



THE REPUBLIC OF UGANDA

Uganda National Policy Guidelines for HIV Counselling and Testing

Ministry of Health

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Foreword

HIV Counselling and Testing (HCT) is the most important service 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 HCT to know their HIV status before deciding on marriage. HCT 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. HCT 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. The government of Uganda now aims to place high-quality HCT service within the reach of every Ugandan. As we continue to scale, we need up to date national guidance and quality assurance.

In the year 2005, new innovations into HCT like, Routine Testing in Clinical settings and Home Based HCT have been introduced. More still as an implementer of the 3 by 5 WHO initiative HCT must become more available and accessible to test the 10 millions Ugandans in order to obtain the required 60,000 on ART by end of 2005 as targets for Uganda.

The government believes in an open and participatory approach to HIV/AIDS policy development and programming. This is the second review of the National Policy on HCT. All have been consulted except people with special needs (disabilities). 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 HCT services.

May 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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Introduction

In order to establish a sero status of an individual, there is need to carry out HIV Counselling and Testing. The testing may be voluntary but other times the testing is carried out under different circumstances where voluntarism does not apply.

Since this document refers to all these types of Testing, therefore the need to change from VCT to HCT which is a broader term than VCT. Where VCT as one of the types of HCT is referred to, it should not be inter changed for HCT.

There are two related guidelines regarding HCT services in Uganda.

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

The related document is the *Uganda National Policy Implementation Guidelines for HIV Counselling and Testing Services*, which restates the national policy on HCT 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 it, the policy statements are highlighted with a shaded background.

The objectives of HCT policy are as follows:

- To provide a framework for providing HCT services in Uganda.
- To empower health workers and counsellors to provide HCT services appropriately to all people.
- To make HCT services part of the wider health care system to help bring about positive behaviour change.
- To spell out different types of HCT available for different circumstances.

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

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

March 2003) in the Ridar Hotel in Seeta Mukono. Successful meetings have been held since 2004 to update and improve on the policy and implementation guidelines. The implementation guidelines also draw from the vast experience of HCT 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 that document.

The secretariat of this process has been in the Ministry of Health STD/AIDS Control Programme. In 2004 6 regional consultative meetings were carried out with support from CDC and UNICEF and input into the review process was obtained. In 2005 (February) the VCT policy was reviewed into the HCT policy.

Circumstances of HIV testing in Uganda

At the moment in Uganda HIV testing is being carried out in a variety of circumstances. Many, although not all, of these types of testing are within the scope of this document.

HIV-testing circumstances that are addressed by the policy statements in this document

Voluntary counselling and testing (VCT) is HIV testing provided to individuals who seek the service out of their own will without any coercion. These persons may be referred by a provider, a sexual partner or a friend, or they may have learned of the service from hearsay or public media. The key point is that the clients make the conscious decision to seek the service and seek it out without coercion. They receive pre-test counselling, HIV testing and post-test counselling during which they are given the HIV test results. Thereafter they are usually referred for follow-up care and support. This type of HIV testing is the main subject of these policy guidelines.

Routine Testing and Counselling (RTC) is HCT in clinical settings. It is facility/hospital based approach aimed at integrating HCT services with existing day to day clinical services. In this model testing for HIV is carried out routinely in health units/facilities. This increase access to HIV testing and early care where needed. (It also helps to reduce stigma and discrimination). However the counselling process is modified from that of the traditional VCT. It must be done by skilled personnel as it can scare off communities from seeking health care services from the facilities. Confidentiality as in all medical circumstances and ethics will be ensured. This document provides guidelines on how RTC can be made part of the health care package in all health units.

VCT and RTC are both appropriate for the prevention of mother-to-child transmission (PMTCT) VCT and RCT provided to the specific target population of pregnant women for the primary purpose of enabling them to make decisions about PMTCT is part of the scope of this document.

Home Based HIV Counselling and Testing (HBHCT) is a community based approach in HIV counselling carried out in the clients' familiar environment in their homes. Counselling and testing are done door to door and results given during the same

visit. The home environment can be convenient and conducive for counselling and testing and eases the workload on the existing health infrastructure.

Testing of people seeking employment, studies or certain services: Some employers, foreign governments and institutions have policies that require knowing the HIV status of certain persons before they are allowed to apply for particular privileges or services. Such policies are usually discriminatory against people living with HIV/AIDS and should be condemned. However, persons seeking such privileges need HCT to indicate their HIV status as part of their application for these services. For this reason this document does provide specific guidelines on how HCT providers should handle clients seeking HCT when applying for a particular privilege or service.

HIV testing of children (legal minors): Only people who have attained the legal age of majority (18 years) are supposed to consent to HCT. Therefore, testing people under the age of 18, whether voluntary or not, may not strictly be VCT. However, sexual activity and hence the need for HCT starts at earlier age groups. Indeed, many who are legal minors are seeking service at HCT centres. Also many children may need HIV testing for clinical purposes to manage HIV disease. For these reasons these HCT guidelines incorporate the testing of legal minors.

HCT for special groups of people: Sometimes HCT may be necessary for people who have disabilities, such as the deaf and the blind, which may not allow them to be fully informed about HCT, or for people who may be in a state of mind that makes them unable to make rational decisions to seek HCT. In such circumstances special communication in pre- and post-test counselling may be needed, or other people may need to consent on their behalf. This document discusses the counsellor's role in such circumstances.

