HIV/AIDS Voluntary Counselling and Testing

Review of Policies, Programmes and Guidelines in East, Central and Southern Africa
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Foreword

HIV/AIDS is a major challenge to health and development. It is putting a tremendous burden on health care facilities and is decreasing economic productivity.

Many governments in east, central and southern Africa have officially declared HIV/AIDS a disaster requiring emergency action. The various approaches being used to combat the epidemic must be intensified, refined and expanded to slow down the spread of the virus and mitigate its impact. Nearly all governments in the region have also developed strategies that indicate the current status of the epidemic, how it is affecting the country, and the priority interventions required to combat it. The multisectoral approach that many countries in the region have adopted calls for increased funding and personnel.

At the 30th CRHCS Regional Health Ministers’ Conference (RHMC) held in Seychelles in October 1999, health ministers, concerned about the rapid spread of HIV in the region and realizing that some strategies currently in use required strengthening, recommended that CRHCS work with member states to mount an effective response to the epidemic and formulate a regional strategy on HIV/AIDS.

To begin putting the HIV/AIDS resolutions of the 30th RHMC into operation, the Secretariat convened a consultative workshop from 26 to 30 March 2001. At this workshop, HIV/AIDS managers, nutritionists, specialists in reproductive health and chief nursing officers identified priority issues the region needed to address to step up the fight against the epidemic.

Voluntary counselling and testing (VCT) was clearly shown to be a key entry point for HIV/AIDS prevention, care and support. Thus it became obvious that it was essential to harmonize and improve VCT policies and guidelines in ECSA, to expand the services to reach more people. To get an overview of what was happening in the CRHC member states, CRHCS commissioned a team of consultants to visit selected states and make a rapid review of their VCT policies, guidelines and programmes. The findings of this review have been and continue to be tabled at various regional forums such as the CRHC Directors’ Joint Consultative Committee and the RHMC to inform policy makers and elicit discussion on the best ways and means to extend VCT services to reach more people in the region.

It is hoped that the findings of this review will contribute to a constructive dialogue among policy makers, programme implementers, and teams responsible for developing policy and guidelines, to chart ways that will increase the availability of VCT to more people in our region.

Dr Steven V. Shongwe
Acknowledgements

This review is a result of joint efforts by various people, from conceptualizing and reviewing the scopes of work, through designing and agreeing on the questionnaire, to preparing the final report.

Foremost is the work of the two consultants, Grace Osewe and Buhle Ncube, who visited the member states, carried out the field review and drafted the report. Their dedication was crucial to the endeavour. The contributions of Janet Hayman, Mary Pat Kieffer, Stephen Kinoti and other USAID/REDSO, SARA/AED and CRHCS staff are also acknowledged. The support and cooperation offered by member states, HIV/AIDS programme managers and ministries of health, permanent secretaries made the work possible.

Leah Sirikwa and Cristin Haggard played key roles in final secretarial and editorial work.

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Executive summary

The Commonwealth Regional Health Community Secretariat (CRHCS) commissioned a review of policies, programmes and guidelines in voluntary counselling and testing (VCT) as part of its strategy to harmonize and improve them and to promote the best practices for managing HIV/AIDS and sexually transmitted infections in east, central, and southern Africa (ECSA). The review team elicited written responses from national AIDS programme managers using a detailed questionnaire; they interviewed VCT programme and administrative staff, and primary stakeholders such as technical partners and donors and implementing agencies. In addition, the team conducted an intensive review of both published and unpublished literature on VCT in ECSA and visited programmes in Kenya, Malawi, Uganda, Zambia and Zimbabwe.

As the burden of HIV has increased to levels beyond which the national health systems in ECSA can handle, efforts have intensified to scale up effective programmes. VCT is increasingly recognized as central to efforts to combat the epidemic through prevention and care. Access to ARV therapy is increasing. However, estimates are that only 10% of people who are HIV infected know their status and thus can take advantage of the therapy—hence the urgent need for better VCT.

HIV testing in east, central and southern Africa

The three categories of HIV testing in ECSA are mandatory, diagnostic and VCT. VCT includes both voluntary pre- and post-test counselling and voluntary HIV testing. The key word is ‘voluntary’: those concerned about their HIV status initiate the service, without coercion. But currently, most HIV testing is initiated not by the client but by employers, insurers, or (for students) institutions of higher learning.

Most of the non-voluntary testing is done in the private sector, and counselling is minimal. VCT is done mostly by NGOs in collaboration with the national ministries of health, and donor agencies provide most of the technical support and funding. Presently, VCT is carried on chiefly in urban areas, with rural populations in all countries except Botswana having only limited access to it. The stage of VCT implementation falls under one of four categories: 1) NGO and private sector with little or no government involvement, 2) NGO and private sector with government pilot projects, 3) NGO, private sector and public sector with limited expansion and consolidation of pilot projects, and 4) scaling up to nationwide coverage.
VCT policies

In their national HIV/AIDS policy documents, all ECSA countries recognize that VCT is a major means of HIV/AIDS control. However, as yet only Botswana, Mauritius, Uganda and Zimbabwe have a national VCT policy. Key components of VCT policy include access to counselling, consent, confidentiality, and overcoming discrimination against people who have undergone testing and are found HIV positive. Persons with a history of high-risk behaviour, couples planning marriage, and pregnant women are the main groups who should receive VCT services; the next most important group is the youth in general. Implementation is ahead of policy development, with standardized policies and guidelines in general lacking.

