health professionals, service managers, policy-makers, donors and community members, especially people living with HIV/AIDS. The government of Uganda is therefore convinced that these guidelines are based on a strong base of cutting-edge research data and experience in delivering services as well as addressing community concerns. It is my sincere hope that the guidelines provide a framework for reaching all Ugandans with high-quality and ethical VCT services.

Finally, I take this opportunity to express the gratitude of the Ministry of Health to all the people and institutions listed in the acknowledgement for the selfless work they did to produce these excellent guidelines.

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Implementation guidelines for VCT services

Introduction to the document

There are two related guidelines regarding VCT services in Uganda.

The *Uganda National Policy Guidelines for HIV Voluntary Counselling and Testing* states what should and what should not be done regarding VCT in Uganda. It has a glossary defining commonly used terms in VCT in Uganda. Policy-makers and planners of HIV/AIDS programmes are the main target audience for the policy guidelines.

This related document is the *Uganda National Policy Implementation Guidelines for HIV Voluntary Counselling and Testing Services,* which restates the national policy on VCT and goes further to spell out how the policy should be implemented. This guide is intended for the wider audience of HIV/AIDS programme managers and service providers but is also a useful resource for policy-makers and planners. In this document the policy statements are highlighted with a shaded background.

Process of development of the guidelines

These guidelines were developed through consensus building. The initial scope of the guidelines was developed in a meeting of the national coordination committee (CT 17)[1] of stakeholders held on 5 August 2002 in Hotel Africana, Kampala. Individual interviews of a cross-section of stakeholders were conducted to seek stakeholder views, opinions and preferences regarding the list of issues raised in the stakeholders' meeting. Policy statements were then developed and discussed with small groups of experts. In December 2002 expert groups met with representatives of counsellors of youth and adolescents, clinicians, laboratory experts and people living with HIV/AIDS (PHAs). Key stakeholders were called on to meet from time to time to review the work in progress. In addition, two national consensus workshops were held: one for the policy guidelines (20–21 February 2003) and another for the implementation guidelines (28–29 March 2003) in the Ridar Hotel in Seeta Mukono. The implementation guidelines also draw from the vast experience of VCT implementers in Uganda and other countries as well as WHO and UNAIDS publications on the topic. These sources of information are listed at the end of this document.

The secretariat of this process has been in the Ministry of Health STD/AIDS Control Programme.

Uganda has much experience in developing and implementing VCT services, pioneered since 1990 by the government and the AIDS Information Centre (AIC) in partnership with other HIV/AIDS NGOs (non-governmental organizations) in the country. Thus there is already a wealth of materials and resources on how to develop, deliver and monitor high-quality VCT services in a variety of settings in the country.

The VCT implementation materials available from these partners are, however, specific to the organizations themselves and the settings under which they operate. These 'how-to' experiences have been summarized in a checklist format for each element of VCT service delivery. It is important to note that every implementer of VCT services

[1] The original members of this committee were 17 key stakeholders.

will need to augment these checklists with details that can only be developed once specifics of the setting, funding and target audience are clear to the planners. To facilitate this process a number of site-specific examples are cited in boxes in the guidelines, which other VCT implementers can adapt and adopt to suit their circumstances.

These guidelines are developed in line with the decentralization policy, which stipulates that the planning and implementation of developmental programmes should take place at the district level.

Chapter 1. VCT services

VCT is a core intervention in the comprehensive strategy of the government and its partners to address HIV/AIDS in Uganda. High-quality VCT services should therefore be widely and consistently available. The demand for VCT is growing. The need thus arises to continue mobilizing resources to meet this demand and to strengthen the infrastructure to accommodate VCT services.

Making the service user friendly to groups such as the youth, commercial sex workers and the elderly should be considered during the planning and delivery of VCT services.

1.1 VCT promotion

Once a VCT service is available it is important that the community be informed about its availability and its role.

Mass education, while explaining the meaning of HIV-positive and HIV–negative results and the procedures at the VCT centre, should encourage the public to take advantage of VCT services voluntarily.

Inform communities about the availability and advantages of VCT through radio and TV programmes, posters and the print media in English or local languages as appropriate. Collaborate where possible with related programmes already using the mass media to promote health services such as the health information programmes in the Ministry of Information, the Health Education and Health Promotion Division of the Ministry of Health (MoH) as well as the AIDS control programmes of other ministries. Collaborate also with non-governmental organizations (NGOs) that are already using mass media to educate the public about HIV/AIDS. Use film vans or video machines appropriately to show films promoting VCT to communities. Collaborate with the private sector such as radio and TV stations and companies as they promote their products to promote VCT as well. Education should target community events and special days such as Youth Day, Valentine's Day and World AIDS Day. Employers and heads of academic institutions should be urged to encourage their employees or students to seek VCT services. VCT promoters should address gender disparity in access to information and services.

Interpersonal communication to mobilize specific target groups

Create awareness about VCT among clients and patients seeking other services such as for sexually transmitted diseases (STDs), TB and antenatal care (ANC) as well as in the general outpatient clinic. Extra effort should be made to create awareness among hard-to-reach people such as commercial sex workers and their clients by approaching them at locations such as bars, hotels and discotheques. Other special groups such as highly placed people and the elite should be especially targeted using favourable environments.

Example: *Voluntary counselling and testing (VCT): a guide for the mobilisation of communities.*[a] This booklet covers the following topics:

- What is VCT?
- Benefits of VCT
- What does living positively with HIV mean?
- When should one go for VCT?
- What makes people attend VCT services?
- Where are VCT services found in the country?
- What should you expect at the VCT centre?
- What does VCT cost?
- How long do you stay at the VCT centre?
- How is blood tested?
- How can you support the VCT programme?

[a] Kasozi, C. R. [no date.] *Voluntary counselling and testing (VCT): a guide for mobilisation of communities.* Kampala: STD/AIDS Control Programme, Ministry of Health.

- The problem and magnitude of STD/HIV/AIDS in the locality
- The need to prevent STD/HIV and to provide care and support for those infected and affected
- Benefits of VCT services and procedure to be used at VCT centres
- Importance of testing as couples, before starting a relationship and during an existing relationship
- Location of VCT services in the district and the community
- Meaning of positive, negative and discordant HIV test results
- The need for follow-up services
- The need for a supportive attitude in the community towards people living with HIV/AIDS and avoidance of stigmatization
- Testimonies of individuals who have gone through the VCT process
- Gender roles and power relationships as regards VCT

To attract interest and participation of the wider community, community mobilization exercises should also include other health-related issues such as—

- Hygiene (both environmental and personal)
- Information about and management of HIV-related illnesses such as TB and STDs
- Prevention options including condom use
- First aid for acute conditions like diarrhoea and fever
- Rational drug use (for example, ARVs, directly observed therapy (DOT) and the necessity for adherence
- Any relevant new information on HIV infection and on AIDS care and treatment
- Planning for the family
- Spiritual care
- Existence of other sources of help, such as community-owned resource persons (CORP)[2] in communities
- Support from other organizations

[2] A general term for all community health workers including community health workers (CHWs) and community-based distributors (CBDs).

Promoting VCT through subsidy

Where cost is attached to VCT services, one way of promoting the service could be by way of subsidy.

For example, the AIDS Information Centre (AIC) promotes VCT on special days and provides coupons for free services. Other possibilities are to provide coupons for women receiving PMTCT (prevention of mother-to-child transmission) services to give to their spouses, encouraging them to seek free VCT. Another consideration is to hold a national day for free VCT in all facilities.

1.2 Types and location of VCT services

Establishing VCT services involves four phases:

- Assessment
- Planning
- Implementation
- Monitoring and evaluation

1.2.1 Assessment phase

A VCT site should be selected after an initial assessment and after consultation with key stakeholders from government, local leaders, NGOs and private practitioners operating in the area. For details of the initial assessment see section 6.1.1.

1.2.2 Planning phase

Determining geographical location of VCT sites. First, it is necessary to agree on national targets for the VCT programme in terms of the number of sites and population coverage. If a wide coverage is aimed for, a phased approach is recommended.

To ensure that VCT services are well distributed the locations should be

- Not too near existing VCT sites to avoid duplication
- Accessible using public transport
- In a location where communities usually gather, like markets or towns
- Not in a sparsely populated area
- Where there is a known target population (an organized population that might need these services)

VCT services will be more effectively delivered where communities have organized follow-up services such as post-test clubs, support groups and ongoing support by community-based organizations (CBOs).

Determining the type of VCT sites to set up. There should also be agreement on what proportion of VCT sites should be of one category or another. The different categories of VCT facilities are as follows:

FREE-STANDING SITES

Free standing is a site offering VCT services that is not physically located in an existing health facility. It may have limited care and support services for HIV/AIDS. It should therefore have a

strong referral system with other health services, and efforts should be made to offer other related services such as AIDS care and support, family planning and STD care in an integrated manner.

A *free-standing* site should be located in high-population-density areas with the aim to attract populations that otherwise would not attend VCT services. It should have an easy link with post-test services.

HEALTH-UNIT–BASED SITES

Health-unit–based VCT services are located in an existing health facility, preferably at a level IV health centre and above, where capacity and associated HIV/AIDS services are available. However, level III facilities with adequate capacity should provide VCT. The health facility may be either government or non-government. VCT services at such a site should be integrated into existing health services on a daily basis. However, if a facility is short staffed, specialized VCT clinic days may be established.

A *health-unit–based* site should be providing a range of curative, supportive and preventive services necessary to support clients after VCT, whether positive or negative—for example TB (tuberculosis), STD (sexually transmitted diseases), FP (family planning), PMTCT and HIV/AIDS care and support.

The site should have at least four qualified health workers including a counsellor and a laboratory technician.

The counsellor and laboratory technician should be available to provide VCT for a minimum of 3 days a week at the facility and once a month as an outreach service.

The site where the VCT centre is located should have space for confidential counselling, laboratory work and a post-test club.

OUTREACH SITES

Outreach VCT services may be provided in smaller health facilities such as levels II and III with a mechanism for ongoing support services for VCT clients. Mobile vans, while helpful in mobilization and staff transportation, should not be used for actual VCT service delivery because follow-up and support are difficult. While counselling can be offered during home visits, actual HIV testing should be limited to laboratories.

Outreach VCT services should feed into an existing VCT static (stationary) site and should be within a manageable distance of the static site. For special populations, such as pastoralists, or in remote rural areas with limited health facilities, outreach VCT services should be considered. Agencies providing outreach VCT should ensure that follow-up services are adequate. Creative and innovative approaches to providing follow-up services may be required in these situations. Outreach VCT services should consider an integrated package of primary health services, including STD detection and treatment, child health screening and antenatal care. To increase VCT access for special groups such as the elite and other hard-to-reach groups innovative means to reach out to these groups should be designed.

VCT IN THE PRIVATE SECTOR

VCT services in the private sector must be registered and certified to conform with national standards for delivering VCT services. At a minimum such a facility should have personnel, space

for counselling and an HIV testing laboratory. It should offer ongoing care and support for HIV/AIDS patients or should have an established referral system or links with other HIV/AIDS services. The facility should adhere to the national HIV testing algorithm and have a quality control link with established reference laboratories.

Private-sector VCT services should be well managed to ensure high quality services.

1.2.3 Implementation phase

Implementation involves the following steps:

- Registration of the VCT services and signing of a memorandum of understanding with the district director of health services (DDHS) to start a VCT service in the district (this does not apply if the VCT service is being introduced by MoH)
- Finalization of the VCT protocol for the site (see chapter 2)
- Finalization of the organization and management structure
- Ongoing technical support and supervision
- Training staff
- Procuring supplies
- Team-building sessions
- Dress rehearsal of services
- Launching the service

1,2,4 Monitoring and evaluation

See sections 6.1 and 6.2.

1.3 Integration

VCT counsellors should assess the client's need for TB, FP, STD, ARV, PMTCT and similar services and be able to provide counselling in any of these areas. If counsellors find that clients need such information, they should supply at least basic information, then refer clients for more information and care if required. Service providers who provide TB, FP and STD services should also counsel clients about HIV and refer for VCT if necessary. HIV counselling services should therefore be present in TB, FP and STD clinics.

In facilities where VCT services are not provided daily it is important to ensure that the service is available on the same days as TB, FP and STD clinics, although this may be a challenge if a facility is short on staff.

Integration works best when all component services are provided as expected and are reliably available.

1.3.1 Integration with tuberculosis services

TB integration with VCT:

- Facilities for TB testing (clinical, x-ray, laboratory) and treatment should be in close proximity to VCT services.
- TB clinics should have HIV counselling services.
- VCT counsellors should be given basic training about TB.

Key approaches include the following:

- Actively promote VCT among TB clients by distributing information materials and health education talks by VCT counsellors in the waiting rooms of the TB clinic. Also during individual consultations health workers should advise all TB patients to seek VCT services.
- Where possible introduce on-site VCT services at TB clinics.
- Actively look to detect TB cases among VCT clients testing HIV positive. All VCT clients testing positive who are not already on TB treatment should be screened for it. If they have active TB, refer them for treatment.
- Improve access to a comprehensive package of care for TB clients.
- Train health workers and community service providers about the integrated approach.

1.3.2 Integration with services for sexually transmitted diseases

VCT providers should take an active role in detecting and treating other STDs. It is highly recommended that STD screening be offered to all VCT clients, and when possible, syphilis testing should be performed on the same blood sample as that used for HIV testing. If possible, on-site syphilis treatment should be offered immediately to any VCT client testing positive for syphilis. During registration, VCT clients should be informed about STD services available on site and should be informed that both HIV and syphilis testing will be performed. The counsellor should also inform the client that syphilis testing will occur and of the importance and benefits of being tested for syphilis. Clients should have the opportunity to refuse syphilis testing if they object to it. Facilities for testing and treating STDs should be within close proximity to VCT services. STD clinics should have HIV counselling services, and VCT counsellors should receive training about STDs.

1.3.3 Integration with family planning services

Basic family planning information should be incorporated into all VCT counselling sessions, for both HIV-positive and HIV-negative clients. Especially for HIV-positive clients, the risks of mother-to-child transmission should be explained and the benefits of family planning should also be explained. 'Dual protection,' which is use of condoms for HIV and STD prevention and hormonal contraceptives for family planning, should be emphasized in the counselling session. When possible, family-planning services should be provided at the VCT site. If family-planning services are not available, or if the VCT counsellor does not have adequate time for family-planning counselling, VCT clients should be referred for family-planning services. Both men and women should be encouraged to use family-planning services to make informed decisions about contraceptive measures appropriate to their HIV status. Staff of the family-planning programme should be trained in maintaining confidentiality of HIV test results and the importance of maintaining a respectful attitude to all family planning and HIV clients.

Facilities for FP should be within close proximity of VCT services. FP clinics should have HIV counselling services. VCT counsellors should be trained in FP.

1.3.4 Integration with services for prevention of mother-to-child transmission of HIV

VCT can benefit women who are or intend to become pregnant. Ideally women should have access to VCT before they become pregnant so that they can make informed decisions about pregnancy and family planning. Pre-pregnancy couple testing should be encouraged. Women who are already pregnant should receive VCT as part of ANC. Thus VCT services should be fully integrated in ANC.

Example: The Ministry of Health policy for reducing mother-to-child transmission of HIV has the following recommendations regarding the use of VCT in preventing MTCT:[a]

- Voluntary counselling and HIV testing within the antenatal clinic is recommended for pregnant women, with at least two laboratory tests: one for screening and another for confirmation.
- This procedure necessitates training and reorientation of counsellors and health workers on issues related to MTCT.