Mandatory HIV Testing in Clinical setting: This refers to testing of a patient/client regardless of consent. Mandatory testing must proceed post exposure prophylaxis and may be done in the following circumstances:-

Medical-legal cases e.g. rape, defilement, indecent assault.

Tissue donation including blood semen, organs, transplant, etc.

In mandatory testing the patient/client is not obliged to take results in the event that the result is given, it must be accompanied with appropriate post-test information giving.

HIV testing after occupational exposure applies to a health worker who has been accidentally exposed to the body fluids of a patient or vice versa. Other emergency workers such as the police, fire fighters and ambulance personnel may also be accidentally exposed to the body fluids of their clients. Operational guidelines may prescribe that the two parties involved—the potential source of infection and the potential recipient—both undergo HIV testing to establish their HIV status. This kind of testing requires pre- and post-test counselling as well as consent of both

parties. Guidelines for counsellors in these circumstances are included in this document.

Circumstances of testing not discussed in these guidelines because they are addressed by other policy guidelines

Research: Many research studies involve HIV testing using a variety of procedures, and the way test results are handled varies from study to study. For each study the principal investigator must submit a detailed proposal including informed consent procedures to the National Council for Science and Technology and get approval before commencing the study. While research may be carried out on HCT services and HCT may be part of a research study, the policies regarding research on human subjects are well stated in *Guidelines and procedures for research registration and clearance in Uganda*² and are not discussed here.

HIV testing of blood donors: People who donate blood are tested for HIV and are informed of their test results through confidential post-test counselling. In Uganda, people desiring to donate blood are counselled about their risk factors and asked to self-refer if they feel that they have recently been at risk of HIV infection. They are then referred to a HCT site to receive HCT services. Similarly those who come to donate blood for the primary reason of knowing their HIV status are referred for HIV testing. The policies regarding the testing and counselling of blood donors are spelt out in *Guidelines for blood donor counselling on HIV*,³ a publication of the World Health Organization, and are not part of this document.

HIV Sentinel Surveillance: Blood samples that have been taken from pregnant women attending an antenatal clinic to test for syphilis are de-linked from any personal identifiers and then subjected to HIV testing, the purpose being to determine HIV prevalence. Women's names are not linked to the results nor are the women given these test results. Hence this kind of testing is not VCT. The procedure for HIV surveillance testing is explained in the *HIV surveillance report* of June 2002.⁴

² Kampala: Uganda National Council for Science and Technology, 2001.

³ WHO/GPA/TCO/HCS/94.2 (Geneva: WHO, 1994).

⁴ Ministry of Health

Circumstances of testing not discussed in these guidelines because they require consultation with the Attorney General's office

HIV testing in suspected criminal situations: In situations in which testing for HIV is required for some people as evidence in court, counsellors and laboratory personnel need clear guidance as to whether and how to obtain consent of the person to be tested, and whether and how to give the tested person the test results. One such example is in the case of rape or defilement, when law enforcement officers may want to test the victim and the suspect to ascertain if the victim was infected by the suspect.

Chapter 1. HIV Counselling and Testing (HCT) services

HCT is a core intervention in the comprehensive strategy of the government and its partners to address HIV/AIDS in Uganda. High-quality HCT services should therefore be widely and consistently available. The demand for HCT continues to grow. The need thus arises to continue mobilizing resources to meet this demand and to strengthen the infrastructure to accommodate new innovations in HCT. Uganda's goal is to have universal access to HIV testing by 2008 (10,000,000 by 2008) and these new innovations in HCT will go along way in helping achieve this.

Making the services user friendly and accessible to groups such as the youth, commercial sex workers, people with disabilities, children and the elderly should be considered during the planning and delivery of HCT services.

Voluntary counselling and Testing (VCT), Routine HIV Testing and Counselling (RTC), Diagnostic HCT, Mandatory HCT and HBHCT are some of the proposed approaches of achieving the 3 by 5 goal set by WHO. These approaches are discussed in detail below.

1.1 Promotion of HCT services

Once HCT services are 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 HCT centre, should encourage the public to take advantage of HCT services as a necessity.

To further increase demand for HCT services, promoters should go out to sensitize and mobilize communities on the benefits of HCT in locations such as markets and places of worship or in homes during home visits. There is also need to have special promotion programs for the difficult to reach e.g the elite in the urban setting and health workers.

Communities should be informed about the different models and approaches to HCT. VCT shall remain voluntary while RTC in the clinical setting shall be available in all Health facilities and applied according to the existing guidelines. Clients can opt out in RTC model but clinicians may also conduct HCT for diagnostic purposes.

Where cost is attached to HCT services, one way of promoting the service could be by way of subsidy. Remember the purpose of HCT is to detect the majority that are HIV negative and keep them negative for ever and for the few positive get them to access early care and support services.

1.2 Types of HCT services

There are various models of HCT services. In all models the HCT services should be linked to care and support and must be of good quality

1.2.1 VCT services

VCT Services are HCT services where the clients voluntarily come on at their will to know their HIV status. There are 4 types of VCT services as below:-

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.