Guidelines for implementing VCT

Most of the current guidelines have been developed by implementing NGOs and are not comprehensive. As VCT is scaled up, with various organizations involved in implementing it, the need for more comprehensive guidelines is becoming critical. In ECSA three approaches to developing guidelines have evolved:

– a partnership of government, technical experts and implementing NGOs, where government, key stakeholders and PLWHA are actively involved in drafting guidelines—as is being done in Kenya, Malawi and Uganda
– leadership of an NGO as the implementing agency, with technical support from agencies such as CDC, FHI, PSI or WHO, with the result serving as de facto national guidelines—as is being done in Kenya, Malawi, Uganda, Tanzania, Zambia and Zimbabwe
– government adaptation and implementation of WHO/UNAIDS/CDC guidelines—as in Seychelles

Except in Kenya, and in the near future, Malawi, Swaziland and Uganda, no comprehensive national guidelines cover all aspects of VCT. More guidance is needed in several areas:

– counselling of particular groups, such as families, discordant couples, adolescents and children
– assurance of competent counselling and testing, including counsellor support and supervision
– standardization of data collection
– criteria for recruitment and training of counsellors
– testing protocol for different settings
VCT programmes

The most common way to make VCT available is through existing public health systems, where VCT services are integrated into general health care. Although this should be the most sustainable model, and one that can be replicated easily, this has not been the case because public institutions lack the capacity to take over. Thus, except for Mauritius and Seychelles, where all VCT services are offered through integrated sites, countries are using a combination of VCT models:

- integrated into family planning (FP), PMTCT, sexually transmitted infection (STI) and TB services in public clinics or hospitals
- NGO providers in their own facilities, alongside other community services
- free-standing sites, strategically located and managed by an NGO
- private commercial enterprises such as mines, farms, and factories

Strategies to promote VCT have focused on increasing access, availability and uptake. The quality of services and resources allocated vary significantly across the region. The principal tasks in successfully implementing VCT are as follows:

♦ **Creating awareness and demand:** Mobilizing communities to increase uptake of VCT, focusing on vulnerable groups, particularly young people.

♦ **Strengthening human resources and infrastructure:** Increasing the number of trained VCT staff; providing training, support and supervision of counsellors to avoid staff burnout; and increasing local ownership of VCT programmes.

♦ **Ensuring high-quality service:** Standardizing guidelines and procedures for both counselling and testing; ensuring timely distribution of commodities; standardizing data collection and management to facilitate monitoring and evaluation of programmes.

Many VCT practices that are effective in one or more countries can be replicated across the region: improving nationwide coverage, as in Botswana and Kenya; national-level coordination, as in Malawi and Zambia; development of comprehensive guidelines, as in Kenya; expansion of counselling and testing capacity, as in South Africa and Zimbabwe; provision of a comprehensive VCT package, as in Uganda; social marketing of VCT and institutionalization of extensive methods to assure high quality of services, as in Zimbabwe; and provision of effective telephone counselling, as in Mauritius.
Priorities for future action

Governments should accelerate policy development while continuing to implement their VCT programmes.

♦ Each government should ensure that national policies, guidelines and standards are developed and disseminated and that the necessary technical and management capacities are created.

♦ Districts should help both their government and NGOs implement programmes, primarily by mobilizing the community.

♦ The focus should be on providing high-quality VCT service, strengthening post-test support services, and continuously monitoring the quality of care.

Issues that lend themselves to regional collaboration include harmonization of policies; guidelines for counselling, testing, data collection and training curricula; coordination in procuring test kits; and resource mobilization.

The potential uses of VCT for HIV prevention and care are likely to increase as treatment and care become more widely available. Although VCT has been proven to have preventive benefits lasting up to 12 months after counselling and testing, its long-term benefits are still unknown. Many questions remain unanswered, and further research is needed in several key areas such as ways to reduce or overcome stigma, the role of social institutions such as churches in providing effective ongoing support for people who are infected, and determining the most suitable way of making VCT available to different populations, such rural people, youth and sex workers.
Background

Introduction
The Commonwealth Regional Health Community Secretariat (CRHCS) was established in 1974 to assist the east, central and southern African (ECSA) countries identify and develop capacity to address priority health needs in the region. The Secretariat is an intergovernmental organization comprising 14 member countries: Botswana, Kenya, Lesotho, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe. The mandate of the Secretariat is to promote and encourage efficiency and relevance in the provision of health-related services in the region.

At the 30th CRHCS Regional Health Ministers’ Conference (RHMC) held in Seychelles in October 1999, health ministers were concerned about the rapid spread of HIV in the region and they realized that some strategies currently in use needed to be re-examined. They therefore recommended that the Secretariat work closely with member states to mount an effective response to the epidemic and develop a regional strategy. A consultative workshop was subsequently convened from 26 to 30 March 2001 to identify priority issues the region should address to intensify the fight against the epidemic. A main priority identified was to improve policies and guidelines for voluntary counselling and testing (VCT), expanding the services to reach more people.

CRHCS commissioned a review of VCT policies, programmes and guidelines as part of its strategy to promote best practices in managing HIV/AIDS and sexually transmitted infections (STIs) in ECSA. This report documents the findings of the review, which was conducted from 15 March to 30 June 2002. The review team wishes to express its appreciation to the host countries, to all those who generously shared their knowledge and opinions on VCT, and to the CRHCS Secretariat for handling the administrative arrangements that made this review possible.