It is recommended that VCT be available at the same facility where antenatal care is offered**.**

[a] Policy for reduction of mother-to-child HIV transmission in Uganda (Kampala, Ministry of Health, July 2001)

To encourage male involvement a general VCT facility should be situated in close proximity to a PMTCT centre. Male partners should be encouraged to attend the nearby VCT centre.

1.3.5 Links with childhood Immunizations

All HIV-positive children identified in VCT should be checked to ascertain if they received all immunizations; if not they should be referred for immunization. Refer children with HIV-like symptoms identified during immunization for VCT.

1.3.6 Counselling VCT clients about antiretrovirals

Antiretroviral (ARV) information should be fully integrated into VCT counselling. Even though ARVs may not be available in public health facilities it is important that counsellors provide accurate information to all their clients. This will help prevent clients from being misguided by false information from elsewhere. The following information should be discussed in the post-test counselling sessions of HIV-positive clients:

- ARVs are useful in suppressing the virus but they do not cure the virus.
- They have to be taken as prescribed for life.
- They have to be taken in combinations of at least three drugs.
- If the regimen for taking them is not adhered to, the drugs are not effective and resistance may arise. They have to be prescribed by a qualified doctor who should first carry out an examination to determine if the patient is biologically eligible to start treatment.

- They should be purchased only from established pharmacies by prescription.
- Patients on ARVs need to be monitored by a qualified doctor at least once a month to see if the treatment is effective and if there are no side effects. Clients need to be told what facilities provide ARV care.

1.3.7 Counselling referred clients who are already on ARVs

Sometimes clients are referred for counselling after they have already been started on ARVs. Ideally the client should have received HIV counselling and testing. The physician should have discussed ARVs with the client. However, this is not always the case. Hence the counsellor should always first determine if the client is aware of their status, if they have received VCT and if they accept their HIV status. The counselling session should then proceed to provide pre-test counselling, HIV testing and post-test counselling as the need may be. The counsellor should provide comprehensive counselling for ARVs emphasizing issues like cost, adherence, side effects and disclosure to significant others. The counsellor should also assess the need for other services such as STD, TB and FP. Refer to the National ARV Policy Guidelines, MoH.[3]

1.4 Support services for VCT

1.4.1 Ongoing counselling

After the post-test counselling session in which test results are given, a number of ongoing counselling sessions should be scheduled for both HIV-positive and HIV-negative clients as part of the VCT package. However, since clients differ in their ability to cope with HIV test results, ongoing counselling should be optional and may be continued on subsequent visits. Clinicians, counsellors and pharmacists who provide care to HIV-positive clients should also provide ongoing counselling.

Ongoing counselling is the provision of follow-up HIV/AIDS psychosocial support to individuals and their families after learning their HIV test results. Counselling or clinical staff usually provides ongoing counselling as part of comprehensive care. It may be provided in a clinic or at the home of the client.

The provider should follow up with these next steps:

- Review previous plans to assess their successes and failures and help the client determine the way forward.
- Help the client identify the problems and issues correctly.
- Discuss the possible options.
- Help the client discuss and make a realistic plan of action.
- Make an appointment, agreeable with the client, for the next visit.

Ongoing counselling should be available for HIV-negative clients as well, to help them remain HIV negative.

Follow-up supportive counselling sessions involve the following:

[3] Antiretroviral treatment policy for Uganda, Ministry of Health, April 2003.

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- Help the client accept the diagnosis and consider a way forward.
- Encourage the client to develop early health care-seeking behaviour.
- Inform the client about antiretroviral therapy, treatment and prophylaxis of opportunistic infections, and alternative remedies such as aromatherapy, reflexology and herbal medicines.
- Give continued emotional and psychological support to help the client cope positively with challenges that arise.
- Encourage the client to confide in people who are directly affected by the client's serostatus and any significant others who can provide support.
- Empower the client to embrace positive living to improve the quality of life (medical and general self-care) and encourage fellowship through day-centre[4] activities, such as music, dance and drama for those who can participate.
- Explain the importance of family planning with HIV infection and AIDS and inform the client how to prevent mother-to-child infection.
- Educate the client about use of condoms to prevent reinfection and infection of sexual partner.
- Discuss gender issues in relation to positive living such as negotiation skills, condom use, pregnancy and partner testing.
- Inform the client of social support and refer to other support systems like the Philly Lutaaya Initiative[5]
- Inform the client of income-generating activities like the day-centre skills-building projects such as tailoring and crafts work. Encourage the client to seek spiritual support.
- Provide information on the importance of proper nutrition.
- Encourage the practice of general hygiene.
- Avoiding overindulgence in substances such as alcohol and cigarettes.

PLANNING FOR THE FUTURE

- Provide counselling to the affected family based on the client's consent.
- Encourage a positive outlook on life, including planning for the future for self and family.
- Encourage clients to join support groups such as the National Guidance and Empowerment for People Living with HIV/AIDS (NGEN+), the Positive Men's Union (POMU), the Mildmay International Client Support Association (MICSA), the Centenary Club for Nsambya Home Care, and the National Community of Women Living with AIDS (NACWOLA), where they can engage in activities such as creating a memory book.[6]

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[4] In the language of AIDS care and support organization, a day centre is a room at the care facility where PHAs drop in to chat and share experiences. Some day centres in Uganda have developed drama clubs as well as other income-generating activities.

[5] This organization of PHAs in Uganda is named after a famous Ugandan musician who died of HIV/AIDS in 1989 after coming out and educating the public about AIDS using his personal testimony. Members of this organization go to public places and school and educate their audiences about AIDS by giving personal testimonies.

[6] The memory book project of NACWOLA is a strategy for enabling parents with AIDS to talk about their impending demise with their children by creating a book of memories that they will leave behind when they die. The book is created together with the children and in it they put pictures and write stories to be remembered.

These steps do not all happen at once but gradually and according to the client's capacity to cope with the situation. Continued contact with the client enables the counsellor to identify crisis moments in the client's life and provide crisis counselling. Such moments include unexpected incidents in the client's life such as suicidal tendencies, unplanned pregnancies and family break-ups.

1.4.2 Post-test clubs

Post-test clubs (PTC) should be made available at every VCT centre and an active effort made to promote them. VCT counsellors should encourage every client, whether positive or negative, to go to the post-test club. In addition a promotional campaign should be conducted to make sure many clients attend PTC. In facilities providing PMTCT services, post-test club services should be located in the antenatal clinic.

Major challenges are how to sustain interest in the clubs and how to increase the capacity of current PTC centres to handle the increasing numbers of clients. PTC planners and managers need to address these issues urgently. Drama clubs, for example, appear to be successful in retaining membership as they are able to generate income. Each PTC should be linked to a comprehensive care and support service such as TASO and Nsambya Home-Based Care. Where such a service does not exist nearby, an effort should be made to provide care and support services as part of the PTC package.

Post-test clubs are a package of services that aim to help VCT clients cope with the knowledge of their HIV status and to live positively with their status. Post-test clubs (PTCs) are a service for both the HIV positive and HIV negative. The serostatus of each individual remains anonymous but some members may choose to share their HIV status with others. The club provides preventive and supportive counselling to members mainly by . . .

- facilitating information exchange and experience sharing
- providing peer counselling and education
- encouraging participation in social and recreational activities
- enhancing the positive-living concept
- supporting members in setting up self-help groups and networks

A post-test club should have enough space for holding meetings, playing games and providing confidential counselling. It should aim to hold regular meetings for members at least once a month. Guest speakers should be invited to give educational talks. Where possible seed money should be provided to operate the facility to enable the club to be independent from the VCT centre. Such funding may be sourced from NGOs and donors, but realistic expectations should be set from the beginning about the type, amount and duration of support the PTC should expect from the parent VCT centres.

Each VCT programme should develop clear operational PTC guidelines to include innovative approaches of sustaining the club.

1.4.3 Care and support

At the time of diagnosis, all HIV-positive clients should be referred for assessment for care and support. This will provide an opportunity for the client and the clinician to plan and schedule

subsequent follow-up sessions where illnesses may be diagnosed and treated, prophylaxis initiated, and decision made on ART use.

Care and support refers to comprehensive services provided to people with HIV/AIDS and their families. They include ongoing counselling, nursing care, diagnosis, treatment and prevention of opportunistic infections, and home-based care.

Health and social workers who have been trained in counselling and clinical management of HIV/AIDS and related conditions such as STDs, TB and FP are needed to provide comprehensive care. Whether the providers are from MoH, NGOs or private facilities, the referral network in a given locality such as a district needs to be strong between VCT and the facilities that provide care and support. This is because the elements of comprehensive care (listed below) often require resources beyond the reach of any given organization, thus making referral links and close collaboration necessary. At the moment most settings lack the resources needed for comprehensive care. The government and its partners continue to solicit resources to provide more and better-quality care and support services for people living with HIV/AIDS and their families. Urge local leaders to spearhead this process.

Comprehensive care has the following elements:

Meets physical health needs. This requires skilled health workers who have a supportive attitude towards people living with HIV/AIDS (PHA), medicines[7] and other medical supplies, home or hospital care for the bedridden, nursing care such as personal hygiene, and help with taking medicines and giving food.

Provides prophylaxis of opportunistic infections. The preventive package includes isoniazid preventive therapy for latent TB among HIV-positive clients and cotrimoxazole (CTX) prophylaxis.[8]

Provides and promotes nutritional support. This may include helping families to improve their food sources, teaching about nutritious foods and how to prepare them, ensuring that drinking water is safe, and actually providing food for the family.

Provides spiritual care. This includes encouraging a supportive environment for PHAs in religious communities in general, establishing or strengthening links with the client's religious community, and facilitating home visits by religious leaders and workers.

Provides socio-economic support. This may include help to finance social needs like school fees, clothing, shelter, health care and food. The community should be mobilized to support PHAs and educated to overcome the fears and prejudices about them that often lead to rejection and lack of community support.

Provides psychological care. This includes helping the client cope with emotional issues such as worries and anxieties relating to spousal relationships, fear of death, change of body image, bereavement and depression. Providers should concentrate not only on meeting the physical and socio-economic needs of the clients. At each contact, they should take time to ask the client how they are feeling, and any emotional issues that crop up should receive due attention.

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[7] For details of clinical care please refer to *HIV infection: diagnostic and treatment strategies for health workers,* edited by E Katabira et al., 2nd ed. (Kampala: STD/AIDS Control Programme, Ministry of Health, 2000).

[8] Ibid.

Provides palliative care.[9] AIDS can be treated although not cured. PHAs soon learn to live with various symptoms and handicaps but require support to overcome the day-to-day suffering. For example, pain control following the analgesic ladder should be promoted at all levels of health care. Providers of home-based care should be trained in the use of oral morphine. Supply and dispensing of oral morphine should be supervised by an established health facility at health centre level II and above.

HOME VISITING

Home visits should take place when there is need such as incapacitating illness and to counsel significant others. Every counsellor should endeavour to visit the client's home (with permission of the client) even if the client is not bedridden, at least once in the first year. This visit would help the counsellor know the home, cross-check information, look at the general environment and assess need for other services. Also in the case of patients who have been admitted, discharge planning can help facilitate continuity of care through home visiting where such a service is available. As much as possible the home visit should be made by a multidisciplinary team or by an individual provider with skills to provide both medical care and psychosocial support.

The counsellor should do the following:

- Give the client information about the availability of the home visit service.
- Seek permission of the client for the visit.
- Make an appointment with the client for the visit and plan the visit.
- Plan for being introduced to the relatives if it is the first visit.
- Assess the need for providing counselling to the relatives and provide it appropriately or provide information or skills on hygiene, nursing, physical and emotional care and nutrition of the patient.
- If the client has any prescribed drugs check on use and adherence.
- Provide information on other sources of support within the community, such as CORPs or a health unit and encourage the client to contact them as appropriate.

1.4.4 Referrals

Referral is often needed for additional services, such as social support services. The referring provider should explain to the client the purpose of the referral and what takes place at the referral site. The referral slip should have both the client's name and the reasons for referral. In addition the client should be provided with a confidential result slip, which they may show to the next service provider if requested. Mechanisms need to be established to encourage feedback between referral sites. All referrals should be addressed to institutions, departments or units rather than individuals.

A referral system means arrangements between institutions providing related services that allow providers to send clients from one institution to another to seek services that the client needs but may not be provided at the first institution. There is usually an informal or formal agreement between the institutions regarding the type and purpose of referrals that can be made to and from the various institutions participating in the arrangement. The arrangement should usually include a feedback mechanism from the recipient organization to the referring institution.

[9] Ibid.

A referral system should be developed in consultation with NGOs, community-based organizations, hospitals and other health facilities as well as networks of PHAs. Regular meetings among service providers should be held to review and improve the referral system. The referral system should have the following components:

- A referral directory should be available that shows the scope and nature of services provided at various sites.
- Standard referral forms that capture integration of services should be universal (see section 1.3 and 'Referral form' in the appendix).
- The referral forms should be addressed to institutions.
- As much as possible, the specific department within the institution to which the client is referred should be indicated.
- The referral form should have a standard list of reasons for referral, which the provider should circle or tick.
- The referral slip should have a detachable feedback note.
- All the referral organizations should have a referral register showing referral in and referral out.
- There should be a separate universal standard HIV results slip.

1.4. 5 PHA support groups

Other than PTCs, which are attended by both HIV-positive and HIV-negative clients, there are specific support groups for people who are HIV positive. These groups are closely linked. Although not necessarily part of the VCT facility, they receive clients referred from the VCT centre, the PTC and AIDS care and support organizations. Some members of the PHA support groups have chosen to come out and be open about their HIV status to the public while others have not. The following activities take place in PHA support groups:

- Providing mutual support and sharing experiences.
- Providing peer counselling. Some members of the group are selected and trained in counselling, and they can provide counselling to their peers and family members.
- Supporting each other in preparing families for the future, such as through the memory books of NACWOLA.
- Sourcing clinical care, social and economic support through income-generating activities.
- Educating the public about HIV/AIDS through public testimonies and dramas.
- Carrying out other HIV preventive activities for the public such as promotion and distribution of condoms.
- Providing solidarity and activism aimed at addressing human rights and equity issues by influencing policies in relation to HIV/AIDS.[10]
- Participating in the planning, management and delivery of HIV/AIDS services.

1.5 Infrastructure

VCT always requires privacy; it should never be carried out in a corridor. Basic furniture for VCT customarily is some chairs and a table. However, in community settings where it is culturally

[10] For purposes of activism individuals who are HIV negative or of unknown status have tended to join PHAs in solidarity activities.

appropriate VCT may be carried out when the counsellor and client are seated on mats. In such cases the counsellor may require a clipboard to make writing easy. In all cases there must be access to laboratory space and equipment for HIV testing.

In the laboratories, especially private laboratories where clients walk in wanting to be tested, there should be a separate room to allow the laboratory staff to provide the client with some counselling before administering the test and while giving results. But if a doctor or counsellor has requested the test, the patient may be received and the blood sample taken in the same room as other patients and the results sent back to the requesting doctor or counsellor.

1.5.1 Space and equipment

A VCT centre should have at least two counselling rooms, a reception area and a laboratory. The counselling rooms should be close to each other and should be in close proximity to the laboratory and clinical rooms.

The *reception area* should have . . .