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

Outreach HCT services and home-based HCT models like HBHCT should be provided with a mechanism for ongoing support services for HCT clients.

HCT services in the private sector must be registered and certified to conform to national standards for delivering HCT 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.

1.2.2 Routine Testing and Counselling (RTC) services

Definition

This is HCT in clinical circumstances where patients presenting to health care facilities are offered HIV testing as part and parcel of the other services that they may require; irrespective of the presenting illness.

RTC is health facility based approach, and should preferably be at a level IV health centre and above, where capacity and associated HIV/AIDS services are available. However, level III facilities with adequate capacity can also provide RTC. The health facility may be either government, non-government or private for profit.

RTC services should be linked to care and support and must be of high quality.

RTC services must be conform to national standards. 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.

1.2.3 Home Based HCT (HBHCT) services

Definitions

HBHCT is a type HCT service, which is community based i.e. conducted in the clients' own environment or home.

HBHCT should be linked to ongoing prevention, care and support for HIV/AIDS patients. It should adhere to the national HIV testing standards and have a quality control link with established reference laboratories.

1.2.4 Diagnostic HCT

Definition

Diagnostic HCT is an approach where patients/clients who are unable to consent are offered HIV testing by providers in order to make decisions about their care. Diagnostic HCT is strictly a facility/hospital-based approach, and should preferably be at a level IV health centre and above, where capacity and associated HIV/AIDS services are available. However, level III facilities with adequate capacity could provide Diagnostic HCT. The health facility may be either government or non-government. 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.

1.2.5 Mandatory HIV Testing in clinical setting

Definition

Mandatory testing in the clinical testing is done is done regardless of consent in the following circumstances: Post-exposure and there is need for prophylaxis, tissue donation and medico legal circumstances such as rape and defilement.

The patient/client is not obliged to take the results but in the event that the result is given, it must be accompanied by appropriate post-test information and support for HIV/AIDS patients.

1.3 Integration of HCT with other Health Care Services

Health care workers should provide comprehensive care for all patients, including information on HIV and offer of HIV testing where it is available. This is particularly important in high prevalence units, such as TB, FP, STD, ART, and PMTCT services. They should at least provide basic information in these areas. In the event that patients/clients require more detailed information and care, they should be provided with appropriate referrals.

In facilities where HCT services are not provided daily it is important to ensure that the service is available on the same days as high prevalence clinics.

1.4 Support services for HCT

1.4.1 Ongoing counselling

After disclosure of results, ongoing counselling sessions may be scheduled as necessary, as part of the HCT package. Clinicians, counsellors and pharmacists who provide care to HIV-positive clients should also provide ongoing counselling.

1.4.2 Post-test clubs

Post-test clubs (PTC) should be made available at every HCT centre and in communities where HBHCT is done and an active effort made to promote them. HCT 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 that 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.

1.4.3 Care and support

At the time of diagnosis, HIV/AIDS care should be initiated and/or referral provided as appropriate, for all HIV-positive patients/clients. This will provide an opportunity for early access to HIV/AIDS care and planning for follow-up support including ongoing counselling, treatment and prophylaxis for opportunistic infections, and/or ART.

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 result slip to aid initiation of care at the referral site. Mechanisms need to be established to encourage feedback between referral sites. All referrals should be addressed to institutions, departments or units rather than individuals.

1.5 Infrastructure

HCT requires confidentiality. Basic furniture for HCT customarily is some chairs and a table. In community settings 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/or equipment for HIV testing. In the health care setting, this may be done by the bedside, but confidentiality should be ensured.

In the laboratories, especially private laboratories where clients walk in wanting to be tested, pre-test and post-test information should be provided. But if a health worker or counsellor has requested the test, the patient may be received and the blood sample taken. In such circumstances, results should be sent back to the requesting health worker or counsellor.

1.6 Hours and days of service

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

HCT services should be integrated with all other health care services. In health facilities where resources are limited and HCT is provided only on specific days, effort should be made to ensure that HCT services are provided on the same days as high prevalence clinics such as TB, FP and STD services. Outreach services remain an important complementary measure to reach communities that do not have access to HCT. Of necessity many outreach services, because they are short staffed, can operate only on selected days of the week. However RTC services should be available whenever needed in the clinical setting.

1.7 Human resources for HCT services

HCT sites should have adequate human resources to provide the services required of them. Personnel include counsellors, laboratory personnel and clinicians. For RTC it is recommended that all health workers have counselling skills so as to make HCT services easily available. In cases where services are integrated and counsellors have other duties, additional counsellors will be needed. Trained counsellors/health workers should provide HIV pre- and post-test information/counselling. When staff is limited, appropriately trained assistants may provide this information/counsel. Counsellors and counselling assistants should have sufficient skills to offer comprehensive HCT services.

1.7.1 Counsellor Qualifications

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

1.7.2 Training in counselling

Training for HCT service providers should be carried out by Ministry of Health and approved Institutions that can provide comprehensive knowledge and skills. The standard 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. This process will be reviewed whenever necessary as new innovations may arise.

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

Laboratory personnel who carry out HIV testing should be equipped with basic counselling skills.

1.7.3 Registration of counsellors

This is for non medical 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. For the medical health workers, certification of acquisition on counselling skills for HIV/ AIDS services is all that is required.