Methods
Using a detailed questionnaire, the review team elicited written responses from national AIDS programme managers, and it interviewed many people and organizations who were implementing VCT. The team also visited countries to conduct a more detailed survey and analysis. A sampling method was selected to gain a representative sample of country programmes, based primarily on VCT approaches and level of implementation. Kenya, Malawi, Uganda, Zambia, and Zimbabwe were the countries selected to be visited, and summaries of VCT status in these countries are provided in appendix 1. The review team also made a
concerted effort to obtain additional information through numerous contacts in the countries not visited.

The team intensively studied both published and unpublished literature on VCT in ECSA. In addition, the team collected relevant documents from each of the countries visited. These included implementation plans, assessments, policies, guidelines, quarterly and annual reports, IEC (information, education and communication) materials, data collection instruments and evaluation reports.

Interviewees, drawn from national and lower levels, included officials from national AIDS councils and national AIDS coordination programmes, VCT programmes and administrative staff, and primary stakeholders such as technical partners and donors and implementing agencies. Structured interviews were held to collect information on structural and functional dimensions of the VCT programmes and on attitudes and perceptions of the various stakeholders regarding policies, guidelines for implementation and other programme aspects. Focus group discussions were also held with some counsellors and programme managers to identify issues affecting VCT access and uptake.

In three countries, the team also visited six VCT centres as ‘mystery clients’—that is, they were unknown to any member of staff—to experience themselves if the counselling protocol was being carried out as described by the staff, to gain insight on differences in quality among various programmes, and to observe the effect of different training approaches.

**VCT—a key intervention**

The last few years have seen many new developments in HIV interventions. For example, research has shown that VCT is a cost-effective intervention in high-prevalence settings and that it motivates a positive behaviour change among both HIV-positive and HIV-negative persons. The burden of handling HIV infections has increased to levels beyond the current capacity of health systems to cope with it. Thus advocacy efforts have intensified to mobilize resources and to extend use of interventions that evidence has shown to be effective, with the result that NGOs and partners have expanded VCT services. Increasing donor support for VCT, more favourable government policies, and the potential for expanded access to antiretroviral (ARV) drug therapy because of significant price reductions and free donations to prevention of mother-to-child transmission (PMTCT) programmes have all served to integrate VCT into public health services. VCT is increasingly recognized as importantly central to effective HIV/AIDS prevention and care efforts to combat the epidemic. At the first global VCT consultation convened by WHO in Harare in June 2001, the participants issued a statement that says in part:
The meeting recognizes VCT as:
- a public health and developmental priority
- a human rights imperative
- a cost-effective preventive measure, particularly in high-prevalence communities
- central to interventions such as PMTCT, access to care and support, and injecting-drug-use harm reduction
- a way to provide individuals with an opportunity to plan for the future and gain access to appropriate health and support services
- a means to destigmatize and normalize HIV and to empower HIV-positive people in the community
- a mechanism that enhances the capacity of health systems to deliver appropriate services

However, UNAIDS estimated in 2000 that only 10% of people who are HIV infected know their status. The task for VCT, therefore, is to get more people to make use of it.

VCT serves as an entry point for prevention and care strategies, as shown in figure 1 and outlined in table 1.

Why VCT is a key intervention
Table 1. Prevention and care strategies that can be linked to VCT

<table>
<thead>
<tr>
<th>Prevention strategies</th>
<th>Care strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Prevention of mother-to-child transmission</td>
<td>• Acceptance of and coping with serostatus</td>
</tr>
<tr>
<td>• STI prevention, screening, and treatment</td>
<td>• Normalization and destigmatization of HIV/AIDS</td>
</tr>
<tr>
<td>• Communication about behaviour change</td>
<td>• Peer, social and community support</td>
</tr>
<tr>
<td>• Access to family planning</td>
<td>• Early access to medical care</td>
</tr>
<tr>
<td>• Access to condoms</td>
<td>• Early management of opportunistic infections</td>
</tr>
<tr>
<td></td>
<td>• Provision of maternity services for people living with HIV</td>
</tr>
</tbody>
</table>

VCT – ECSA overview

Definition of VCT

VCT is an HIV intervention that includes both voluntary pre- and post-test counselling and voluntary HIV testing. People, of their own free will, opt for VCT, and it provides them with an opportunity to confidentially explore and understand their HIV risks and to learn their HIV test results. VCT stands for . . .

Voluntary—without coercion, a person decides to take an HIV test

Counselling—about risk assessment, risk reduction, emotional support and referral

Testing—done using an approved HIV testing protocol

The major components of VCT are

- counselling
- laboratory tests
- management information systems
- links to care and support services
- IEC to address benefit, availability, access to VCT and how to deal with stigma

The expected effect of VCT is to lower HIV transmission through reduction in high-risk sexual behaviour, improved medical care (particularly for sexually transmitted infections), and improved access to care and support services for both HIV-positive and HIV-negative persons.
HIV testing in ECSA

At the beginning of the last decade, national blood transfusion centres served as the main testing sites for those who wanted to find out their HIV status. Those who were HIV negative were invited to become regular blood donors, while those who were HIV positive were advised to seek medical advice. Thus most people received their HIV test results without any counselling. Although HIV testing services are now available in most major hospitals and cities in ECSA, they remain inaccessible to many people because for rural people, they are not located nearby, and for the great bulk of the population, because of their cost. Most current HIV testing is not voluntary but requested by employers, insurers, clinicians or institutions of higher learning. Three categories of HIV testing are done in ECSA:

- **mandatory**—as a prerequisite for employment, health insurance, visas, and so on
- **diagnostic**—by clinicians such as during pregnancy
- **voluntary**—voluntary HIV counselling and testing, or VCT

Most of the non-voluntary testing is done in the private sector, with a waiting period of up to two weeks for test results. Counselling is minimal, particularly with mandatory or diagnostic testing.