- a reception desk
- comfortable furniture to accommodate at least 20 people
- reading materials
- drinking water and disposable cups where possible

Counselling room. At VCT sites the counselling room should have the following conditions, necessary for quality VCT:

- The counselling room should have adequate space and furniture to accommodate the counsellor and at least 5 people.
- The counselling room should not have devices for locking from inside.
- The room should have . . .
  - materials and counselling aids such as counselling checklists or protocols, flip charts, job aids,[11] dildos, and supplies such as condoms and leaflets to be handed out to clients
  - adequate storage space for blood-drawing equipment (syringes, needles) and medical consumables
  - tissues
  - standard disposal for medical waste
  - lockable cupboards for storing counselling records
- Privacy should be adequate:
  - The door of the room or cubicle should be closed or the curtain drawn unless the client requests otherwise. A notice should indicate that a session is in progress.
  - If outdoors, the client and counsellor should be well isolated from others at the centre and seated under a shed.

If the counselling session is in the client's home, relatives should be excluded unless the client requests their presence or if the counsellor deems their presence necessary

[11] Items that facilitate counselling; they include games, illustrative charts and a sand tray, which can be used to enhance communication in special cases .

and the client finds it acceptable. If they are seated on the floor or ground, mats and cushions should be provided, if possible.

Ventilation should be adequate with air inlet and outlet and the atmosphere tranquil. If the setting is indoors, there should be . . .

- adequate light to enable the counsellor to see the face of the client well enough to read the client's expression
- adequate circulation of air

Efforts should be made to reduce disruption, thus making concentration and confidentiality possible.

During the counselling sessions interruptions, including phone calls, should be minimal.

The laboratory should have . . .

- working space enough to accommodate the test equipment
- space for at least two clients (for phlebotomy) , with a minimum of two staff
- a small anteroom for phlebotomy and minimum counselling, administration writing
- waiting room for clients awaiting test results
- working counter
- desk and chairs
- space for records
- refrigerator
- wash basin
- sink with elbow tap
- running water (hot and cold)
- towels
- medical consumables including gloves, needles, syringes, lancets, swabs, spirit
- lockable storage for test kits
- sharps disposal
- standard waste disposal

Post-test club. The PTC does not have to be on the same premises as the VCT centre. It needs . . .

- space and furniture enough for meetings of a minimum of 20 people
- offices for counselling and administration
- storage space
- a resting room
- recreation room, with space for indoor games
- medical booth
- TVs, videos, radios
- records room with space enough for shelves and lockable cabinets and a maximum of two staff members
- a computer

1.6 Hours and days of service

Where resources permit, VCT should be provided during all working days. Effort should be made to recruit enough counsellors who can work in shifts, thus providing VCT on weekends also. However, because of concerns for security for both clients and counsellors, VCT should not be provided after working hours.

In health facilities where resources are limited and VCT is provided only on specific days, effort should be made to ensure that VCT services are provided on the same days as TB, FP and STD services. VCT outreach services remain an important complementary measure to reach communities that do not have stationary VCT sites. Of necessity many outreach services, because they are short staffed, can operate only on selected days of the week.

Hours and days of service are to be determined by the site management in consultation with community leaders.

1.7 Human resources for VCT services

VCT sites should have adequate human resources to provide the services required of them. Personnel includes counsellors, laboratory personnel and clinicians. Ideally a VCT counsellor should counsel not more than six clients a day. In cases where services are integrated and counsellors have other duties, additional counsellors will be needed. VCT counselling should be carried out by trained counsellors. When staff is limited, appropriately trained counselling assistants may counsel. Counsellors and counselling assistants should have sufficient skills to offer comprehensive VCT services.

At any time, a counselling centre should have a minimum of two counsellors.

Counsellor refers to a cadre of providers comprehensively trained to provide HIV counselling. According to the Ministry of Health, the counsellor should operate at the level of a district or national health facility and should have received at least 4 months of training in HIV counselling.

Sometimes providers with a medical background are trained as HIV counsellors and serve as counsellors. They are often referred to as *medically trained counsellors.* Usually such counsellors are nurses or midwives but they could be clinical officers, physiotherapists, doctors, laboratory personnel, pharmacists, dentists or other medical professionals. But other counsellors have no medical background although they are also fully trained as HIV counsellors and serve as counsellors. Usually these counsellors are psychologists, graduates in social sciences, social workers, religious workers, teachers or persons trained in other non-medical professions.

Counselling assistant refers to a cadre of providers below the level of a counsellor. According to the Ministry of Health, a counselling assistant should have received at least 8 weeks of training in HIV counselling and may operate at a health facility level III.

Counselling aide refers to a cadre of providers below the level of a counselling assistant. According to the Ministry of Health, community counselling aides should have received at least 2 weeks of training in HIV counselling and they may operate at a health facility level II. They should have a minimum education of 'O' level or its equivalent.

1.7.1 Counsellor qualifications

VCT counsellors should have an educational background of at least 'O' level or its equivalent. This applies equally to those with or without a medical background.

On recruitment, VCT counsellors should present their certificate and the recruiting authority should check with the training organization.

1.7.2 Training in counselling

Training for VCT counsellors should be carried out by a recognized training institution providing comprehensive knowledge and skills in the field of counselling. The training period should not be less than 1 month (3 weeks of block training plus 1 week of practical experience) with pre- and post-training assessments.

Counsellor assistants with relevant qualifications ('O' level or equivalent) can be oriented into VCT counselling in a period of 2 weeks.

Laboratory personnel who carry out HIV testing should be equipped with basic counselling skills for a period of at least 2 weeks.

The Ministry of Health aims to standardize counselling training and develop a standard certificate. To be effective, counsellors must keep up to date with the epidemiological and social trend of the epidemic. After earning the basic certificate in counselling, counsellors should regularly update their knowledge in the same way as do other health workers in their continuing medical education (CME) programme, and a CME record be kept for each counsellor. They need a minimum of 24 hours of CME a year. Counsellor supervisors should be responsible for finding CME opportunities for the counsellors.

Counsellor training should cover the following basic topics but the flow will depend on the training curricula of various training organizations:

Overview of VCT
Basic facts about HIV/AIDS
Concept of counselling
Ethics and attitudes in counselling
Integration of VCT in health unit services
Communication skills
Behaviour change process
Counselling process
Pre-test counselling
Post-test counselling
Crisis counselling
Risk-reduction counselling
Couple counselling
Counselling on ARVs
Counselling on opportunistic infections
Counselling in PMTCT
Counselling on STDs
Counselling on FP
Counselling of children and adolescents
Phlebotomy
Positive living
Comprehensive care
Testing protocol
Infection control and immediate prophylaxis
Quality assurance in counselling
Community mobilization
Counselling of affected family members
Managing stress and burnout, care of caregivers
Review of the client's flow chart
Data collection and record keeping
Coordination and referrals
PTC formation and management
Community mobilization
Mental health issues relating to HIV/AIDS
Gender issues relating to VCT

Refresher and in-service training. To maintain and improve high-quality counselling and testing services, counsellors must keep themselves up to date on current trends in counselling, testing and HIV through refresher courses, which also provide a way to share experiences and exchange information. Two types of refresher courses should be available, one for counsellors and one for VCT site managers and supervisors. These courses should last 2 to 5 days. Other counsellors, from NGOs, community-based organizations (CBOs) and health facilities working in related HIV/AIDS services that are part of the referral network of VCT sites, should be included as course participants.

Objectives of the refresher course:

- to update counsellors' knowledge and skills in HIV/AIDS counselling and testing
- to provide an avenue for feedback on VCT counselling issues
- to minimize counsellor burnout
- to motivate counsellors
- to update counsellors on new developments in the field of HIV counselling and testing

TRAINING OF TRAINERS OF COUNSELLORS

The Ministry of Health is to develop a national team for training counsellor trainers. These trainers should be counsellors themselves. They should have had full training in counselling from a reputable counselling organization and should have practised counselling for at least 2 months. Training of counsellor trainers should cover the following topics:

- facilitation skills and techniques
- training cycle
- interpersonal relationships
- group dynamics
- adult education skills
- updates of HIV/AIDS knowledge

TRAINING OF COUNSELLOR SUPERVISORS

Supervisors of counsellors should be counsellors themselves. They should have had full training in counselling from a reputable counselling organization and be currently providing counselling services. Supervisors should also be trained in—

- counsellor supervisory skills
- updates of HIV/AIDS knowledge
- human resource management
- programme planning and management

TRAINING OF SUPPORT STAFF

All staff and volunteers involved with the VCT site, including the receptionist, drivers, medical records officers and secretaries, should receive basic introductory training in the role and purpose of VCT, how services are delivered, basic communication skills

and the need to observe strict standards of confidentiality, not only for results but also regarding who has requested VCT services.

1.7.3 Registration of counsellors

After the initial training of 1 month from a recognized training institution and a follow-up period of not less than 6 months of practice as a counsellor under supervision, VCT counsellors should be certified and enrolled in a national register.

A national register for counsellors is to be set up in the Ministry of Health in the office of the programme manager of ACP until such time that the counselling profession has developed a counsellors' council like, for example, the Zambia Council of Counsellors.[12] In Uganda the counsellors' council is still in its infancy.

1.7.4 Counsellor support

Counsellors need support to prevent burn-out, to share experiences and learn from each other on how to handle hard tasks, to receive technical updates, and for quality control. Regular meetings with each other give them support and encourage them.

Counsellors should also receive support and should learn through regular meetings with their supervisor, who deals mainly with administrative and professional issues, and with the visiting senior counsellor, who gives personal and professional support.

One way to prevent burnout among HIV counsellors is to organize retreats for relaxation and ventilating. For example, each full-time HIV counsellor could be provided with an opportunity to attend at least one such retreat per year. A separate counsellor retreat could be organized by each major counselling organization. For smaller organizations such a retreat could be carried out as a joint activity—say, at a district level. For some organizations, full-time counsellors also get one paid afternoon off per week in addition to 30 days of annual leave. When counsellors need HIV counselling for their own HIV worries, they should go to counsellors of their choice.

1.7.5 Who should perform the HIV test?

HIV ELISA tests should be performed by personnel not below the level of medical laboratory technician. Where available, medical laboratory technicians are also the most suitable personnel to perform rapid HIV tests. But owing to staff shortage medically trained counsellors with diploma level in basic medical training can be trained in how to carry out HIV rapid tests, which they can perform under supervision of personnel not below the level of medical laboratory technician. Counsellors without a medical background must not perform any HIV tests. HIV tests, including rapid tests, should not be performed in the presence of the client. Clients must not perform HIV tests.

All laboratory technicians in the country should be trained in rapid HIV testing as a minimum. All medically trained counsellors should be trained in rapid HIV testing.

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[12] Hector Chiboola and Alan Howarth, eds., *Code of ethics and practice for counselling in Zambia* (Lusaka, Zambia: Zambia Counselling Council, 1999).

1.7.6 Who should manage the VCT centre?

Dedicated managerial support is critical for effective VCT service delivery. For each VCT service there should be an overall site manager who recruits and administratively supervises all the VCT staff. The manager is also responsible for ensuring a good infrastructure, supplies and equipment for VCT. The manager may delegate some of these responsibilities to the counsellor supervisor, head counsellor or head laboratory person or other departmental head who may have a direct supervisory role over service delivery. The manager of a site that provides VCT should receive orientation on HIV counselling skills, the laboratory protocol, and administration of the lab and should be up to date on HIV/AIDS issues.

Management of the VCT site should draw up a clear statement of the roles and responsibilities of VCT providers. If the VCT counsellor or laboratory technician is dedicated full time to VCT services, this should be clearly spelled out. If the VCT counsellor or laboratory technician is dedicated only part time to VCT services, the timing of when these services will be provided should be clearly understood by the counsellor, laboratory technician, site management and other health professionals working at the same site. VCT counsellors and laboratory technicians assigned to VCT should not be drawn away from VCT responsibilities during hours dedicated to VCT activities except in the case of a genuine medical emergency.

1.8 Supplies

The quantity of supplies depends on the volume of clients anticipated and the test algorithm adopted.

Additionally if other medical tests such as for syphilis are provided as part of VCT service in stand-alone facilities the relevant supplies will be necessary. VCT supplies include the following:

- HIV test kits (see sections 3.1.3 and 3.1.4 for further details)
- gloves and other supplies for universal precautions
- disinfectant and detergents
- medical consumables including needles, syringes, lancets, swabs
- soap
- tissues
- stationery

1.9 Financing VCT services

VCT should be considered a public health preventive service and should be free in public health facilities.

The Ministry of Health aims to provide free test kits to all public VCT sites including NGOs.

Fees and cost sharing: When possible, it is recommended that VCT services be provided free of charge, especially in low-income communities. An affordable fee may be charged to enhance the sustainability of VCT services, but the fee should not be a barrier to access to services. If a health facility charges a fee, it should be approved by the facility management. If it is a government facility, the fee should be approved by

the DDHS office and guided by national policies. The fee should be posted clearly so clients know in advance what it will be, and receipts should be given. If a fee is charged, discounts or waivers should be put in place to render free services for clients unable to pay. The site manager determines whose fees should be waived based on recommendation from the counsellor. Free days may also be considered as a way of attracting clients for whom a fee would represent a barrier to using VCT.

Chapter 2. VCT protocol

In Uganda the VCT protocol for HIV starts with client registration followed by pre-test counselling and consent for testing (see figure 1). Pre-test counselling also enables those clients who decline the test to receive counselling without testing, which in itself is a useful service that VCT centres provide. A specimen is obtained from clients who consent to be tested and is tested for HIV. Depending on the type of test, the testing algorithm and the workload, the results of the test may be available within an hour or a few days. When the results are ready the client is provided post-test counselling, during which the test results are given. Clients are then provided follow-up support, which may be available at the VCT site in the form of post-test clubs or ongoing counselling or they may be referred elsewhere for care and support.

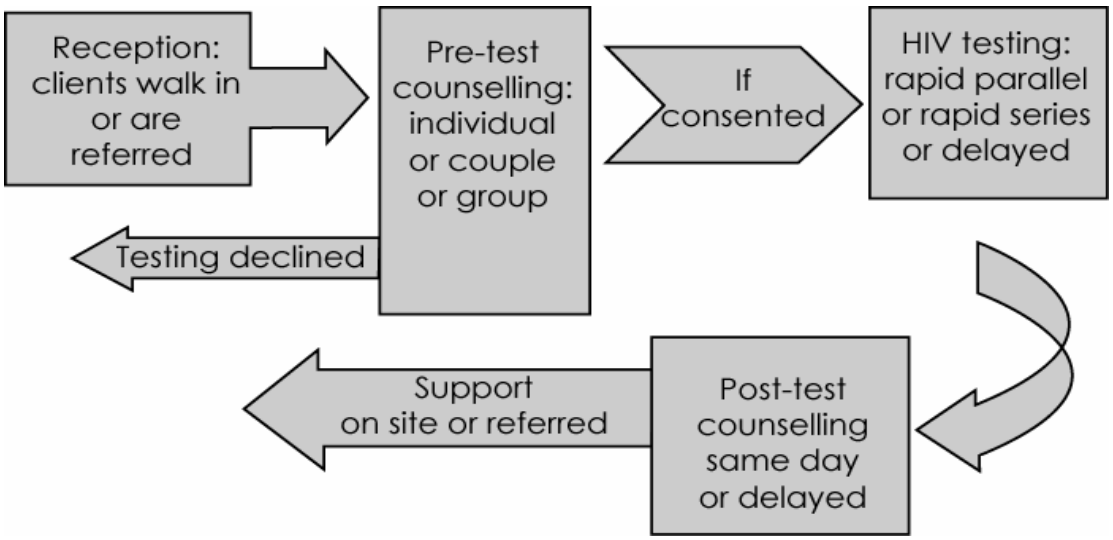

Figure 1. VCT protocol.