1.7.4 Counsellor support

Counsellors need support to prevent burnout, 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.

1.7.5 Who should perform the HIV test?

Personnel not below the level of medical laboratory technician should perform HIV ELISA tests. Where available, medical laboratory technicians are the most suitable personnel to perform rapid HIV tests. But owing to staff shortage medically trained personnel/counsellors 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 may also perform rapid testing if adequately trained and supervised. **NB: Clients must not perform HIV tests.**

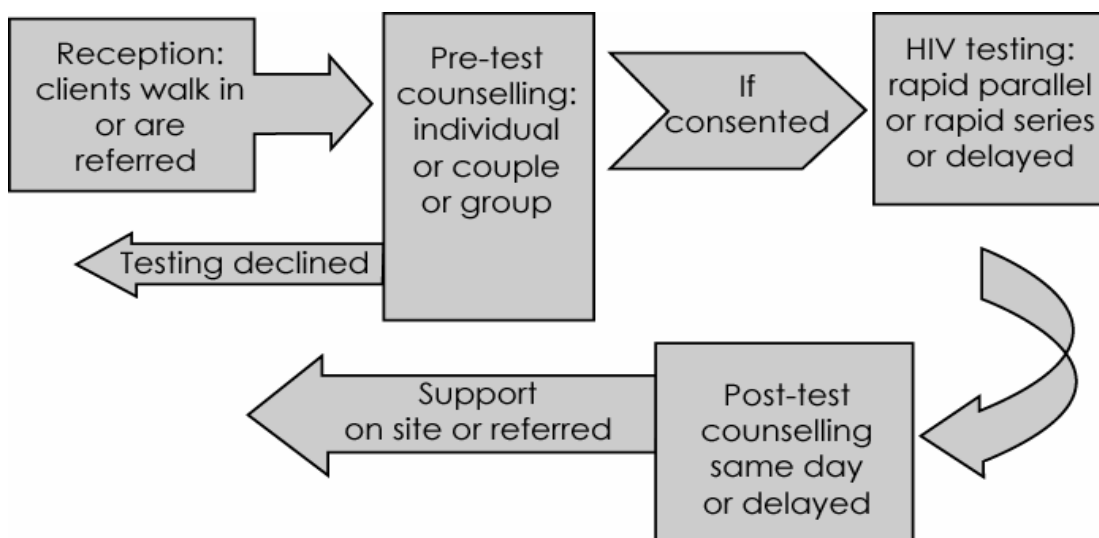
1.8 Financing HCT services

HCT should be considered a public health care and preventive service and like others should be free in public health facilities.

Chapter 2. HIV Counselling and Testing protocols

In Uganda the VCT and RTC protocol for HIV starts with client registration followed by pre-test counselling and consent for testing (see figures 1 and 2). For HBHCT the protocol is different (see fig 3). Pre-test counselling enables those clients who decline the test to receive counselling without testing, which in itself is a useful service that HCT centres provide. A blood specimen is obtained from clients who consent to be tested for HIV. The results of the test may be available within an hour or a few days, depending on the type of test, the testing algorithm and the workload. When the results are ready the client receives post-test counselling, during which the test results are given. Clients are then provided follow-up support, which may be available at the HCT site in the form of post-test clubs or ongoing counselling or they may be referred elsewhere for care and support. Shifted and Inserted in the introduction

Figure 1 VCT Protocol



2.1 Client registration

HCT registration can either be anonymous or clients may register with their names. All HCT sites are bound to ensure confidentiality of client information. Where HCT is provided in health facilities HCT clients may register like other patients at the outpatient department to avoid being stigmatized. HCT 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. HCT should be included in routine health education talks and the concept of integrated services explained.

Figure 2 Routine HIV Testing protocol in Clinical Settings in Uganda

This protocol will be used by all health providers during the process of history-taking and physical examination of patients. HIV testing will be provided to all clients unless they decline. HIV testing will be offered alongside other procedures and tests. There is no requirement for separate private rooms/space for pre-test information, but disclosure of results and post-test information should be confidential. Results should be disclosed and/or documented as per national guidelines.

The protocol is presented in tabular form but remember every experience will be unique. In general, we anticipate that the major focus of the testing process will be risk reduction, and HIV/AIDS care, and/or effective referral to follow-up care for HIV-positive clients.