VCT currently constitutes the smallest proportion of HIV testing in ECSA. It is mostly implemented by NGOs, in collaboration with the national Ministry of Health. Governments have been followers rather than leaders in implementing VCT. VCT centres are largely urban at present, and except in Botswana rural populations have little access to them. The stages of implementation of VCT fall in four categories (table 2).

<table>
<thead>
<tr>
<th>Stage</th>
<th>Countries</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NGO or private sector</strong></td>
<td></td>
</tr>
<tr>
<td>Little or no government involvement</td>
<td>Lesotho</td>
</tr>
<tr>
<td>Negligible effect</td>
<td>Namibia</td>
</tr>
<tr>
<td><strong>NGO or private sector</strong></td>
<td></td>
</tr>
<tr>
<td>Government pilot projects</td>
<td>Mozambique</td>
</tr>
<tr>
<td>Very limited effect</td>
<td>Swaziland</td>
</tr>
<tr>
<td><strong>NGO, private sector, public sector</strong></td>
<td></td>
</tr>
<tr>
<td>Consolidation of pilot projects</td>
<td>Malawi, Mauritius</td>
</tr>
<tr>
<td>Limited expansion</td>
<td>South Africa</td>
</tr>
<tr>
<td>Limited effect</td>
<td>Tanzania</td>
</tr>
<tr>
<td><strong>NGO/private sector/public sector</strong></td>
<td></td>
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<tr>
<td>Substantial progress in implementation</td>
<td>Botswana, Kenya</td>
</tr>
<tr>
<td>Expansion to nationwide coverage</td>
<td>Seychelles, Uganda</td>
</tr>
<tr>
<td>Moderate effect</td>
<td>Zambia, Zimbabwe</td>
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</tbody>
</table>
Currently many agencies are involved with VCT, ranging from community-based organizations to governments and donor agencies. Donor agencies provide most of the technical support and funding for VCT activities. They engage in collaborative arrangements with both ministries of health and NGOs to strengthen and expand implementation of VCT and related services. They convey a strong sense of urgency about HIV and the significance of VCT.

The donors and partners most extensively involved in VCT are CDC, DfID, JICA, MSF, Norad and USAID. In particular, USAID and CDC have provided and continue to provide significant support to governments, cooperative agencies such as FHI and PSI, and local NGOs. This support increases access to, availability of, and use of voluntary HIV counselling and testing through

- collaborating and assisting the Ministry of Health and other in-country partners in implementing, monitoring and evaluating voluntary HIV counselling and testing programmes
- identifying barriers and concerns raised in providing VCT and working to promote policies and programmes that help reduce the fear, stigma, discrimination and isolation associated with HIV infection and AIDS.

Reports from all ECSA countries show increasing acceptability and demand for VCT, with numbers of clients continuing to increase. Currently, all efforts have focused on making the services available, not on documenting the effect of VCT on reducing risk or changing behaviour. VCT for special groups such as youth and for PMTCT has been largely limited to pilot projects and research activities.

**VCT policy development**

**Current status of VCT policies**

The health-sector approach to HIV/AIDS started with a medical response in the late 1980s, evolved to a public health one in the early 1990s, and the current multisectoral response from 1995 onwards. With the exception of Uganda, initial medium-term plans for HIV/AIDS did not include VCT as part of the response. VCT was embraced as a strategic intervention with the advent of the multisectoral approach, and currently it is a component of all HIV/AIDS strategic plans in ECSA.

All ECSA countries identify VCT as a major tool for HIV/AIDS control. Countries including it in their national HIV/AIDS policy documents are
Botswana, Lesotho, Malawi,¹ Mauritius, Seychelles, Swaziland, Tanzania, Uganda,¹ Zambia¹ and Zimbabwe; those including it in their national framework or charter are Kenya, Mozambique, Namibia and South Africa.

VCT is addressed in broad terms as a strategy to prevent transmission and promote care.

Development of detailed VCT policies to expand on the broad statements in the HIV/AIDS policies, or to address specific target groups and emerging issues has been limited. Only Botswana, Mauritius, Uganda and Zimbabwe have a national VCT and testing policy.

**COMPONENTS OF VCT POLICIES IN ECSA**

- Voluntary HIV testing is to be made universally available and accessible.
- Informed consent with counselling and confidentiality are to be observed in all voluntary HIV testing.
- HIV testing should not be included as part of a routine medical examination without the knowledge and consent of the client.
- HIV testing for purposes of discrimination should not be conducted by insurers, employers, immigration, and so on.

The aspects of counselling and testing most commonly highlighted are access to counselling, consent, confidentiality, mandatory/routine testing and discrimination. In Lesotho, Uganda and Zimbabwe, the national HIV/AIDS policy identifies couples that are planning marriage as a specific group needing VCT services. Zimbabwe also provides guidelines with respect to vulnerable groups such as pregnant women and infants, and situations such as employment, training and promotion, education and travel. Seychelles identifies men and youth as key targets for VCT; the military and the police, immigrant workers and students proceeding overseas for education are subject to mandatory testing.