2.1 Client registration

VCT registration does not have to be anonymous. Clients may register with their names. All VCT sites are bound to ensure confidentiality of client information. Where VCT is provided in health facilities VCT clients may register like other patients at the outpatient department to avoid being stigmatized. VCT should be promoted within and outside the health facility and listed as one of the services provided by that health facility on the existing clinical forms and registers. VCT should be included in routine health education talks and the concept of integrated services explained.

2.1.1 Waiting room, reception area

The VCT waiting room or reception area will vary according to the type of VCT facility. It should be supervised by a receptionist. In the reception area there should be

- IEC (information, education, communication) material on VCT and related services
- client flowchart and information sheet about services of that centre
- video machine showing HIV- and health-related material
- general health education talks by counsellors or other experts

IEC materials should have positive messages that are encouraging, not scaring.

Counsellors come and pick up clients from here according to the sequence organized by the receptionist. The receptionist should, as much as possible, observe the principle of first come first served.

2.1.2 Client reception

In all facilities that provide VCT, management should ensure that the distance between the table of the receptionist and the waiting clients is enough to enable incoming clients to state the purpose of their visit out of earshot of the other waiting clients. Receptionists at these facilities should undergo orientation in HIV counselling skills and confidentiality. The following activities should take place at the desk of the receptionist out of earshot from the rest of the clients:

- statement and clarification of purpose of visit
- review of referral slip if the client has one
- explanation of procedures and assurance of confidentiality
- entry of client into the site register
- issuance of a client's number and counselling and testing card
- collection of service fee if applicable
- direction to the client of when and where to go next
- offer of exit interview forms to every 10th exiting client or any other number agreed upon at the site

2.2 Pre-test counselling

Under VCT no HIV test should be provided without pre-test counselling. If a sufficient number of waiting clients exist, pre-test counselling should be preceded by a comprehensive health education talk.

Pre-test counselling should be provided to each client alone and not in a group. When staff is limited, however, group counselling may be provided, followed by a brief session of individual counselling. Couples should be given the option of being counselled together or individually. Similarly, people in polygamous marriages should also be given options of all coming together, as separate pairs with the husband or as individuals.

Pre-test counselling should be comprehensive enough to allow the client, in addition to preparing for the test, to make appropriate risk-reduction plans.

In private laboratories where counsellors are not available, laboratory staff handling HIV testing should be trained in counselling skills to enable them to provide a brief session of pre-test counselling before the test. However, it is important that the laboratory staff member who carries out the test not be the same as the one who provides the pre-test counselling.

Pre-test counselling is a discussion held between a provider and a client aimed at preparing the client for the HIV test. It consists of clarifying the client's knowledge about HIV/AIDS, informing the client about test procedures and how HIV test results are managed, preparing the client for the outcome of the test, assisting the client to make a decision about testing, obtaining the informed consent of the client, and counselling about prevention options.

The steps below may appear to be distinct but in some sessions some of the steps will overlap, depending on the client. The steps listed here are a checklist to ensure that no important element is left out.

2.2.1 *Introduction and orientation*

- Greet client, introduce yourself and establish rapport.
- Explain the services offered at the centre and establish a working relationship (contract) with the client.
- Explain confidentiality procedures at the centre.
- Explain consent procedures.
- Review the rapid test process and client flow.
- Address immediate concerns and questions.

2.2.2 *Risk assessment*

- Assess the client's HIV concerns and reasons for coming for VCT.
- Assess incidents or pattern of risk such as under what circumstances, with whom, when and where the client might have been exposed or might continue to be exposed.
- Assess the ability of the client to negotiate for and use any protective measures such as condoms or other forms of safer sex like non-penetrative sex.
- Assess gender power relationships and level of communication with partner about HIV risk.
- Assess risk triggers or situations that predispose client to risk such as alcohol or drug use.
- Summarize client's story, reflecting on the risks identified.

2.2.3 *Decision-making for testing*

- Review client's reason for VCT, who or what motivated them to come and any previous HIV-testing experience.
- Assess client's understanding of possible results and fill in the gaps.
- Identify with whom the client would like to share the results.
- Discuss benefits of disclosure to significant others.
- Discuss benefits of HIV testing for either positive or negative results.
- Determine client's readiness or decision to take the test.
- Have client sign or apply thumbprint on consent form when ready for HIV testing.
- Take blood sample.
- Remind client of post-test counselling arrangement.
- If client does not consent to HIV testing, provide preventive counselling.

2.2.4 *Preventive counselling*

The counsellor can provide preventive counselling as the client waits for test results or before the blood sample is taken, depending on the policy of the centre.

- Review client's previous risk-reduction experience.
- Identify obstacles to risk reduction.
- Place risk in larger context of client's life.
- Enhance communication skills of client with partner about risk.
- Enhance client's ability to negotiate abstinence or safer sex.
- Demonstrate condoms and provide a supply or information about where to obtain them if desired.

- Role-play or discuss with client about risk and how to negotiate with partner for safer sex or abstinence until both have received VCT and shared results. This role-play should take into consideration gender and relationship issues.
- Take blood sample if not already taken.
- Remind client of post-test counselling arrangement.

2.3 Consent for HIV testing

Knowing one's HIV status helps a person more rationally carry out preventive options such as partner notification, abstinence and safer sex. It also enables the person to seek care and support. Both preventive and care outcomes of knowing one's HIV status thus are dependent on the voluntary actions of the individual.

VCT is a voluntary service that people should be encouraged to seek but not be coerced into. For VCT to be beneficial the person should voluntarily consent to it after fully understanding its benefits. Hence no rules or regulations should be passed to make particular individuals or groups of people go for VCT. However, the service needs to be promoted actively once it is available. VCT has health benefits for certain groups of people in particular, and these people should be strongly encouraged to seek VCT. Examples are couples intending to get married, pregnant women, couples or individuals intending to engage into a new sexual relationship, and people whose work involves much mobility such as migrant workers and truck drivers. Other groups include commercial sex workers, barmaids, housemaids, people in polygamous relationships, rape victims, patients with cardinal signs of HIV/AIDS and all health workers.[13]

Therefore, regardless of the reasons for VCT, it is the client's decision to be tested for HIV. Consent should be documented by the VCT client signing or putting a thumbprint on a consent form before being tested.

If an attending health worker identifies a patient who may benefit from VCT, the worker may refer the patient. The role of the health worker is to provide the client with education and counselling to enable the client to make the decision regarding their blood being tested for HIV. Health workers should counsel their patients to go for VCT, not just ask them to go for testing. TB patients, for example, may need to be supported to understand the need for VCT.

Consent is a voluntary agreement by a fully understanding adult person, aged 18 years and above, to have a procedure (HIV test, operation, and so on) performed on oneself or on a specimen from one's body. It also applies to agreement to give information about oneself such as in research or to have such information used for any purpose. Informed consent is therefore an agreement the client makes with the service provider or researcher after having received and understood the purpose of the procedure or the exchange of information. For consent regarding children and special groups, refer to chapter 4. (Client consent form is in the appendix.)

2.4 Post-test counselling

Clients should not be given HIV test results without face-to-face counselling. Partners in a couple should be encouraged to be counselled together but also be given the option of being

[13] Where ARVs for post-exposure prophylaxis (PEP) are available an institutional policy on PEP should be developed. Such a policy should state timing of the baseline HIV test and provide for a short course of ARVs and a follow-up test to determine if infection occurred. The policy should also state the consent issues regarding testing the patient to whose fluids the health worker was exposed.

counselled individually. During pre-test counselling of a couple, the counsellor should try to get the couple to agree as to whether they want to receive their results together or individually. Similarly, people in polygamous marriages should be given options to come all together, in separate pairs with the husband, or as individuals.

Laboratory staff handling HIV testing in private laboratories should be trained in counselling skills to enable them to provide clients who walk in for testing with a brief discussion of the results and refer the client if necessary. But where the test is requested by a clinician or counsellor the laboratory staff should send the results to the requesting service provider and not give them to the client without counselling.

Post-test counselling is a discussion held between a provider and a client with the aim of informing the client of their HIV results and assisting them to cope with the results. This discussion consists of giving the test results clearly, without ambiguity, assessing the client's emotional and mental understanding of the test results, addressing any immediate emotional reactions, making plans for involving significant others, making ongoing plans for care and risk reduction, and making arrangement for follow-up support.

Effort should be made to cover as many of the above issues as possible in post-test counselling, but since the client's ability in the post-test state to absorb information may be limited, relevant materials should be handed to the client to read at home. This will, however, depend on the client's being able to read in a confidential atmosphere at home.

2.4.1 Giving of test result

- Provide and explain results clearly and simply.
- Explore client's understanding of results and reaction to them.
- Address immediate emotional concerns.
- If result is positive, discuss positive living and continuum of care.
- For either positive or negative results, discuss risk reduction.
- On request, provide written results.

2.4.2 Disclosure and partner referral

- Identify significant others for disclosure (sexual partner, family, friend)
- Explain the need for disclosure and its advantages.
- Discuss practical approach to disclosure and partner involvement.
- Assess client's needs and identify where to refer client for care and support and provide referrals: post-test club and other services such as FP, STD, PMTCT, TB and ARVs that the client may need.

2.4.3 Risk-reduction plan

- Identify priority risk-reduction behaviour.
- Discuss enabling factors and hindrances, including gender concerns, that may influence behaviour change.
- Develop incremental steps towards behaviour change.
- Develop an action plan for changing behaviour.
- Discuss negotiation skills to address gender barriers to behaviour change.
- Make an appointment agreeable with the client for the next visit.

2.4.4 Ongoing counselling

Effort should be made to meet with the client in a follow-up session. See section 1.4.1 for details.

2.4.5 Points to remember in a counselling process

Essential elements to be covered in counselling include the following steps:

- Interpersonal relationships
  - Greet client.
  - Introduce self.
  - Create rapport.
  - Assure confidentiality.
  - Listen actively (both verbally and non-verbally).
  - Be supportive and non–judgemental.
- Information gathering
  - Use appropriate balance of open-ended and close-ended questions.
  - Use silence well to allow for self-expression.
  - Seek clarification about information client gives.
  - Probe appropriately.
  - Avoid premature conclusions.
  - Summarize main issues discussed.
- Giving of information
  - Always have up-to-date knowledge about HIV/AIDS.
  - Before giving information assess what the client already knows and build on that.
  - Give information in clear and simple terms.
  - Give client time to absorb information and to respond.
  - Respond accordingly to issues that the client raises.
  - Repeat and reinforce important information.
  - Check for understanding or misunderstanding.
  - Summarize main issues.
- Handling of special circumstances
  - Accommodate any language difficulty.
  - Talk about sensitive issues plainly and appropriately according to the culture.
  - Prioritize issues, to cope with limited time in short contacts.
  - Use silence well to deal with difficult emotions.
  - Be innovative in overcoming constraints, such as space for privacy.
  - Manage client's distress.
  - Assess partner relations and be flexible about involving partner or significant other.

2.5 Repeat testing

Repeat HIV testing may be undertaken by a client who has already been tested and informed of the test results. It usually requires that the client provides another sample. It does not refer to the repetition of tests on a sample before the results are given to the client.

To rule out the window period before a client is declared to be truly HIV negative the client should return for repeat testing in 3 months, contingent on the client's story of how recently they were exposed. While they wait, they should be counselled to practise safer sex or abstain.

All clients should be told about the *window period.* This is the period, ranging between 2 and 3 months, from the time the body is exposed to HIV until it produces enough antibodies against the virus to be detected on the routine HIV tests used. Thus people who have recently been exposed to HIV risk may test HIV-antibody negative.

Denial is a frequent cause of repeat testing**.**

Clients in denial can also be assisted to repeat the test. This may depend on the period of denial. Clients who deny the results immediately may need time to come to terms with the news. If HIV-negative clients do not believe their results, the repeat test should be delayed for at least 3 months, as they may be in the window period.

Some people may respond to news of their infection or disease by denying it ('This cannot be happening to me'). While initial denial may help reduce stress, if it persists, it can prevent appropriate behavioural change and adjustments in life, necessary to cope with HIV and prevent transmission. If denial is not challenged, people may not accept the social responsibilities that go with being infected.

Indeterminate results may necessitate repeat testing. A test result is considered indeterminate if it is neither clearly positive nor clearly negative.

If the laboratory issues indeterminate results the counsellor should explain to the client what they mean.

Outside of laboratory error, human or otherwise, the most plausible cause of indeterminate results is insufficient antibodies, which is most likely to occur when a person is in the window period. People in advanced stages of AIDS may also have an indeterminate result caused by a decrease in antibodies.

The client should then be asked to repeat the test in 3 months. If after 3 months the results are still indeterminate another blood sample is taken and sent to a reference laboratory.

WHO[14] recommends that if a second sample also produces indeterminate results the person is considered HIV negative. However, if the person was tested when donating blood that blood is considered unsafe.

But the client waiting for results of repeat testing after an indeterminate result needs psychosocial support. It is important for counsellors to re-emphasize that the client should undertake the precautions recommended for HIV-positive persons until their status is proven otherwise. The uncertainties associated with this period may lead to acute and severe psychosocial difficulties. The counsellor should assess and help the client manage such issues, making appropriate referrals if necessary.

Partner involvement is extremely important for HIV prevention and care. But sometimes a VCT client may find it difficult to disclose test results to a partner who may not be aware that the client even went for testing in the first place.

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[14] World Health Organization, *Source book for HIV/AIDS counselling and training*. WHO/GPA/TCO/HCS/94.9 (Geneva: WHO, 1995).

Sometimes counsellors may encourage a client to repeat the test with their partner, as if the testing were new, as a way of notifying the partner.

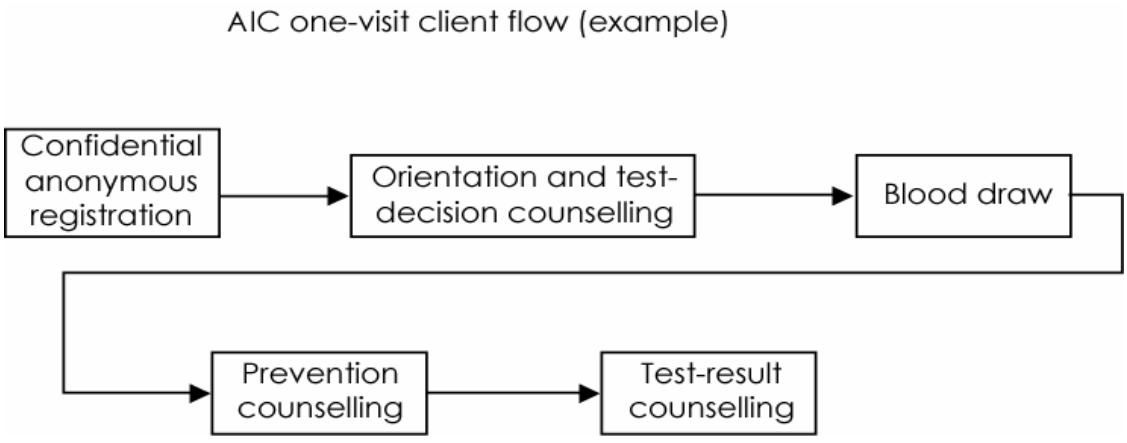
If the client chooses this option, the counsellor and VCT management should keep the client's confidentiality about the first test and should provide the full VCT package to the couple.