CLINICAL SITE

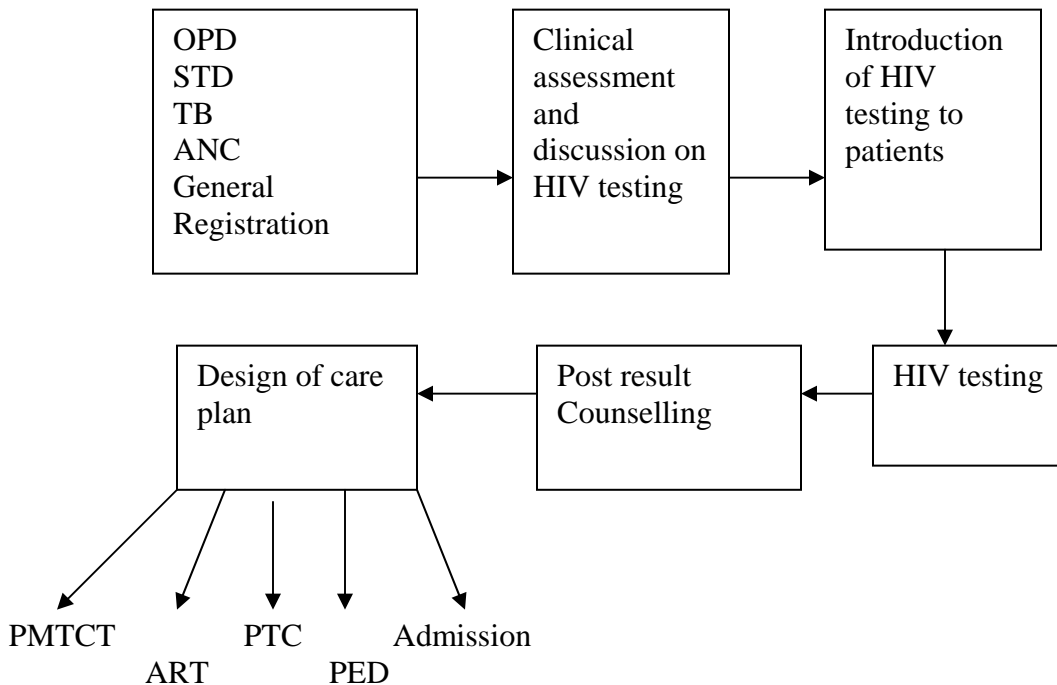
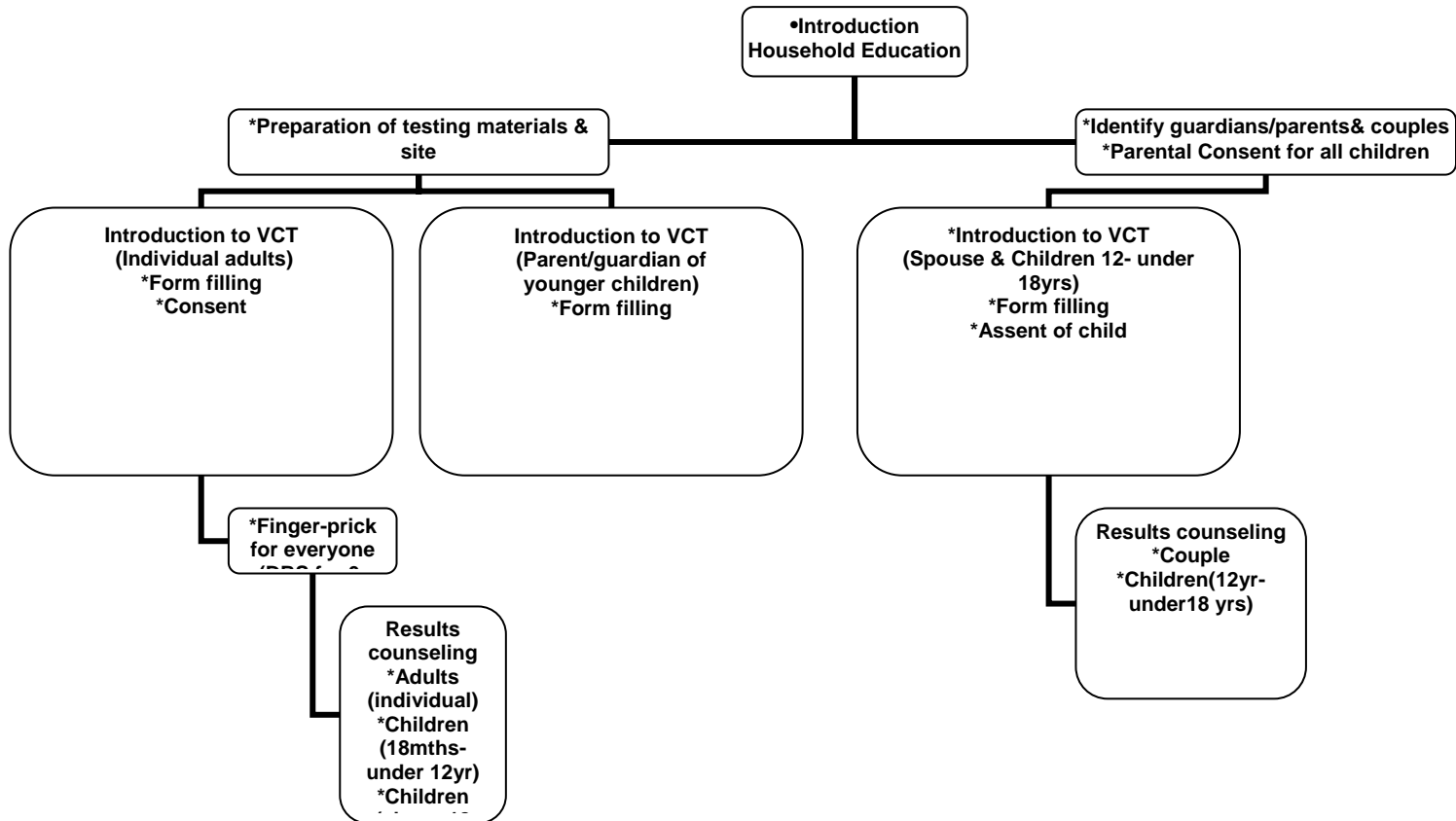


Figure 3: HBVCT Protocol



2.2 Pre-test counselling

In HCT pre-test counselling should be provided to each client alone and not in a group.