Issues of giving special consideration in programming and referrals to youth, pregnant and nursing women, or high-risk groups are currently not adequately addressed. Policy emphasis is on voluntary testing and public-sector services, with limited discussion of private-sector testing. Implementation is ahead of policy development, and in general, standardized national policies and guidelines on both counselling and testing are lacking.

¹ Document is in draft form.
Policy development

The impetus for developing policy has arisen from donor pressure coupled with the increasing need to provide a legal framework for implementing programmes. Developing HIV/AIDS policy has overall been a consultative process. It has typically involved government and NGOs, PLWHA associations, research institutions, religious and socio-cultural institutions, legal experts, technical experts in various areas of HIV/AIDS, and a team of consultants who do the actual drafting. This draft has been followed by cabinet or presidential approval and national workshops to disseminate information about the policy. In reality, however, policies are put into use even in draft form because the formal process is usually slow. In countries like Uganda, the process is reviewed and updated every few years, addressing areas of need as they emerge. In some countries where the policies have just been developed or are still being developed, the gaps are being filled in as needed through the development of guidelines. A comparative analysis of the process in Kenya, Malawi, Uganda, Zambia and Zimbabwe highlights the general experience of the VCT policy development process:

♦ VCT began being used in Kenya in 1995. In 1997, Sessional Paper no. 4 on HIV/AIDS was tabled in parliament. In it, VCT was identified as a major tool for HIV/AIDS control and a viable means of preventing mother-to-child transmission of HIV. It was not until 2000, however, that the government initiated and actively supported the development of comprehensive guidelines for counselling and testing in the context of VCT, which now serve as the policy on VCT. These guidelines were developed by a team of technical experts drawn from relevant fields of expertise and practice, led by the CDC office in Kenya. PLWHA were also represented. The process was relatively fast with the guidelines completed and published within a period of months.

♦ In Malawi, VCT has been implemented since 1992 by the Malawi AIDS Counselling and Resource Organisation (MACRO) ahead of HIV/AIDS policy development. A national HIV/AIDS strategic framework for the period 2000–2004 was developed with nine thematic areas including VCT. Its development was consultative. A draft national HIV/AIDS policy is currently being developed.

♦ In Uganda, HIV/AIDS policy is being developed through a lengthy process of consultation among a wide range of stakeholders. The first HIV testing policy was developed in 1990 by the AIDS control programme and the AIDS Information Centre (AIC) has been providing VCT services since then. The existing national health policy was approved in 1999. Although there have been several rounds of review on HIV/AIDS policy, VCT has been addressed only in very broad terms—in relation to access, confidentiality, informed consent and counselling. A national HIV/AIDS policy has been drafted and is
officially under discussion. The AIDS control programme has also brought together a team of experts that is currently drafting a comprehensive VCT policy for Uganda. AIC has developed counselling and testing protocols to guide implementation, with technical assistance from CDC and USAID. The AIDS Support Organization (TASO) has also developed guidelines for general HIV/AIDS counselling.

♦ In Zambia, the HIV/AIDS/STD/TB strategic framework for 2001–2003 identifies VCT as one of the priority interventions. A draft national HIV/AIDS/STD/TB policy is currently being developed to guide individual and collective actions against these diseases. However, VCT has been implemented since 1991, ahead of policy development. The Kara Counselling and Training Trust developed VCT guidelines for its own use.

♦ Zimbabwe in 1998 launched the national New Start VCT initiative, with technical assistance from PSI and funding from USAID. In addition, a few NGOs are also implementing VCT. Some counselling and testing VCT guidelines and an operating procedure manual were developed in 1998 to guide implementation. In 1999, the national AIDS policy was launched by President Mugabe, in which VCT was identified as an entry point to most interventions. Protocols for rapid HIV testing were developed and after extensive evaluation were approved for national use in 2001.

Policy implementation

VCT implementation plans—indépendant de la pol icy—exist in all ECSA countries except Lesotho and Namibia. VCT programme implementation has been guided more by lessons learned in pilot and research projects than by national policy. No priority has been given to VCT in any national or district health planning.

Although all ECSA countries receive increased funding for VCT either directly through government borrowing or through donor support, there is no evidence from the interviews and document reviews that funds are allocated to implement the policies. In addition, VCT policies are being developed as implementation continues and presently serve more as a guide to VCT practice than define the scope of VCT implementation. As a result, there is little evidence of policy adaptation or interpretation by implementing organizations, with two exceptions:

♦ In Seychelles, government policy is to make VCT available at all hospitals, and this has been implemented.
♦ In Botswana, the government has provided universal access to VCT in the context of MTCT, in line with its policy to reduce MTCT of HIV.

Donors have made significant commitments in funding VCT implementation, with government contributions consisting primarily of personnel and physical space. In Kenya, however, the government has a loan from the World Bank to finance HIV/AIDS activities, part of which will include expanding VCT to every district in the country.

Monitoring policy did not appear to be a pressing issue for the policy makers interviewed at the time of this study. Although monitoring and evaluation of the HIV response in general has become important in recent times, no framework has been developed to facilitate monitoring policy or process.

Key policy issues

Policy throughout the ECSA community still needs to address the following:

♦ **Counselling as a profession:** Counselling should be recognized as a specialized profession, with a defined career path. Different categories of counsellors should be created and accredited at different levels of the VCT service.