2.6 Learning HIV test results

It is up to the client to decide if they want to know the results of their HIV test. Where the option of getting HIV test results the same hour, same day or another day exists, it is also up to the client to decide when to learn the test results. If the test was a rapid test in parallel, which confirms the results instantly, the client may be shown the test strips or the test results if they so desire. In other types of tests the written results of the HIV test may be issued to the client if they so desire.[15] HIV results should never be issued at the reception desk of a laboratory where there is no privacy. They should always be issued in a special session with the client alone.

2.7 Issuance of written HIV test results

Written results can be issued to a VCT client regardless of whether the test is positive or negative. But the client should be counselled against misusing the written results. Where written results are issued, the client's name and number, the date, and the stamp and signature of the issuing authority should be clearly written on the results slip.



2.8 Disclosure of HIV test results to other people

It is up to the client to decide if they want to share the HIV test results with anybody else. It is also up to the client to decide when to share the results with another person. The role of the counsellor is to discuss with the client the pros and cons of disclosure and the timing of disclosure.

It is also up to the client to decide how to share the results of their HIV test. The counsellor should discuss with the client the pros and cons of various options of disclosure such as provider-assisted notification versus client notification.

In testing a couple, results should be given to both partners of the couple together. Counsellors and clinicians should strongly encourage their clients to disclose their results to each other,

[15] See sample Laboratory results form in the appendix.

especially discordant couples, and in particular premarital discordant clients who came separately.

Results can be released only subject to the client's consent, when the client is of sound mind. Where written results are required by a third party, such as NSSF,[16] for the benefit of the client, the counsellor may release these results to an appropriate agent of the third party upon receipt of a written authorization from the client.

[16] Currently in Uganda, individuals who are entitled to National Social Security Fund (NSSF) benefits can have access to their NSSF terminal benefits upon proof that they are suffering from a terminal ailment such as AIDS. To verify the authenticity of the claim, NSSF sends an agent independently to obtain the HIV test result from the testing centre that the client names.

Chapter 3. HIV testing in VCT

Testing clients for HIV is a key VCT component. There are many tests on the market that can be used to determine whether a person is infected with HIV. Information regarding one's HIV status is so crucial in a person's life that every effort should be taken to ensure that the results given in post-test counselling represent the client's true HIV status. This chapter outlines policies intended to ensure that VCT centres provide clients with accurate and confidential results. Mechanisms should be put in place to guard against all forms of error, both technical and clerical, in VCT centres. Laboratory staff should not test a client unless they are sure that the client has received pre-test counselling.

An HIV test is either an antibody test that detects the body's response to the virus or an antigen test that detects the presence of the actual virus or its components.

The requisition for the HIV test should be designed to include the name and signature of the counsellor.

3.1 HIV testing algorithms

Specimens collected from VCT clients should be tested on two rapid kits using either the parallel method or the series method (see figures 2 and 3 illustrating these methods). The two kits, which will have been validated by the national health reference library (NHRL),[17] should be of different antigenic specificities that define HIV. Either method could be used, depending on the capacity of the service provider.

HIV testing algorithm is a combination of HIV tests that have been tested and agreed by a reference laboratory to represent HIV testing for a given purpose.

3.1.1 Parallel test algorithms

Parallel testing means that two different HIV rapid tests are applied together (in parallel) to all blood samples. Samples that show HIV-positive results on both tests are reported as positive. Those that show HIV-negative results on both tests are reported as HIV negative. Samples that show positive results on one test and negative on the other are not reported to the client but instead a third test is carried out—a tie-breaker, which has different antigenic specificity from the first two. If the tie-breaker shows a positive result, the sample results are reported as positive and if it shows negative, the sample results are reported as negative.

Advantages of parallel testing algorithm:

- Shorter waiting time may lessen time taken from work, resulting in a lower cost to the client.
- Similar waiting time for all the clients, positive or negative, reduces the potential for stigma.
- Client's perception that two tests are better than one reduces shopping around and increases public trust in VCT.

[17] Currently there is no designated NHRL, but this function is the responsibility of the Central Public Health Laboratory (CPHL). MoH is to strengthen CPHL to enable it to carry out this function. In the meantime the practical role of NHRL is carried out by a number of reference laboratories as designated by MoH from time to time. See section 5.2.2 for reference laboratories.

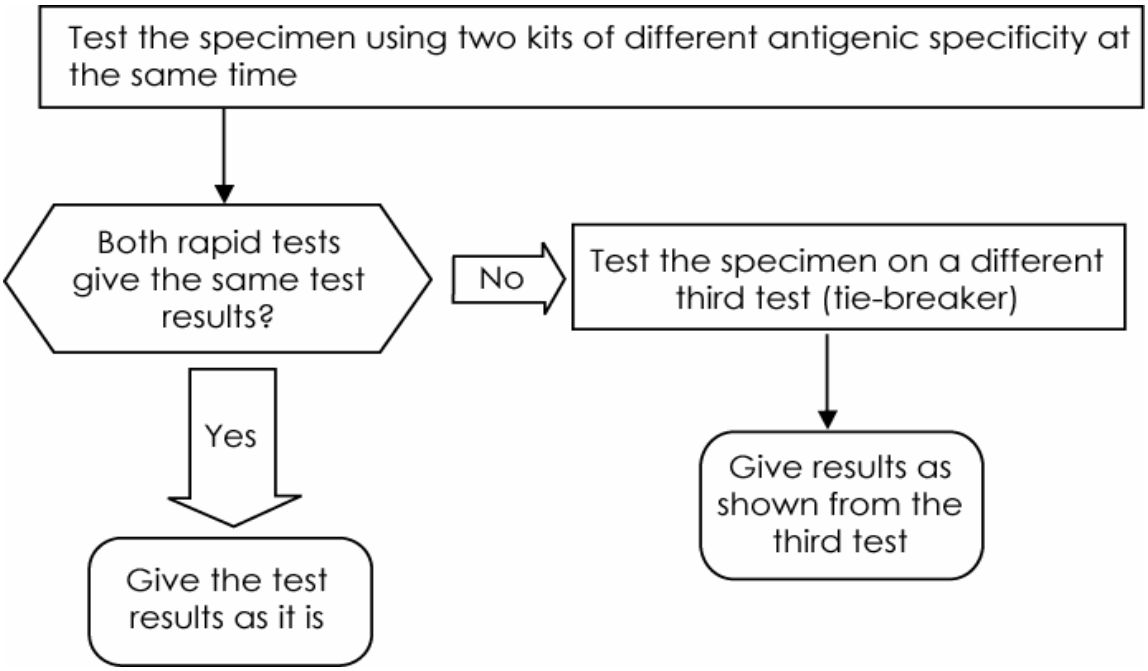


Figure 2. Parallel algorithm for rapid HIV testing.

Disadvantage: It is more expensive than serial testing.

3.1.2 Serial test algorithms

Serial testing means that two different tests are applied one after another (serially). Each blood sample is subjected to one rapid test, and if it tests negative it is reported as HIV negative. But if it tests positive it is subjected to a different rapid test, and if the second rapid test is positive the blood sample is reported as positive. If the second rapid test is negative when the first one was positive a third test, the tie-breaker, is applied. If the third test is positive the blood sample is reported as HIV positive and if negative it is reported as HIV negative.

Advantage of serial testing: It costs less, thus increasing the chances for sustainability and freeing up funds for wider reach of VCT.

Disadvantage: Possibility of a longer waiting time for clients who test positive on the first test and thus a potential for stigmatizing clients who test positive.

The Ministry of Health currently proposes the following for the series algorithm:

First test	Second test	Tie-breaker
Determine	Uni-Gold	Hemastrip
Capillus	Serocard	Multispot
Bionor	Determine	HIV Orgenic

3.1.3 Selection of test kits for VCT in public facilities

Issues to consider when selecting test kits from among those that NHRL has validated:

- cost
- shelf life
- ease of use
- ease of storage

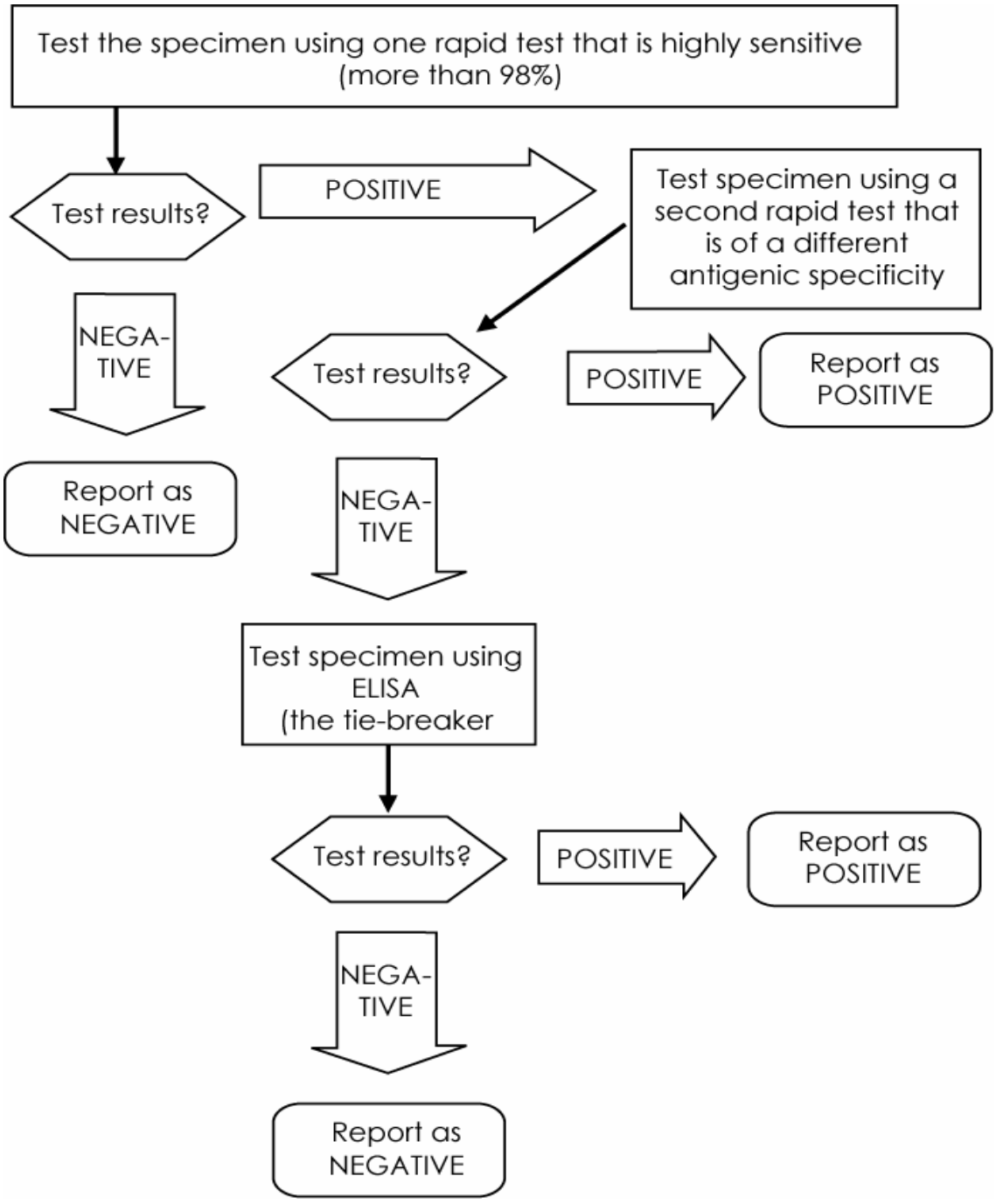


Figure 3. Series algorithm for rapid HIV testing.

- portability
- consistency of use in the country, considering that laboratory personnel perform better on kits they have been trained to use
- what to use if supply of kits runs out

3.1.4 Procurement, storage and stock management of test kits

The quantity of test kits required will vary from site to site depending on the volume of clients expected, the testing algorithm adopted and the prevalence of HIV.

An estimate of the expected volume of clients should be made. Factors to consider when making service uptake estimates:

- increase in demand as the centre gets known
- demand of outreaches and other institutions wanting to use testing facilities of your site
- effect of specific promotional activities such as on Valentine's Day
- the shelf life of the test kits purchased
- guidelines from the National Health Reference Laboratory (NHRL)

3.2 Specimens for HIV testing

At the moment the recommended specimens for use in HIV testing for VCT remain limited to whole venous blood, plasma or serum. Other specimens like urine, saliva and dry blood spots should be used after NHRL validates the tests.

Specimens for HIV testing must be accompanied by a laboratory request form[18] filled in and bearing the signature and name of the requesting clinician or counsellor who did the pre-test counselling.

In private laboratories where clients walk in seeking to know their HIV status, the laboratory request form should be filled in and signed by the laboratory staff, who provide mandatory brief pre-test counselling and take the blood sample. Note that neither the staff member who carries out the counselling nor the person doing phlebotomy should be the one to conduct the test.

3.2.1 Handling specimens for HIV testing

The counsellor who provides pre-test counselling should obtain the specimen for HIV testing and send it to the laboratory with the laboratory request form duly completed. In most VCT circumstances, the blood sample is obtained from the patient in the same location as the test is performed. However, in a pre-test counselling facility that does not perform the test, the following precautions should be taken to ensure high ethical and technical standards in handling specimens.

The samples or specimens should be

- collected in recommended blood specimen containers
- kept refrigerated in the range of 4 °C to 8 °C if the specimens are not being processed immediately
- delivered to the testing centre within 48 hours
- transported under cold-chain conditions
- recorded in laboratories under confidential numbers
- handled with mechanisms that ensure anonymity of clients during testing

Issues to consider when taking a blood sample for VCT:

- If the sample is to be transported by car ensure that the specimen containers are packed in cooler boxes.
- If the person taking the blood sample is different from the one who provided pre-test counselling, they should first verify that the client has received pre-test counselling and is ready for the blood draw.
- Explain to the client how the blood will be drawn.

[18] See sample 'Laboratory request form for HIV and syphilis testing' in appendix.

- Follow standard operational procedures for phlebotomy and universal laboratory safety precautions

Each institution should have a policy of what to do in case of accidental exposure and where possible this policy should include post-exposure prophylaxis (PEP).

General phlebotomy guidelines, specimen collection and handling

- Verify identification of patient.
- Choose proper vacutainer tubes and other necessary equipment for phlebotomy.
- Wear gloves on both hands for all phlebotomy procedures.
- Drawing order of tubes:
  - Sterile tubes
  - Tubes without additives
  - Tubes for coagulation (blue)
  - Tubes with other additives (heparin, EDTA and SST)
- Coagulation (blue) tubes must be full.
- If capillary testing, wipe off first drop of blood following puncture.
- Label all specimens with the appropriate patient information (name, medical record number, date of birth, date, time of collection).

3.3 Handling results

HIV test results should be sent to the requesting clinician or counsellor who did the pre-test counselling. An insurance agent or employer or any other third party ***must not*** be given the results unless it is with the written consent of the client.

In handling results, laboratory staff should adhere to the following:

- Anonymity should be maintained by using numbers and a coding system until the results get back to the counsellor.
- A register should be maintained and kept in the laboratory to receive all incoming specimens by *date*, *time* and *requesting counsellor*.
- Worksheets should be kept after the laboratory report has been sent to the requesting service provider for decoding.
- Only authorized persons should have access to the worksheets.
- Reports should be submitted regularly to relevant authorities.

Chapter 4. VCT for children and other special categories

VCT for children should be for the best interest of the child. It should be to improve the child's health, survival, development and social well-being. Children should participate in the process, and it should not be imposed on them. The policies stated here are in the context of wider international and national policies and laws concerning children, like the Uganda Children's Statute and the UN Convention on the Rights of the Child (UNCRC).[19] Children of any age are vulnerable to HIV, and VCT services should therefore be child friendly.