When staff is limited and there is sufficient number of clients waiting, 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. For HBHCT, counselling may be done to a family as a group but there must be individual informed consent.

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 preferred that the laboratory staff member who carries out the test not be the same person who provided the pre-test counselling.

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. Therefore both preventive and care outcomes of knowing one's HIV status are dependent on the voluntary actions of the individual.

HCT is a service that people should be encouraged to seek HCT benefits should be fully understood so people freely seek and access services. The service needs to be promoted actively once it is available. HCT has health benefits for certain groups of people in particular, and these people should be strongly encouraged to seek HCT. 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.⁵ It should also be mentioned that many new infections seem to be occurring in older and established couples. Married couples are therefore encouraged to regularly seek HCT services.

Therefore, apart from Mandatory, and diagnostic HIV testing explained in section 1.2.3 for HCT, should be client's decision to be tested for HIV. Consent for any health care service should be explained and obtained in all circumstances. Where possible consent should be documented by signature or thumb. Where not possible after thorough explanation the counsellor can show evidence for consent.

If an attending health worker identifies a patient who may benefit from HCT, 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 HCT, not just ask them to go for testing. TB patients, for example, may need to be supported to understand the need for HCT.

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 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

⁵ 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.

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 patient without counselling.

2.5 Repeat testing

This may be done under various circumstances.

- a) Clients in denial can also be assisted to repeat the test. . Clients who deny the results immediately may need time to come to terms with the news. If an HIV-negative client does not believe the results, the repeat test should be delayed for at least 3 months, as they may be in the window period.
- b) If the laboratory issues indeterminate results the counsellor should explain to the client what they mean. 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.
- c) Sometimes counsellors may encourage clients intending to start new relationships or reunions to repeat the test with their partner, as if the testing were new, as a way of notifying the partner about the results.
- d) To rule out window period (obsolete).

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 is, the same hour, same day or another day exists, it is 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. 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. HBHCT enables easy issuance/disclosure of results and should regularly be utilised as it ensures confidentiality and reduces stigmatisation.

Normally disclosure of HIV results should be done to the clients, however for RTC, when the client is too ill or unconscious, the results should be disclosed to the next of kin.

2.7 Issuance of written HIV test results

Written results can be issued to a 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

All medical records are always confidential. 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, 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,⁶ for the benefit of the client, the counsellor may release these results to an appropriate agent of the third party upon receipt of written authorization from the client.

⁶ Currently in Uganda, individuals who are entitled to National Social Security Fund 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

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.

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),⁷ should be of different antigenic specificities that define HIV. Either method could be used, depending on the capacity of the service provider. The testing in HBHCT should be rapid HIV testing i.e. counselling/testing/giving results on the same day.

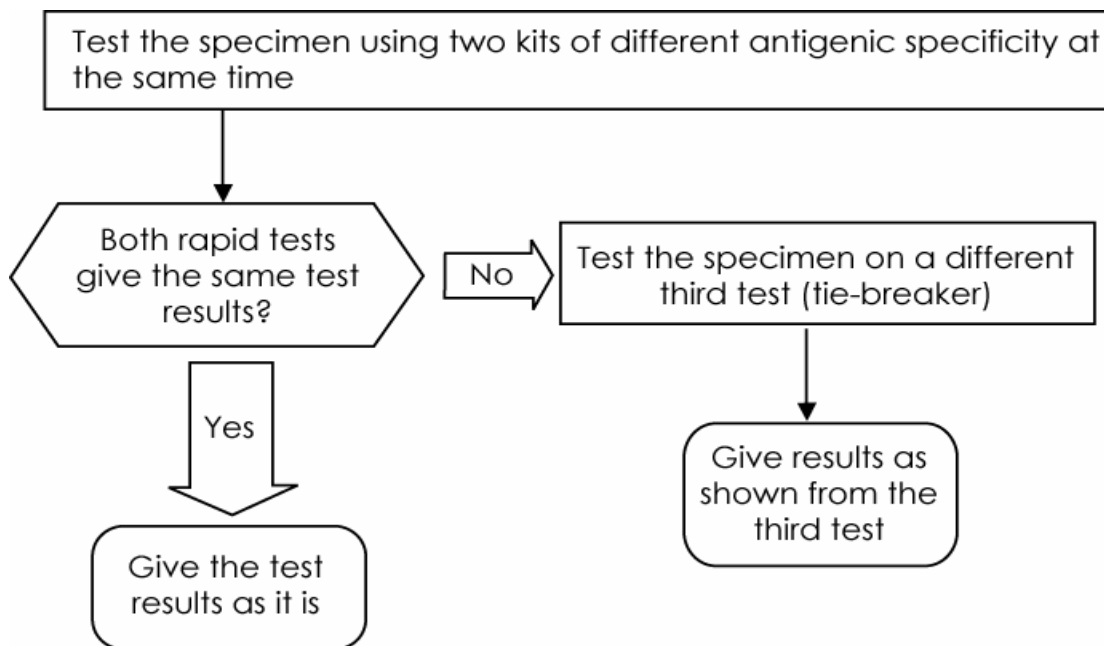


Figure 2. Parallel algorithm for rapid HIV testing.