♦ **Minimum standards:** These should be set for all types of HIV testing—mandatory, diagnostic and voluntary. All types of HIV testing need to be regulated, since VCT still constitutes only a small portion of all HIV testing. Current testing policy should be more broadly disseminated and enforced in the private sector.

♦ **Testing policy for special circumstances:** This needs to be established—for example instituting counselling as an integral component of testing, and determining conditions for potential opt-out versus opt-in options.² (Given the high prevalence rates, should mandatory counselling be provided followed by an HIV test, with the client having the option to opt out of the test, rather than to opt in, during pregnancy or with positive test results for TB or STIs?) This would be somewhat similar to the current process of testing for syphilis.

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² VCT models that require clients to ‘opt-out’ if they do not want testing appear to increase uptake more than those that require clients to ‘opt-in’ or choose to undergo testing. [this is not clear] Opt out means it is offered almost as routine and clients can opt out if they do not want where as opt in means it is available by choice although clients are made aware of it.
♦ *Testing of minors:* Under what circumstances can or should children be tested?

♦ *Conducting HIV tests:* Who can administer tests in different settings, and under what conditions? Should nurse counsellors administer HIV rapid tests, given the shortage of laboratory personnel?

♦ *Disclosure:* Under what conditions can confidentiality be breached?

♦ *PLWHA:* What mechanisms are there for involving PLWHA?

**Guidelines for implementing VCT**

**Current status of VCT guidelines**

Most of the present guidelines were developed by NGOs to deal with different aspects of VCT, such as counselling or testing, and therefore are not comprehensive. A summary table is provided in appendix 2.

**Guideline development**

As VCT expands, with multiple partners involved in implementing it, the need for guidelines has become more critical. Implementing organizations, ministries of health (MOHs), technical agencies and regional bodies such as CRHCS and SADC are working to establish minimum standards for delivering VCT. Three main approaches have been used to develop guidelines in ECSA:

♦ Partnerships among government, technical experts and implementing NGOs, in which government, key stakeholders and PLWHA are actively involved in drafting guidelines. In Kenya, MOH, the national AIDS/STD/TB and leprosy control programme, CDC and other partners\(^3\) developed the first set of comprehensive national guidelines for VCT in ECSA. Using these as a starting point, Malawi has now developed draft guidelines. In Uganda the AIDS/HIV Integrated Model District Programme (AIM) project, on behalf of the AIDS control programme and funded by USAID, has collated and revised all guidelines that were in existence in Uganda. These were to be presented for review and discussion in a poster presentation during the 2002 AIDS conference in Barcelona. Once reviewed, these guidelines will then be field tested and finalized.

\(^3\) These were FHI, the Kenya Association of Professional Counsellors, the Liverpool School of Tropical Medicine VCT Project, the national association of PLWHA and the Kenya Medical Research Institute.
NGO and implementing agency leadership, which is how most available guidelines have come into existence. Some have been adapted from others in the region; others have been developed with support from technical agencies such as CDC, FHI, PSI or WHO and serve as de facto national guidelines. This has been happening in Kenya, Malawi, Uganda, Tanzania, Zambia and Zimbabwe.

Government adaptation and implementation of WHO/UNAIDS/CDC guidelines. Seychelles adopted WHO testing guidelines, under which VCT is integrated into all health centres. USAID and CDC have been instrumental in providing support for developing guidelines for both counselling and testing in ECSA. Countries have learned greatly from each other at workshops and through site visits, contributing to better VCT programming throughout the region.

Key issues related to VCT guidelines

With the exception of Kenya, and in the near future, Malawi and Uganda, no comprehensive national guidelines cover all aspects of VCT. Guidelines are poorly disseminated and implemented, especially in integrated settings and rural areas.

More guidelines are needed in several areas:

- counselling for specific groups such as families, discordant couples, adolescents and children
- assurance of high quality of both counselling and testing including counsellor support and supervision
- standardization of data collection
- criteria for recruiting and training counsellors—the term ‘counsellor’ presently meaning different things to different people
- testing protocol for different settings—should the protocol take into account sites with high and with low client flow for which batch testing may or may not be suitable, or rural sites with no electricity or cold storage facilities or easy access laboratories?