Counselling for children depends on the important roles of counsellor, child, and parents or guardian. As soon as children are able to understand, they should be educated about HIV/AIDS with the involvement of the parent or guardian. Counsellors should promote VCT for children who were vertically exposed even if their mothers received PMTCT services. Children who have HIV-related symptoms may be tested when the clinician deems necessary for purposes of child care, irrespective of age and ability to understand. The child may not be informed of the results until they reach an age when they can understand, at which time they should be specially counselled. The parent or guardian should also be counselled at both times.

Antibody testing should not be used for diagnosis of HIV infection in children aged less than 18 months. In Uganda the tests that can be used to detect HIV in this age group, such as PCR, are currently available only for research. It is therefore recommended that VCT for children be provided only after the age of 18 months.

Children should be tested only from the age of 18 months onwards. If a guardian expresses the desire to test before 18 months the counsellor should explain why this is not recommended. Earlier than that, if the child's mother is HIV positive, the child may still have maternal antibodies for HIV in the blood. Most HIV tests check for antibodies and not the virus itself. Therefore, antibodies detected could be from the mother, giving a false positive. They do not necessarily indicate that the child has the virus.

4.1 Age of consent for VCT

The age of consent for VCT should be the age at which the child understands the results—considered 12 years. The right of dissent to testing should also start at age 12. For children between 12 and 18, the legal age of consent, the child should consent but with the approval of the parent or guardian.

For children below 12 years the parent or guardian should sign the consent and for those children without a parent or guardian the head of the institution, health centre, hospital, clinic or any responsible other may sign. Emancipated minors should be treated like adults.

If a child below the age of 12 asks for HIV testing, their parents or guardians should be fully involved.

The counsellor should assess the child's ability to understand and the emotional capacity to cope with the results. Basing the policy on the counsellor helps children who are on their own without a parent or guardian. Such a policy also helps if a parent or guardian is abusing the child, sexually or in another manner. Parents or guardians, however, need to know the status of the child. The

[19] Formally adopted in 1989.

child should be asked first and should agree on which other person should be involved, and how. Some children without parents may choose other people in their social network such as a neighbour.

4.1.1 Age of consent

Health workers providing care for children and families living with HIV should be trained in child counselling skills. The service provider should not express an opinion as to whether the child[20] should be told the diagnosis if the test is positive. That is a decision the parent or guardian has to make, with the help of the counsellor, who will explore the parent or guardian's understanding and wishes and never force them to make any decision but instead help them understand and make their own decision about the issues.

The counsellor will conduct a pre-test counselling session with the parent or guardian and with the child, if old enough and if the parent or guardian wishes it. The counsellor should see the parent or guardian alone, then the child alone. Depending on the decision taken by the parent or guardian the counsellor talks to both the child and the parent or guardian before proceeding to have the blood sample taken.

The laboratory, whenever possible, sends results to the same counsellor who did the pre-test counselling, who gives the results to the parent or guardian. The counsellor explores with them the issues around disclosure, as discussed in pre-test counselling. The parent or guardian can make a decision about when or if and how the results should be disclosed to the child. If a difficulty in disclosure develops the counsellor should consult other service providers as the need arises.

But ultimately, it is the parent or guardian's own responsibility to decide whether to disclose the results to the child. Each child and each family are unique and they should never be forced to do anything for which they are not fully prepared. The counsellor's opinion, while it may be held in great respect, may not be applicable to this family.

4.1.2 Increasing utilization of VCT by young people

Young people aged 12 and above should have access to VCT services if they so desire without any barriers. Parents or guardians of children under 12 years of age who have been exposed to HIV such as through MTCT, child abuse or blood transfusion should be encouraged to seek HIV testing for these children. To ensure that VCT services are youth friendly VCT programmes should provide the following:

- Youth-oriented advertisement and promotion of services. This may include outreach activities to educate and mobilize young people for VCT.
- Youth-friendly counselling and referral to other health and psychosocial support services. These may include ongoing counselling and youth-friendly post-test clubs.
- Non-judgemental health care providers.
- Access to particularly vulnerable young people such as out-of-school and street children.
- Access to partner and premarital counselling and testing for young couples.

[20] In these guidelines the word 'child' refers to anybody below 18 years.

Operational research is needed to understand a number of issues such as how youth learn of HIV and VCT, the characteristics of youth who seek VCT, who they consult before seeking VCT, who escorts them to VCT facilities and to whom they disclose their HIV status.

Strategies AIC Kampala and the Naguru Teenage Reproductive Health Centre use to increase youth access to VCT

- Train VCT providers in counselling skills for youth. A youth-specific VCT counselling curriculum was developed.
- Set up a youth corner at the VCT centre of AIC so that youth do not meet with adults when they go for VCT.
- Provide VCT at the Naguru Teenage Reproductive Health Centre.
- Reduce the price of VCT for youth.
- Create a multimedia campaign to inform youth about VCT.

4.2 Parental consent for VCT

Parents may consent to the HIV testing of legal minors. But before proceeding with the test the counsellor should always assess the situation to ascertain that the HIV test is being carried out for the benefit of the minor. If the parent or guardian is the one proposing the test, the counsellor should assess if the parent or guardian wants to do the test in good faith. If the counsellor is in doubt, the child should be allowed to decide.

Always the child should be told about the importance of the significant other person who needs to know. As the child continues with the sessions someone else should come along—a guardian or someone else of the child's choice, for example, an older sister.

When considering testing for a child, remember that each child is an individual person. Start the session by talking to the parent alone followed by the child alone and then both together. Explore as far as possible with the child, the family, the parent or guardian the advantages and disadvantages of having an HIV test for that particular child. Consider the following questions:

- Who is asking that the child be tested and why? Is the child's best interest the main motive?
- How would having the test benefit this child?
- What does the child know and understand about HIV?
- What would a positive test result mean to the child?
- Does the child want to have a blood test? If not, why not?
- How do those who are closest to the child, for example, a parent, guardian or older sibling, think that the child would cope with being tested and possibly finding that they are HIV positive?
- Who will be able to provide emotional support for the child if found positive? Does this person have the knowledge and skills needed to give emotional support to the child? Does the child have a good relationship with this person?
- Do the health care professionals and counsellors who will be involved in testing the child and supporting the child's parent or guardians have the knowledge and skills needed to do this well?

The decision about testing should be taken only after considering these questions and the issues they raise. As far as possible, the child should be involved in the decision, along with the parent or guardian.

4.3 Counselling children who have been sexually abused

At every stage of child counselling the child's rights must be observed. The decision taken by the counsellor should be in the best interest of the child. Sometimes there is need to meet with legal personnel.[21] More health workers and counsellors need to be trained to counsel children. The training for child counsellors should incorporate training in legal and ethical issues. If the child has been defiled, counsellors at their own discretion should refer to the appropriate agency. The counsellor should at all times keep up the relationship with the child and the parent or guardian and keep providing support.

Many times sexually abused children are brought to the VCT counsellor to find out if they have been infected by HIV. Handling sexually abused children requires a multidiscplinary approach including the police, the probation office, child protection organizations and others. What follows are guidelines to VCT counsellors on how to link with these other services in handling such a case.

What to do if a child has been abused or someone has tried to abuse them

- Listen to the child calmly and encourage the child to tell the whole story. The child may find it very difficult to tell you. The child may have been threatened with harm or even death by the abuser if they tell what happened.
- Help the child report the incident to the nearest authorities. There are specially trained police, the Family Protection Unit, the local council leader, probation officers, teachers, community development officers, family and children courts, child rights services, and NGOs like Hope after Rape, Hope Counselling Centre and FIDA Uganda.
- If the child has been defiled or sexually assaulted they need medical attention. If possible the child should be medically examined by two doctors, one a police surgeon. This must be within 24 hours before the child bathes or washes their clothes, especially knickers and underwear. Keep the clothes in a plastic bag and give them to the police.
- The child and family also need counselling from trained counsellors.
- The child needs medical treatment and testing for STDs.
- The child needs legal advice.

The counsellor should link up with other services as spelled out in the box above.

In dealing with sexual abuse, consider the following points:

- Generally children are abused by people they know and live with; these include close relatives, neighbours and teachers.

[21] Should be clarified with the attorney general.

- Comprehensive counselling is required for all children who have been sexually abused. Where possible the perpetrator (abuser) should also be counselled.[22]

But VCT is an urgent need as it is necessary to know the child's status before starting post-exposure prophylaxis (PEP). The child also needs referral for further support, which may include medical treatment, help in coping with the situation, legal services, and possibly temporary relocation or custody.

An example of how counsellors and parents or guardians should handle a child who says they have been abused (from Childline website South Africa)

- Let the child know you BELIEVE them.
- Let the child know you are glad they TOLD you.
- Let the child know you are SORRY this happened.
- Let the child know it is NOT their fault.
- Let the child know you will get them some HELP.
- Don't call the child a LIAR.
- Don't BLAME the child for what has happened.
- Don't tell the child 'they were asking for it'.
- Don't allow the child to be abused further.

Children traumatized by the abuse often find it difficult to express themselves. Remember that a child's first language is play, and if the child finds it difficult to talk, try activity-based strategies:

Make-believe play: In spontaneous play, children may express distressing experiences, emotions and memories. Use toys, puppets and masks to help the child communicate ideas or feelings that would otherwise be difficult to express verbally.

Music and dance: These are powerful tools, especially if the music is familiar and linked with happy memories.

Stories: Stories or experiences about characters who have overcome difficulties in their lives help children imagine themselves doing so too.

Drama: Taking part in drama can help children act out their own story or make up one that expresses something important to them.

Drawing and painting: Again, children may find it easier to draw a picture depicting a scenario than talk about it.

Sand tray: Children like playing with sand and it is psychologically refreshing. Children mould and draw in the sand to express their inner feelings.

4.4 Giving HIV test results to legal minors

In post-test counselling of minors, counsellors should be careful in making a decision as to whom to give results. It may not be to the one who gave consent for the testing. Children should not be

[22] To be cleared by the attorney general's office. There is need to clarify who should counsel, where this counselling should take place, and whether the counsellor has a legal obligation to report the matter to the police.

tested simply for the parents or guardians to know their own status. Before disclosing results, the counsellor should assess if the parent or guardian is willing to discuss HIV and the test results with the child openly. If the child is HIV positive the counsellor should work with the parent or guardian to plan for the child's future care. The counsellor should provide ongoing support and counselling until the child is old enough to be disclosed to.

Emancipated minors should be given their results like adults. Children who are 12 years and above should be given results after proper counselling and with the involvement of parents or guardians. Children below 12 years of age should be given results only with the consent of parents or guardians and with proper counselling.

In all groups mentioned above ongoing counselling and support should be provided by parents or guardians and the counsellor. Never should anyone lie to a child of any age about their HIV results.

Notification to schools: An important first step is to ensure that teachers and students are sensitized about HIV/AIDS to try to avoid stigma at school. Teachers should be trained in how to handle HIV-positive children. School nurses should also be sensitized. Giving information about the HIV status of a child should be done only in the interest of the child and only to trustworthy teachers or school nurses who have received training in HIV counselling.

Giving results to children is sensitive. Give results to an adult—preferably the parent or guardian who participated in the pre-test session. Provide the adult with comprehensive post-test counselling. Decide on the plan for giving results with the parent or guardian during pre-test counselling. Review the decisions made at pre-test about giving results to the child after the parent or guardian has learned the results. Explore the situation again to determine if learning the results is in the interest of the child. Assess the child's capacity to understand the results before giving them. If the child is not able to cope with the results, delay disclosing them or disclose them gradually. In all cases provide the child and the parent or guardian with ongoing supportive counselling.

Ongoing support for children includes medical care and psychosocial, spiritual and economic support.

Communication with children. Parents or guardians often worry about the questions children may ask if the family talks openly about HIV. Here are key principles for answering difficult questions.

- All communication with children needs to be with people they trust, people who love them and give them a sense of security.
- Treat the child as an individual. Start by assessing what they already know and understand.
- Games, stories and writing can encourage the child to communicate more openly. Refer to section 4.3.
- Sit at the same level as the child—this will make the child feel more comfortable.
- Reflect what the child says; for example, if a child says, 'Mummy isn't coming back, is she?' you say, 'So you think mummy isn't coming back?'
- Explore answers with the child; for example, ask the child to tell you more about why they think mummy isn't coming back.

4.5 VCT for people unable to be fully informed

People who may be unable to be fully informed include the deaf, the blind, the dumb and the mentally retarded.

People who have disabilities that make it difficult for them to understand information about HIV and VCT well enough may not be able to make an informed consent for VCT. This category includes people with hearing disabilities that make it difficult for them to receive verbal information from the counsellor. Also people with speech disabilities may not be able to express their concerns about HIV and VCT to the counsellor well enough to clarify issues. People with visual disability or reading difficulties may not be able to use written information to prepare for VCT. Mental health patients may neither be able to understand information nor be able to make rational decisions.

If the blind, the deaf and the dumb are not mentally retarded, the same procedure should be followed as for counselling and testing others for HIV. What should differ is the method of communication with them. The mentally retarded should be tested only with consent of their parent or guardian.

All people 12 years and above tested for HIV should be given their results with counselling.

Children with disabilities are entitled to VCT. Children 12 years and above with disabilities but not mentally retarded should consent with the approval of a parent or guardian. They should be taken through the whole process of pre- and post-test counselling like any other child. Parents or guardians of these children should be fully involved.

The counsellor should work together with a parent or guardian and any other person with skills to communicate with children with disabilities (if need arises) to ensure effective communication during the counselling process.

Counselling for the mentally retarded child should be given to the parent or guardian, who also consents on behalf of the child.

4.6 Clients who may require consent of others on their behalf

In the very rare circumstances where a patient is not able to consent to HIV testing and the life of the patient or that of others depends on knowledge of the HIV status of the patient, the attending clinician or next of kin may decide, on behalf of the patient, that the blood of the patient be tested for HIV. But as soon as the client is able to understand, they should receive counselling. It is important for the service provider to give adequate counselling to the next of kin. If a patient is unconscious and the next of kin asks the clinician to test the patient, clinicians must use their own discretion. The most senior clinician in the institution should be the one to take responsibility for the ultimate decision regarding testing such a patient. The next of kin should be counselled and supported to understand the test results and cope with the impact.

4.7 Patients with cardinal symptoms and signs of HIV/AIDS[23]

HIV testing for clinical purposes is aimed to assist the attending clinician to manage patients. The clinician usually requests the test and the results are linked to the name of the client. Hence, this type of testing has similarities with VCT.

The clinician may decide to conduct the test without the patient's consent if the management of the patient depends on the test results. Knowing the HIV results may help the clinician prescribe the right medication and give prophylaxis against opportunistic infections. Upon getting the results, the clinician can decide how to approach the patient with the results and how to provide counselling.

Ideally rather than testing the patient without consent the clinician should refer the patient for VCT. Where this is not possible but the clinician feels the patient should be tested for HIV to guide clinical decision-making, the clinician should go ahead and test the patient as stated above. At the earliest opportunity, however, the clinician should refer the client for counselling and the full package of VCT. To facilitate this process all clinical facilities should have access to VCT facilities on site or in close proximity.

[23] Cardinal symptoms and signs of HIV disease include Kaposi's sarcoma, cryptococcal meningitis, oesophageal candidiasis, and in patients below 50 years of age, herpes zoster or oral thrush.

Chapter 5. Quality assurance

To ensure that VCT sites offer their clients quality VCT services, professional counsellors, well-trained HIV testing personnel and appropriate HIV testing kits with good infrastructure are needed. These therefore require an effective management and quality control system with continuous monitoring and evaluation.