⁷ 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.

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. These specimens can either be drawn by doing phlebotomy or using finger stick testing. Finger stick testing is gaining popularity because it reduces fear and anxiety; is simple to do and is time saving; and requires little amounts of blood.

Other specimens like urine, saliva and dry blood spots should be used after NHRL validates the tests.

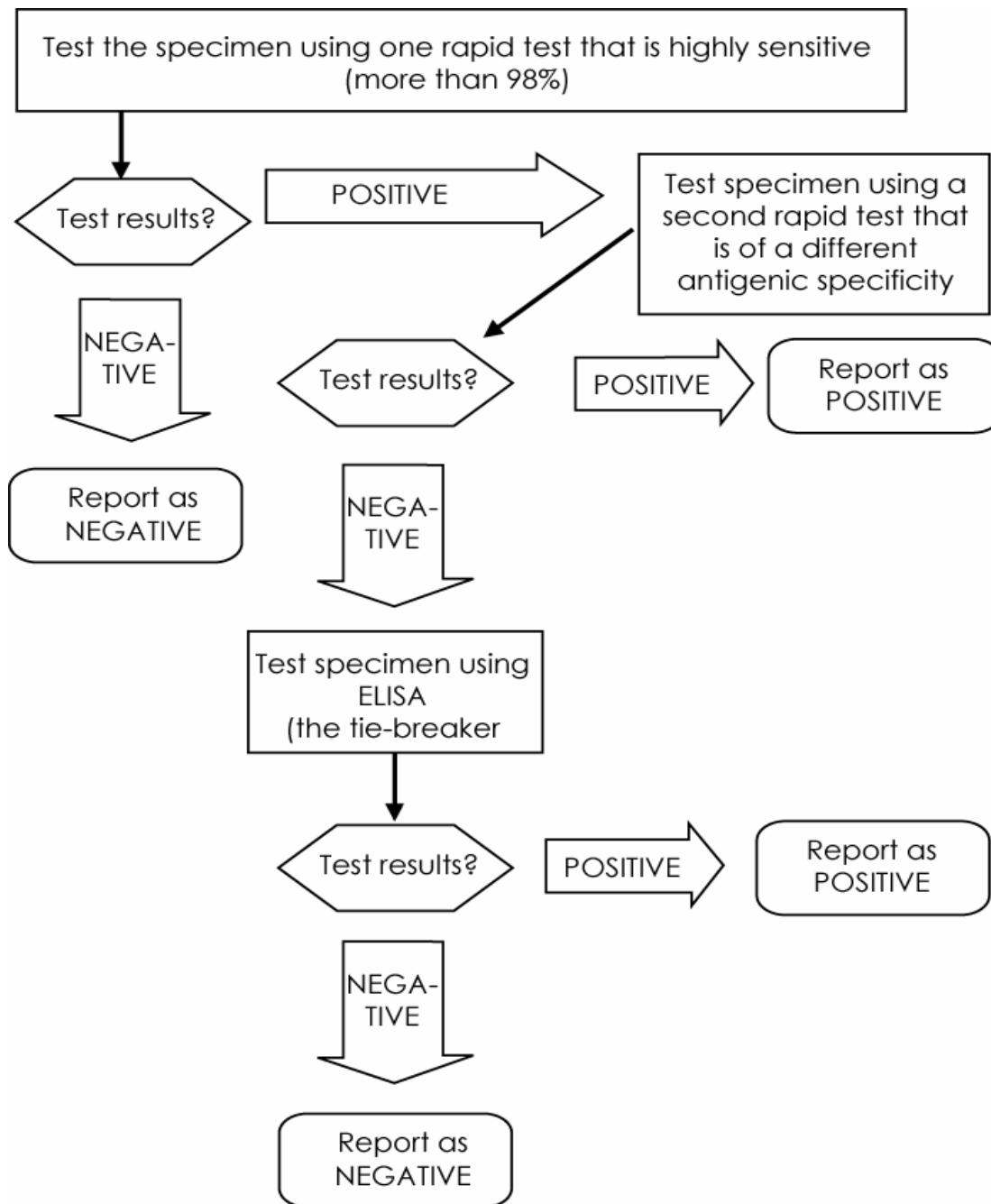


Figure 3. Series algorithm for rapid HIV testing.

Specimens for HIV testing must be accompanied by a laboratory request form 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 where 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 2 °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

3.2.2 Finger prick method of sample collection

For HIV rapid testing could be used in parallel testing (see fig. 2).

However, the problem of client recall where discordant results have been obtained from the two kits makes finger stick unstable.

3.2.3 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, ID No* 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.

3.4 HIV testing in children.

Children under 18 months do not have notable antibodies for the rapid HIV test methods. PCR technology should be the recommended method of testing.

Chapter 4. HIV Counselling and Testing for Children

HCT for children should be in the best interest of the child aiming at improving a child's health, survival, development and social well-being. Parents and guardians should not suggest HCT for a child for the sake of it; for example to establish the HIV sero status for the Parents. During the process the Counsellor, child and parent(s) or guardian have different roles to play. 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 HCT 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.