VCT programmes

Delivery models

The most common way of providing VCT services is through the public sector in what are commonly called integrated sites. VCT services are simply integrated into existing health care facilities. This was envisioned as a sustainable model, which could be replicated easily even after outside funding was withdrawn. According to AIC’s experience in Uganda,
however, this has not been the case because public institutions have not had the staff to take over, and the supply of commodities in the public health system is often erratic. All countries have thus had to use a combination of models for delivering VCT services. Only Mauritius and Seychelles are offering all VCT services through integrated sites. Table 3 details VCT delivery models.
<table>
<thead>
<tr>
<th>VCT model</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
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</table>
| **Public sector provider** | VCT service provision in public facilities such as clinics or hospitals.  
Integrated into FP, PMTCT, STI, TB services  
In a variation of this model an NGO provides technical support and commodities, while the public sector provides staff and other physical overhead. | • Commitment to implement dependent on leadership at site  
• Staff perceive VCT as additional burden  
• Low motivation because of relatively lower salaries  
• Low perceived capacity to implement VCT in a private and confidential manner  
• Long waiting periods  
• Comparatively low use of VCT in many sites  
• Inflexible clinic hours |
| **NGO provider**         | Services are exclusively provided by NGOs in NGO facilities, alongside other community services.  
• Specialized in providing HIV/AIDS services  
• Long tradition of working with communities  
• Mobilization of community resources  
• Able to acquire staff according to demand and resources | • Weak management structures—potential problems scaling up  
• Diversion from core activities  
• Work primarily through volunteers |
| **Free standing**        | Applies a private sector approach to public health. Usually strategically located, for example, in densely populated areas, and managed directly by implementing NGO.  
• Convenient location  
• Flexible hours and management  
• Full-time counsellors  
• Quality assurance, M&E systems  
• Well-developed IEC, advertising component  
• Friendly atmosphere  
• Increases access to males  
• High average client flow | • High start-up costs  
• Requires continuous community awareness programme  
• Sustainability without funding an issue because cost recovery is minimal  
• Limited to urban areas |
| **Private institutions** | VCT service provision in private facilities, like commercial enterprises such as mines, farms and factories.  
• Funded by provider  
• Easy accessibility to target community  
• VCT combined with treatment for OI | • Varying quality of counselling and testing  
• Limited access to vulnerable groups  
• High likelihood of coercion  
• Confidentiality not always guaranteed |
Strategies to promote VCT and increase its use

The most common reasons people give for seeking VCT range from ‘planning for the future’ in Kenya, ‘marriage’ and ‘worry’ in Uganda, to ‘curious’ in Zimbabwe. After the initial counselling, most people agree to be tested and most have accepted results both before and after the advent of same-day testing.

Recent advances in HIV testing technology have resulted in a variety of rapid assays, many of which are relatively easy to administer and do not require refrigeration. In Malawi, the introduction of rapid tests and same-day results caused a significant increase in demand for VCT, with a sixfold increase in the number of persons informed of their sero-status.

However, while more people are willing to seek VCT they are still reluctant to disclose their results to their partners and others. This takes on added significance because of the large proportion of couples who have discordant test results. So considerable work needs to be done to promote VCT. Strategies have focused on improving access and availability to increase uptake:

- community mobilization for VCT
- mass media campaigns
- social marketing and giving the testing a catchy brand name
- special promotions, for instance, sponsoring big outdoor events
- increased number of VCT sites
- increased use of mobile and outreach services

Quality assurance

The quality of services provided varies significantly across the region, especially between free-standing and integrated sites, and in the amount of resources allocated to assure quality. Ways of ensuring high quality include the following:

♦ Internal
  - weekly group meetings of counsellors with supervisors
  - weekly individual counselling sessions
  - after-session reflections among counsellors, with a supervisor
  - direct observation of counselling sessions by supervisors or peers
  - regular variation in counsellor duties (counselling, outreach, laboratory, lecturing)
  - refresher training for counsellors
  - regular stress management workshops to alleviate burnout

♦ External
– periodic visits by VCT programme officers
– ‘mystery client’ (incognito) check on counselling
– client exit surveys, in which clients are interviewed about their experience and opinion immediately after they have been counselled
– suggestion boxes for clients
– exchange visits to other VCT sites to share experiences
– sending of about 5–10% of specimens to a reference laboratory as a control check

♦ Other
– VCT site accreditation: sites have been accredited in Kenya and the AIC commercial marketing strategy AIM project in Uganda is considering accrediting sites as part of its strategy to give VCT a brand name
– counsellor accreditation

Implementation challenges

It is evident that ECSA countries face formidable problems in trying to implement VCT nationwide. Following is a list of the most serious obstacles:

♦ Creating awareness and demand
  – mobilizing communities to increase uptake for VCT and to encourage reducing stigma
  – ensuring that programming focuses on vulnerable groups, especially youth

♦ Strengthening human and infrastructural capacity of VCT providers
  – addressing the critical shortage of trained VCT counsellors and laboratory technicians by expanding the pool of potential staff; South Africa has established a precedent by assigning primary responsibility of counselling to lay counsellors
  – providing training, support and supervision of counsellors to avoid staff burnout; Kenya, Uganda, Zambia and Zimbabwe are implementing a new training programme for counsellor supervisors to assist counsellors in acquiring the skills they need to prevent burnout
  – linking VCT with support groups to provide ongoing support including effective follow-up counselling
  – ensuring links are made with other services, such as screening for TB and managing STIs and opportunistic infections
  – increasing local responsibility for district level and integrated VCT programmes. Currently most integrated services are erratic and
subject to political whim. Uncertain support by hospital administration in integrated sites is attributable to the lack of a clear relationship with other health services, coupled with the lack of incentives for counsellors and laboratory technicians to take on the additional responsibility of VCT.

♦ Establishing high-quality systems

- institutionalizing systems for assuring high-quality services—including standardized guidelines and procedures for both counselling and testing—within countries and across ECSA.
- establishing logistics systems to ensure timely distribution of adequate test kits and other commodities
- standardizing data collection and management to facilitate monitoring and evaluation of programmes; Kenya, Uganda, Zambia and Zimbabwe have each developed a national standardized data form
- establishing national and regional standards; quality of service differs from urban to rural settings, with lack of resources significantly decreasing standards of service at lower levels of the health system.

Best practices

Based on lessons learned in sub-Saharan Africa, VCT should consist of a comprehensive package of services centred around counselling and testing, especially for the HIV positive. Ideally, VCT should . . .

- maintain anonymity and confidentiality
- have convenient location and hours of service
- link prevention and care services

♦ Counselling should . . .