Quality as it applies to VCT. The Ministry of Health defines quality as 'doing the right thing right, right away'. Quality assurance can therefore be defined as the process of ensuring that performance is done according to the set standards. These guidelines form the national standards for VCT services in Uganda.

To ensure that VCT sites offer their clients quality VCT services, professional counsellors, well-trained HIV testing personnel and appropriate HIV testing kits with good infrastructure are needed. These therefore require effective quality control mechanisms with continuous monitoring and evaluation. Quality assurance measures for VCT need to be applied at all levels—national, district and site. These measures should fit into the overall national quality assurance programme for HIV/AIDS care and support. The national quality assurance programme details the responsibilities for implementing quality assurance at all levels.

Accreditation of VCT sites:

- NGO and private clinics and labs that want to provide VCT sites should be accredited by MoH once they meet the criteria in section 1.2, which covers VCT in the private sector
- The accrediting authority should be the STD/AIDS control programme of MoH; accreditation should be based on DDHS recommendation.
- Accreditation of VCT centres not meeting the criteria in section 1.2 should be withdrawn.

5.1 Quality control of counselling

To ensure quality in providing services, the counselling environment should be friendly and accessible with well-trained counsellors. Tools to evaluate the quality of counselling should include self-evaluation, mystery clients, sit-in sessions, counsellors' meetings, fellowships, exit interviews, suggestion boxes, community assessment and regular support supervision.

Counselling environment. The environmental setting for counselling should be comfortable for the client and the counsellor. For details see section 1.5 on infrastructure.

Counselling standards. To maintain providing high-quality VCT service, the following standards of counselling should be adhered to.

In the counselling process, counsellors should . . .

- Observe the VCT protocol as described in chapter 2.
- Be able to adjust to and respect the social, cultural, religious educational differences and developmental stage of the client.
- Not impose their own views or opinions but respect and follow the client's agenda or priorities; however, counsellors should use their discretion to help the

client consider the implications of their issues and concerns so that the client can make decisions that are appropriate for their situation.
- Maintain positive attitudes towards all clients at all times.
- Use effective communication skills to help clients make appropriate decisions relevant to the prevailing situation.
- Provide proper guidance for the client to face realistic options and act accordingly.

Ethical values in VCT. Ethics is defined as a professional code of conduct. In VCT ethics focuses on the relationship between a service provider and the client. Counsellors must know and practise universal counselling principles of respect for the client, confidentiality and personal behaviour that is beyond reproach.

In the ethics of HIV/AIDS counselling and testing, counsellors need to observe the following points:

- Be properly trained as stipulated in section 1.7.
- Always observe and maintain confidentiality about the client.
- Never coerce a client into making decisions; allow clients to make decisions at their own free will after counselling.
- Always respect the client's ideas, interests and informed consent in making their own decisions.
- Treat clients with respect; never belittle, demoralize, ridicule or shout at them.
- Do not copy or remove confidential information relating to clients.
- Do not indulge in self-advertisement.
- Refer clients appropriately.
- Do not prescribe medications to clients if you are a non-medical counsellor.
- Do not demand, expect or accept material gain from the client in return for counselling services. This does not refer to official user fees charged at the VCT centre.
- Do not enter into any business transactions with or on behalf of the client.
- Do not develop sexual relationships with clients.
- Dress in a manner that commands respect and promotes professionalism.
- Promote good interstaff relationship:
  - avoid ill talk of one another and of other staff
  - consult one another's opinion on issues of concern
  - avoid accusations and confrontations

Record keeping. The counsellor should maintain proper records, ensuring the following:

- Session forms should be correctly filled in.
- Information on the forms should be consistent with the client's submissions and comprehensive enough to enable any other person to follow them up.
- Record forms and any other written documents must be filed and stored properly.
- Only counsellors and other staff directly involved in the care of the client should have access to records bearing the client's name. Every service provider is bound to keep confidentiality.
- Information on session forms must be entered correctly into the information management system.

5.1.1 VCT coordination and supervisors

To ensure quality, VCT services should be coordinated and supervised. There should be national and district VCT coordinators as well as site supervisors.

Supervisors are key in maintaining the quality of VCT services. District VCT coordinators and site supervisors should be counsellors who have been trained in VCT supervisory skills by a recognized training institution. Their roles and responsibilities should be clearly spelled out.

COORDINATION OF VCT AT THE DISTRICT LEVEL

- Each district should have a VCT district coordinator based at the DDHS office.
- The district VCT coordinator should be selected from the district health team by the DDHS.
- The person should have good know-how of VCT service delivery and preferably be a trained counsellor.
- The person should have the following roles:
  - Collect and submit regular management information systems (MIS) reports (see section 6.1).
  - Supervise all VCT sites and services in the district.
  - Function as the link with headquarters on matters of VCT services.
  - Plan and mobilize resources.
  - Plan and organize training and capacity building for VCT.
  - Collaborate and network with VCT partners in the district.
  - Regularly update district stakeholders on VCT.
  - Participate in the strategic planning on HIV/AIDS and ensure integration of VCT.

National and district VCT coordinators, health subdistrict and site VCT supervisors should be counsellors who have been trained in VCT supervision by a recognized training institution.

VCT supervisors from all levels should plan regular support supervision programmes as follows (see Supervisory checklist form in the appendix):

  - national and district VCT coordinators—quarterly
  - health sub-district VCT supervisors—monthly
  - VCT site supervisors—every 2 weeks

Standard methods of providing support supervision should be applied. The supervisory atmosphere should allow the staff to feel free to express their concerns and share the difficulties they encounter in their VCT work. Staff should be encouraged to identify opportunities for improving performance.

During support supervision, VCT supervisors should carry out the following:

- Compare current performance to set standards, identify and address gaps as well as report issues that require attention by local or central management.
- Provide on-the-job training and support to VCT service providers.
- Assess and support the process of community mobilization.
- Assess and support the quality of counselling and filing of VCT data.

- Review and support the process of data management.
- Assess the state of storage.
- Give presentations on selected topics at the post-test club.
- Ensure timely submission of requisitions and timely delivery of supplies to avoid stock-outs.
- Document supervisory activities using a checklist.

5.2 Quality control of HIV testing

Ensuring that the quality of HIV testing is high requires accurate testing materials that are well stored, have not expired and are handled by qualified laboratory personnel as defined by the Allied Health Professional Council. Good training and supervision of the laboratory staff as well as good administration of records in the laboratory are key to quality HIV testing.

Every laboratory conducting HIV testing should be linked to a higher-level laboratory, which should be equipped with more advanced HIV testing techniques for quality assurance, training and supervision. For external quality control, 3% of positive and 3% of negative samples should be retained and sent to a higher-level laboratory. Where quality control results differ from the results issued to the client, they should be used to identify weaknesses and strengthen the performance of the laboratory. Quality control testing should be paid for by the user laboratory. To be able to check for sources of error, samples should be kept for a minimum of 3 months.

5.2.1 Supervision of laboratory work

To supervise the HIV testing process, a senior laboratory technologist should carry out the following:

- Observe the process and quality of performance of the laboratory test according to set standard operating procedures.
- Examine and support the process and quality of processing blood samples.
- Examine the process of recording and reporting HIV test results.
- Assess the state of storage and of requisitioning supplies.
- Ensure timely submission of quality-assurance samples to the quality-assurance centre.
- Assess if the equipment is functioning satisfactorily and determine the need for maintaining or replacing it.
- Document supervisory activities using a checklist.
- Assess human resource needs for lab VCT service provision and give recommendations to the service manager.
- Ensure that an institutional policy on accidental exposure exists and is well known to all staff.

5.2.2 Local validation of HIV test kits

Validation of all HIV testing kits is a must in Uganda. All HIV test kits used in the country for various purposes including research should be validated before they are imported, on their arrival and during their use, as a quality control process. A new batch of test kits should be tested alongside the existing batch, using retained samples of known positivity and negativity.

The Central Public Health Laboratory (CPHL), which functions as the national health reference laboratory (NHRL)[24] should do the validation. All sellers of HIV test kits should have a certificate of approval from NHRL for each type of kit being sold.

While the capacity of CPHL is being strengthened the function of NHRL is supported by reference laboratories.

Reference laboratories should . . .

- have at least one staff member at the level of a registered medical laboratory technologist
- be doing HIV ELISA and Western Blot as part of their test methods
- be testing a minimum of 5000 specimens a year
- have the technical capacity to conduct research on HIV

Examples of reference laboratories: JCRC, Nakasero Blood Transfusion Services and UVRI.

Different forums should be set up to share information and experiences of the performance of VCT services nationally and all VCT service providers should regularly attend these forums.

5.3 Data management

All data obtainable from VCT services such as the number of clients counselled, number tested, discordancy rates, and the number of negative and of positive clients should be collected and analysed in a timely manner, as it provides useful information for improving the service.

[24] This function is currently being carried out by a number of existing labs, but MoH aims to strengthen CPHL and enable it to carry out this function.

Chapter 6. Monitoring and evaluation

Monitoring and evaluation of VCT services should be done in line with the Uganda National Strategy for M&E of HIV/AIDS.[25]

6.1 Monitoring

Management information systems (MIS): During the planning phase, a system should be established for routine MIS, to consist of client name, address, age, sex and brief risk-assessment data. Routine MIS forms should be adjusted to incorporate key VCT data. Any special information desired from VCT clients should be collected during special evaluations that are well managed and time limited.[26]

Inputs and outputs: Monitoring should keep track of programme inputs as well as outputs. This information should be made available to programme managers at the site and at district and national levels to be used in the planning cycle of VCT programmes. This information is also vital on a day-to-day basis in forecasting and planning commodities.

6.1.1 Initial assessment

Before starting a VCT site it is recommended that an initial assessment be carried out to determine the suitability of location, space, infrastructure and personnel, and the training needs of the providers. Programme planners and managers should consider the outcome of these assessments to determine what the resource needs are for setting up the programme.

Initial assessments should have two components:

ASSESSMENT OF VCT-RELATED SERVICES

An assessment should be carried out on a selected sample of VCT-related health facilities including NGOs and private practitioners in the district. For each site the assessment should include the following:

Exit interviews of a sample of clients attending the following HIV/AIDS-related services at the facility: TB, STD, FP, ANC and HIV/AIDS care and support clinic if available. The aim is to obtain an idea of the services received and client satisfaction.

- In-depth interviews with the facility manager and with providers of the specific services listed above. The aim is to assess current constraints and opportunities as well as their views on how VCT services should best be delivered.
- An observation of service delivery sessions of a sample of the above services.
- A review of the nature and quality of records.
- A review of the state of supplies for the above key services.

COMMUNITY ASSESSMENT

Community members' knowledge, attitudes and practices regarding HIV and VCT should be assessed. This will inform the programme of community knowledge of the

[25] Uganda AIDS Commission and Ministry of Health, 2000.

[26] See sample of this form in the appendix.

benefits of VCT and the proportion of community members who have ever been tested. It will also provide information about their views and feelings regarding the introduction of VCT. Where resources permit this could be carried out as a quantitative survey on a statistically representative sample of community members. Qualitative methods could also be used.

For example, participatory rural appraisal (PRA) methods have been used to determine community views, perceptions and attitudes to HIV/AIDS and VCT in the district. Community members can be recruited to assist in gathering information using semi-structured interviews and focus group discussions. After such an assessment a community action plan can be developed and shared with stakeholders. See community mobilization, section 1.1.

6.1.2 Input indicators

It is important that programme inputs are clearly documented.

- Meetings held with district authorities and local NGOs to establish VCT sites in the district
- Equipment procured
- Counsellors, counselling assistants (health centre level III) and community counselling aides trained
- Laboratory personnel trained in HIV testing
- Amount of money provided for operational costs of each site
- Quantity of supplies procured (including test kits)
- Counselling and laboratory personnel who have received refresher training
- Support supervisory visits

6.1.3 Output indicators

To have statistical meaning, the numbers of clients receiving VCT should be based on well-defined denominators.

VCT service indicators. To have statistical meaning, the numbers of clients receiving VCT should be based on well-defined denominators, for example

- Number of clients who received pre-test counselling out of the target population
- Number who received HIV testing out of those who received pre-test counselling
- Number who received post-test counselling out of those who received HIV testing

Other VCT service outputs:

- Number of couples who come in together for counselling
- Number referred (to where and for what)
- Socio-demographic, health-related and HIV risk profiles of clients

Level of integration. Monitoring the level of integration of VCT with TB, STD and FP services is an important programme indicator. Proportions of STD, TB and FP clients receiving VCT should be periodically analysed to determine the trend.

Other indicators

- Radio programmes broadcast on VCT (not site specific)

- TV broadcasts on VCT (not site specific)
- Newspaper inserts produced or feature stories published (not site specific)
- Billboards displayed, posters and leaflets distributed (not site specific)
- Sites submitting quarterly returns to the DDHS on time (not site specific)
- Local video or film shows
- Sensitization meetings with local council leaders
- Sensitization meetings with religious leaders and workers

Post-test club indicators: Centres with facilities for PTC should keep a record of the number of registered members (new and cumulative) and the number of members attending specific PTC services and activities. Centres with no PTC facilities should refer clients to other sites with these facilities and report the number referred for PTC.

6.1.4 Information flow

Information should flow from the grassroots upward: from the VCT centre to the health sub-district, the district director of health services, the Ministry of Health, and ultimately to the Uganda AIDS Commission.

Ultimately VCT data in a given district from all types of facilities (MoH, NGO, private) should be submitted quarterly to DDHS. Service statistics should be used to monitor how local and central programme management in particular is implemented. VCT monitoring data should be aggregated without client identifiers. VCT reporting should, however, be disaggregated by gender, age and marital status.

Counsellors and laboratory staff at VCT centres should collect and keep raw service data in registers and client forms. Data management staff should enter these data in computers. Where the facility does not have staff or computer for entering the data, the data can be entered on a laptop computer by a visiting data management staff member from the district or photocopied registers and forms can be sent to the district for entry.

Entered data can either be emailed or sent on a diskette to the DDHS office, where they are analysed and feedback is sent to the VCT site. Data for the district are merged and used for district-level coordination and planning. Merged district data are then sent to the national level, where there should be a VCT evaluation officer. Similarly merged national data should be sent to the district for information and motivation. At the district level VCT data management should be carried out by officers of the health management information system, trained in computer management of the system.

6.2 Evaluation

Systematic evaluation of the VCT programme in a given location should be undertaken. This could consist of a client's survey of knowledge, attitudes and practices (KAP) as well as the client's intention to change behaviour. Such an evaluation could be carried out regularly for a limited period, for example, for 1 month every 2 years. In addition, ad hoc qualitative evaluations could be carried out to assess the process of service delivery—for example by using qualitative narration of the content of a counsellor's counselling using a record that lists problems the client presents, options discussed, and decisions the client took. Also, an external agent could be contracted occasionally to carry out an evaluation of the quality of care. Tools such as a checklist of counselling content could be used to observe counselling sessions. Client exit interviews and mystery clients could also be used to assess client satisfaction.

The objectives of evaluation of VCT services are . . .

- to determine the extent to which the VCT service has achieved its objectives in coverage and in impact on behaviour and on care and support, as assessed by the indicators
- to perform a SWOT (strengths, weaknesses, opportunities, and threats) analysis of the VCT service
- to assess acceptability and affordability of the service
- to assess the availability and sustainability of the service
- to recommend refinements in the service

6.2.1 Process evaluation

Process evaluation uses information such as service delivery data, supervisory reports, client satisfaction, providers' views and quality-assurance data. It is important to elicit client feedback. Three useful methodologies for process evaluation are explained below.