Antibody testing should not be used for diagnosis of HIV infection in children aged less than 18 months.

Children below 18 months can be tested using appropriate method ie PCR (see Chapter 3, Sec. 3:4)

4.1 Age of consent for VCT

In Uganda the legal age for consent is 18 years. For HCT, the age of consent should be the age at which the child understands the results – preferably 12 years. The right of dissent to testing should also start at age 12.

Children 12-18 years can consent and the parents consent may or may not be sought depending on the child's wish. Parent/guardian approval should not be mandatory at this age. However, children are encouraged to where possible communicate to their parents/guardians about their need to test for HIV.

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, such as child mothers and fathers, children heading homes and abandoned children.

If a child below the age of 12 asks for HIV testing, their parents or guardians should be fully involved. However if it is established that they can understand the test results, they should be counselled, tested and given their results.

Testing of children under 18 months should not be done during HBHCT

The counsellor should assess the child's ability to understand the test results and the emotional capacity to cope with them. 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 child should be asked first to agree on which other person to be involved, and how. Some children without parents may choose other people in their social network such as a neighbour.

4.2 Parental consent

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.

The right of Consent for VCT in children should be at the age when a child can understand and cope with the results basing on the counselors discretion (no age limit i.e. 12-18 years).

The child should consent for VCT services with the involvement of parents/guardian or any other person in the interest of the child.

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.

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.⁸ 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 make a follow up where possible.

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 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. Disclosure should be done with the person with whom the child feels most comfortable. If the child is HIV positive the counsellor should work with the parent or guardian to plan for the child’s future care. For children who can not clearly understand the results, the parent or guardian should be fully involved and should sign the consent. The counsellor should provide ongoing support and counselling until the child is old enough to be disclosed to.

⁸ Should be clarified with the attorney general.

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.

4.5 HCT for children with special needs

Children with special needs should be given special attention using appropriate media and techniques to cater for their disability.

This category includes children with hearing, speech, visual and mental disabilities.

Counselling for these children should be conducted in an environment that takes in to consideration of their special needs. Counsellors dealing with a child under this category should be equipped with appropriate skills or else refer.

Chapter 5. Quality assurance

To ensure that VCT/RTC sites offer their clients quality VCT/RTC 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/RTC. 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/RTC services in Uganda.

To ensure that VCT/RTC sites offer their clients quality VCT/RTC 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/RTC 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/RTC sites:

NGO and private clinics and labs that want to provide VCT/RTC sites should be accredited by MoH once they meet the criteria in section 1.2, which covers VCT/RTC 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/RTC 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/RTC service, the following standards of counselling should be adhered to.

In the counselling process, counsellors should . . .

Observe the VCT/RTC 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/RTC. Ethics is defined as a professional code of conduct. In VCT/RTC 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/RTC 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/RTC coordination and supervisors

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

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

Coordination of VCT/RTC at the district level

Each district should have a VCT/RTC district coordinator based at the DDHS office. The district VCT/RTC coordinator should be selected from the district health team by the DDHS.

The person should have good know-how of VCT/RTC 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/RTC sites and services in the district.

- Function as the link with headquarters on matters of VCT/RTC services.

- Plan and mobilize resources.

- Plan and organize training and capacity building for VCT/RTC.

- Collaborate and network with VCT/RTC partners in the district.

- Regularly update district stakeholders on VCT/RTC.

- Participate in the strategic planning on HIV/AIDS and ensure integration of VCT/RTC.

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

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

- national and district VCT/RTC coordinators – quarterly

- health sub-district VCT/RTC supervisors – monthly

- VCT/RTC 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/RTC work. Staff should be encouraged to identify opportunities for improving performance.

During support supervision, VCT/RTC 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/RTC service providers.

- Assess and support the process of community mobilization.
- Assess and support the quality of counselling and filing of VCT/RTC 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)⁹ 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/RTC services nationally and all VCT/RTC service providers should regularly attend these forums.

5.3 Data management

All data obtainable from VCT/RTC services such as the number of clients counseled, number tested, discordance 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. At an appropriate time VCT/RTC data management system may be integrated in the traditional HMIS.

⁹ 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 HCT services should be done in line with the *Uganda National Strategy for M&E of HIV/AIDS*.¹⁰

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 HCT card or Register data. Any special information desired from HCT clients should be collected during special evaluations that are well managed and time limited.

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 HCT programmes. This information is also vital on a day-to-day basis in forecasting and planning commodities.

6.1.1 Monitoring tool site assessment (planning for HCT services)

Initial site assessment should be documented and used as a baseline.

Before starting an HCT 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.

6.1.2 Input indicators

It is important that programme inputs such as kits, consumables are clearly documented.

6.1.3 Output indicators

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

6.1.4 Information flow

Information should flow from the grassroots upward: from the HCT centre to the health sub-district, the district director of health services, the Ministry of Health, and ultimately to the Uganda AIDS Commission. Feed back should always be given down wards

¹⁰ Uganda AIDS Commission and Ministry of Health, 2000.

6.2 Evaluation

Systematic evaluation of the HCT 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.

6.3 Specific research studies

At district and national levels HCT stakeholders should develop a HCT research agenda. In addition to evaluating programme impact and process, specific research studies should be carried out to answer research questions regarding HCT. 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 HCT and cost per client served.