CLIENT EXIT INTERVIEWS

It is recommended that a self-administered questionnaire be provided to every 10th client leaving the services. A client exit interview form (see appendix) should be brief, taking not more than 5 minutes to complete. The form can be given out by the receptionist to clients as they exit. Willing clients are asked to fill out this form anonymously and deposit it in a suggestion box to be collected at the end of the day. A staff member not directly involved in service delivery should assist clients who cannot read to complete the form. Clients must be told that their suggestions will be used to help improve the services. Client exit interviews focus on the following key issues:

- Do clients receive the services they come for?
- Do they receive information related to the services they receive?
- What do they like best about the facility?
- What do they like least about the facility?
- What are their suggestions for improving services?

The exit interview method has the advantage of reflecting what the patient has learned as opposed to what the provider has said. Both the provider and clients may also consider exit interviews more acceptable than observations, which see below. A disadvantage, however, is that the patient may not always recall everything the provider did during the consultation.

MYSTERY CLIENT SURVEYS

Mystery clients are hired either by the service or by an evaluation agent. It is imperative that the mystery clients reflect the usual clientele of the VCT services being evaluated. When deploying mystery clients, try to ensure that they visit a wide variety of VCT services and that they are a fair mix of male and female, old and young, single persons and those who pose as couples. They are trained to act out typical scenarios that include credible reasons for seeking VCT. After the session each mystery client fills in a form detailing the experience. The form is then submitted to the supervisor of the evaluation. For ethical reasons mystery clients are hired to go through the process only

up to the end of the pre-test counselling; thereafter they decline the test. Hence they cannot be used to evaluate the entire VCT process.

OBSERVATION OF COUNSELLING SESSIONS

Observations are carried out by an experienced counsellor or a counsellor supervisor who sits in a counselling session to observe the quality of counselling. Before the supervisor sits in, the counsellor explains to the client that another counsellor is coming to sit in to observe what is taking place and that the observation will be used to improve the service. If the client accepts, the supervisor comes in and attends the session. The supervisor uses a checklist (see Observed practice form in appendix) to record and score the session and then discusses it with the counsellor afterwards.

Observations are difficult to implement because 1) some providers object to being observed, 2) the very process of being observed may cause providers to alter their behaviour, 3) being present for enough cases may be logistically difficult, and 4) it intrudes upon the privacy of the patient. Every method of evaluation has bias associated with it. However, observations have been used in several domains of public health including STD, FP, child survival and essential drugs. Their advantage is that what people actually do is assessed instead of what people say they do.

6.2.2 Impact evaluation

At each district indicators of VCT impact should be developed that focus on client behaviour and on care and support issues. Ideally a survey should measure baseline levels of these indicators before VCT services start. However, because of the urgent demand for VCT services many of these services have been started before a systematic baseline survey could be carried out. It is therefore recommended that districts carry out cross-sectional surveys using these indicators in evaluations to be carried out once every 2 years.

6.3 Specific research studies

At district and national levels VCT stakeholders should develop a VCT research agenda. In addition to evaluating programme impact and process, specific research studies should be carried out to answer research questions regarding VCT. For example, operations research could be carried out to test the feasibility of new VCT protocols, such as rapid test protocol, or to examine provider and client acceptance of new services, such as TB prophylaxis. Studies could be designed to test the impact of interventions such as training of counsellors about FP. Cost analyses should be conducted to determine cost effectiveness of VCT and cost per client served.

At district and national levels VCT stakeholders should develop a VCT research agenda and circulate it widely among interested research organizations. The agenda should focus on research questions the VCT management team wishes to answer to refine delivery of its services. Study proposals should be developed and reviewed by the National Council for Science and Technology before a study begins. Adequate funds for research should be available to enable quality and ethical collection of data as well as analysis and dissemination of the results.

As a means to ensure quality VCT services, operational research should be done according to need, to assess the set VCT standards.

Possible areas of such research should include

- continued viability and implications of the proposed testing algorithms and VCT protocol
- assessment of client satisfaction with VCT services
- assessment of knowledge, attitudes and practices (KAP) of the health workers and the public on VCT policy and implementation guidelines

Where possible data collection forms should be standardized for use nationwide, to compile comparable data that are easy to analyse.

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APPENDIX—FORMS

Referral form

Referral form no. _____

Client's name _____

D.O.B. _____ Client test no. _____

Address (place of residence) _____

L.C. 1 _____ Zone _____

Place referred to ***(tick all that apply):***

1. Care and support (name of organization_____)
2. STD (name of organization_____)
3. TB (name of organization_____)
4. FP (name of organization_____)
5. VCT (name of organization_____)
6. Other service _____ (name of organization_____)

Referred by _____

Title _____ Code no. _____

Date _____

_____

Official stamp and signature

DETACH HERE AND SEND BACK TO REFERRING CENTRE……..

Referral form no. _____

Client's name _____

Client received by _____

Title _____

Name of receiving centre _____

Date received _____

_____

Official stamp and signature

Client consent form

This is to certify that I came to this testing service to have an HIV test and I hereby request the service to draw blood and test it.

I agree to confirm that the number on the blood sample is the same as on the client card.

I accept to give a blood sample to confirm my HIV infection status.

I understand that taking an HIV test is purely voluntary. It is my choice to receive the results.

Client signature or thumb print

_____

Witness signature (counsellor)

_____

Date: _____

Laboratory results form

LABORATORY HIV TEST RESULTS

Confidential

Name of site_____

Name of client_____ Age of client _____ Sex of client_____

Client number _____ Date tested_____

HIV test results

Reactive (positive) _____

Not reactive (negative)[27]_____

Indeterminate[28] _____

Name and title of issuing officer_____

Signature_____Date_____

[27] Please note that HIV negative results indicate that the person tested had no antibodies to HIV on the day they took the test. Persons who have recently been exposed to HIV may test antibody negative for up to 3 months from the time they were last exposed to risk. This is called the window period. Clients who have tested HIV negative should see their counsellor again to discuss their risk and the possibility of retesting after the window period. Also note that clients who have tested HIV negative are not immune to becoming infected with HIV if they do not protect themselves.

[28] Indeterminate results are neither positive nor negative. Clients with indeterminate results should see their counsellor for repeat testing after 3 months. In the meantime these clients should either abstain from sex or practise safer sex.

Laboratory request form for HIV and syphilis testing

LABORATORY REQUEST FORM

Name of site _____

Client number _____ Age of client _____ Sex of client_____

Date tested _____

Tests requested (please tick):

HIV antibody test _____

Syphilis antibody test _____

Other test (specify) _____

Other test (specify) _____

Other test (specify) _____

Name and title of requesting officer _____

Signature _____ Date _____ _____

_____

LABORATORY REPORT (please tick)

HIV antibody test: reactive _____ non-reactive _____ indeterminate _____

Syphilis antibody test: reactive _____ non-reactive _____

Other test (specify) _____result_____

Other test (specify) _____result_____

Other test (specify) _____result_____

Name and title of laboratory officer_____

Signature_____Date_____

Supervisory checklist

Date ……..…. Day of week…… ……..Name of site……..
Time of visit: morning / afternoon
Name of supervisor……. Designation of supervisor……..
Institution of origin of supervisor…….

To be completed by supervisors during bimonthly supervisory visits to sites. Visit should be made on day of week when most services are being provided.

A. Timetable of services at this centre

Tick days on which these services are provided						
Service	Mon	Tue	Wed	Thur	Fri	Sat
VCT						
CS						
STD						
TB						
FP						

Comments……

B. Observation of service delivery on the day of supervisory visit

Service	Are providers present in the clinic?	Are clients receiving services?
VCT	Yes No	Yes No
CS	Yes No	Yes No
STD	Yes No	Yes No
TB	Yes No	Yes No
FP	Yes No	Yes No

Comments……

C. Examination of clinic records

Service	Are clinic records for previous clinic day available?	Are clinic records being used on current day?
VCT	Yes No	Yes No
CS	Yes No	Yes No
STD	Yes No	Yes No
TB	Yes No	Yes No
FP	Yes No	Yes No

Comments……

D. IEC materials

Service	Are posters currently on display?	Are leaflets being distributed?	Is a video being shown?
VCT	Yes No	Yes No	Yes No
CS	Yes No	Yes No	Yes No
STD	Yes No	Yes No	Yes No
TB	Yes No	Yes No	Yes No
FP	Yes No	Yes No	Yes No
Integrated	Yes No	Yes No	Yes No

Comments……

E. Supplies and drugs stocks

Service	Are there any stock-outs at the time of the visit?
VCT	Yes No
CS	Yes No
STD	Yes No
TB	Yes No
FP	Yes No

If the answer is yes to any of the above please indicate the item(s) that are out of stock:

F. Staff changes

Service	Number of new providers who have joined since last visit	Number of providers who have left since last visit
VCT		
CS		
STD		
TB		
FP		

Comments……..

G. What other issues have the service managers and providers presented today? If no issues are mentioned spontaneously please probe?

H. What suggestions have been made to address these issues?

MIS form

Attach HIV Results

Attach RPR Results

Date ____/____/____ Branch/Site Code:

AIC No.

CT No: _____ PTC No: _____

FP No: _____ Med. No: _____

Mother's Name _____ _____
Surname Other Name

Languages: 1._____ 2._____

Sex 1 = Male 2 = Female Date of birth: ____/____/____

Marital Status: _____ Education: _____

Employed?: 1 = Yes 2 = No

Nature of Work: _____

District of Residence: _____ Tribe: _____

Rural/Urban: _____ 1 = Individual 2 = Couple

ATTACH CLIENT CODE HERE

PARTNER CODE: _____

COST SHARING FEES

PAID
0= Free day
1= Paid
2= Exempted

AMOUNT
1= 5000/=
2= 4000/=
3= 3500/=
4= 3000/=
5= 2500/=
6= 2000/=
7= 1500/=
8= 1000/=
9= 500/=

Why exempted? _____

VISIT REASONS (Tick all that apply)

[ ] HIV/AIDS Symptomatic
[ ] STD/Other Symptoms
[ ] Exposure to HIV risk
[ ] Don't trust Partner
[ ] Feel ill
[ ] Worried
[ ] Reunion
[ ] For marriage
[ ] Planning Specify _____
[ ] Confirmation
[ ] Referred (by) _____
[ ] Other Specify _____

COUNSELLOR CODE _____

TESTED? 0= No 1= Yes

If No why? _____

OTHER TESTS

SYPHILIS 0= No 1= Yes
_____ 0= No 1= Yes
_____ 0= No 1= Yes

PREVIOUSLY TESTED?
0= No
1= Yes, Non Reactive
2= Yes, Reactive
9= Other

PREVIOUS NO. _____

DATE TESTED ____/____/____

TEST CENTRE _____

When did you last have sex? Sex partners in last 6 months	Month _____ Year ____ 99= Never Number steady _____ Number Non-steady _____
Condom use in last 6 months Used condom last time	0= No 1= Sometimes 2= Always 9= NA 0= No 1= Yes 9= NA
Family planning method in last 6 months	0= None 1= Pill 2= IUD 3= Injection 4=Condom 9=NA 99= Other specify _____
(COUPLES ONLY) Ever had sex with today's test partner ?	0= No 1= Yes 9= NA
Are you expecting a child?	0= No 1= Yes 2 = Don't know
EXPECTED RESULT	0= Non Reactive 1= Reactive 2= Not Sure

POST-TEST

TEST RESULTS (CIRCLE appropriately)
HIV 0= Non reactive 1= Reactive
RPR 0= Non reactive 1= Reactive
____ 0= Non reactive 1= Reactive
____ 0= Non reactive 1= Reactive

COUNSELLED?
0= No 1= Yes

CONDOMS
GIVEN? 0= No 1= Yes
Number given _____

REFERRAL MADE
0= No 1= Yes, Internal 2=Yes, External
(Tick all that apply)
TASO [ ] STD [ ] TB [ ] FP [ ] PTC [ ]
Others [ ] _____

Client exit interview

Date _____ Venue _____ Site _____ No. ____ Sex: M ___ F ___

We are conducting a survey with users of our health centre to find out what you think about our services. This will help us improve quality for future clients. Your answers are strictly confidential and we thank you for your participation and honesty.

1. How long did you wait to see the counsellor?
[ ] less than 30 min [ ] 30 min–1 hour [ ] 1–2 hours [ ] more than 2 hours

2. How did the counsellor welcome you?
[ ] warm [ ] neutral [ ] cold

3. Did the counsellor explain to you what to expect in the session?
[ ] yes [ ] no

4. Did the counsellor help you to feel free to talk about all your concerns and personal issues?
[ ] yes [ ] no

5. Did you feel the counsellor listened to you?
[ ] yes [ ] no

6. Did you feel the counsellor understood your concerns and personal issues?
[ ] yes [ ] no

7. Did you feel your personal issues would remain safe between you and the counsellor?
[ ] yes [ ] no

Did the counsellor discuss the following issues with you?

8. Risk behaviour? [ ] yes [ ] no

9. Disclosure to partner? [ ] yes [ ] no

10. Condom use? [ ] yes [ ] no

11. Was the counsellor comfortable discussing these issues with you?
[ ] yes [ ] no

12. Was condom use demonstrated?
[ ] yes [ ] no

13. Did you have a blood sample taken today?
[ ] yes [ ] no

14. How many times did the counsellor prick your finger to take the sample?
[ ] once [ ] twice [ ] 3 times [ ] more than 3 times [ ] not applicable

15. Did you feel comfortable when your sample was taken?
[ ] yes [ ] no [ ] not applicable

16. Did you feel the counsellor was confident in their job?
[ ] yes [ ] no

17. Was the counsellor respectful towards you?
[ ] yes [ ] no [ ] not sure

18. Was the counsellor genuine towards you?
[ ] yes [ ] no [ ] not sure

19. Was the counsellor non-judgemental towards you?
[ ] yes [ ] no [ ] not sure

20. Did you have privacy during the counselling session?
[ ] yes] no

21. Did you have enough time with the counsellor?
[ ] too long [ ] just right [ ] too short

22. Did you feel that you received all the information you needed to know?
[ ] yes [ ] no

23. Was the counselling room in a convenient place?
[ ] yes [ ] no

24. How was the attitude of the other staff at the health centre?
[ ] very good [ ] fair [ ] poor

25. Will you recommend the service to others?
[ ] yes [ ] no If no, why not? _____

_____

26. Overall, what do you think about the service you received today?
[ ] very good [ ] fair [ ] poor

27. Are there any other special comments you wish to make?

_____

_____

Thank you very much for your patience and time.

Observed practice form

Date: _____ Venue: _____ Observer: _____

Please score as follows: 0 = not done, 1 = not achieved, 2 = attempted but with little success, 3 = achieved, N/A = not applicable

Aspects of service being assessed	*Score*	*Comments*
Explained what to expect		
Applied SOLER		
Applied counselling skills, such as reflecting		
Client spoke more than counsellor		
Performed a risk assessment		
Condom discussed and demonstrated		
Helped client attain risk-reduction plan		
Finger-pricking done adequately		
Client understood meaning of test result		
Gave results comfortably		
Discussed disclosure of test results		
Client determined an action plan		
Dealt with client's emotional reaction		
Dealt with own emotional reaction		
Gave adequate time to the client		
Discussed referral options with client		
Assessed availability of social support		
Conducted client-centred session		

Observer: _____ Session date: __/___/___

Session: Start time: ____: ____ Stop time: ___: ___