- be client-centred
- have counsellor support and supervision
- link with ongoing counselling and support services after VCT

♦ Counselling procedures should include . . .

- pre- and post-test counselling
- a risk-reduction plan and partner referral support for HIV-negative clients
- support and referrals for care, partner disclosure and risk reduction issues for HIV-positive clients

♦ Testing should aim at . . .

- high-quality laboratory testing
- on-site rapid results, where possible
– informed consent

♦ Monitoring and quality control is needed for . . .
  – counselling: internal and external measures to assure quality
  – testing: internal and external measures to assure quality

♦ Addressing vulnerable groups such as . . .
  – young people
  – women
  – sex workers

Unique features of existing VCT programmes

♦ Botswana is the only country to have implemented a rapid expansion of MTCT services to cover the whole country, centred around VCT.

♦ In Kenya, there is accelerated, simultaneous implementation by multiple partners in different parts of the country. National guidelines on counselling, testing and training have been developed and are being disseminated to support this process. Quality will be ensured through a site accreditation system.

♦ In Malawi and Zambia, a highly functional national VCT coordination forum regularly brings together government, implementers and key partners to review progress and plan for the future.

♦ South Africa has established a policy that ‘lay counsellors, solely dedicated to VCT, must assume primary responsibility for the provision of VCT in all settings and sectors in South Africa’. Expanding the capacity for counselling will ease the shortage of nurse counsellors and increase people’s access to counselling.

♦ in Kenya and Zimbabwe nurse counsellors, rather than laboratory technicians, conduct rapid HIV tests.

♦ In Uganda strong institutionalized links to post-test support services are provided primarily by TASO. AIC also provides treatment for STI, TB and some opportunistic infections.

♦ Zimbabwe is implementing social marketing of VCT, and has developed a strong nationally recognized brand name, ‘New Start’, to help remove stigma. New Start has become synonymous with voluntary HIV testing in the country. So people do not mention that they are going for HIV testing, they simply mention New Start; when a person says ‘New Start’, people know what is meant. Botswana is
implementing a brand campaign for ‘Tebelopele’, modelled along the lines of New Start.

♦ In Zimbabwe, extensive quality assurance mechanisms have been instituted to maintain high-quality standards.

♦ Mauritius offers hot-line counselling as a major component of VCT services.

Way forward

Priorities for future action

There are opportunities to benefit from work already done within the region because some countries in ECSA have policies and guidelines that can be adapted or adopted. Following are priorities that need to be addressed.

POLICY DEVELOPMENT

National AIDS programmes should accelerate the development of policy even as VCT projects are being implemented.

♦ They should identify risk groups, populations and issues to be targeted in each country. Specifically, they should . . .
  – define specific needs to be dealt with and programmes to be implemented
  – monitor how policy is being implemented and develop or revise it as needed; follow how policy is translated into programmes

VCT IMPLEMENTATION

As VCT is pivotal for HIV prevention and care, several actions need to be taken simultaneously at national and other levels of the health system to ensure it is effectively implemented.

♦ Each national government should ensure that national policies, guidelines, and standards are developed and disseminated, and the necessary technical and management capacities are developed. It should . . .
  – formulate a strategic framework and operational plans, complemented by systems for collecting data and monitoring
  – develop a logistics and management system to ensure adequate and timely supplies of test kits and commodities at VCT sites
– train the necessary personnel through pre- and in-service training
– advocate government and NGO commitment and support, especially for integrated VCT sites

♦ At district level the focus should be on providing support for programme implementation by both government and NGOs. Districts should . . .

– support NGOs, religious and community-based organizations to mobilize the community and support complementary activities including community-based post-test care, peer education and condom distribution
– train counsellors and laboratory personnel
– strengthen referral networks
– particularly provide services to vulnerable groups such as adolescents and women

♦ At operational or site level the focus should be on providing the client with high-quality VCT service. The site should . . .

– conduct community awareness to create demand for VCT
– ensure high-quality service
– ensure availability of well-trained counsellors and laboratory personnel
– strengthen post-test support services and links
– continuously monitor the quality of care and the effectiveness of the service provided

REGIONAL COLLABORATION

National governments should work with international and local partners to strengthen policies and practices; they should designate responsibilities for action and mobilization of resources to build local capacity.

The expansion of existing VCT programmes lends itself to regional collaboration. Possible areas of collaboration include the following:

– harmonization of policies, guidelines for counselling, testing, data collection and training curricula
– regional standardization of counselling curriculum
– training of national trainers for different aspects of VCT
– use of existing regional resources for ongoing evaluation, such as setting up a regional reference laboratory to deal with quality control matters
– regional coordination on procurement of HIV test kits
– networking, sharing of experiences, resource mobilization
Issues for further research

The use of VCT for prevention and care of HIV is likely to increase as general HIV treatment and care become more available. Some countries, by expanding PMTCT programmes and making ARVs more widely available for managing HIV infection, have already created a tremendous demand for national VCT programmes.

Although VCT has been proven to have preventive benefits lasting up to 12 months after counselling and testing, the long-term benefits of VCT are still unknown. A number of areas need further research:

♦ Does VCT lower stigma in a community if a critical mass of people are counselled and tested?

♦ What is the best way of involving faith-based organizations in VCT? They should be encouraged to play a part, as most Africans are religious, many participating regularly in religious activities.

♦ Does one-time VCT have a permanent effect on behaviour or do people tend to regress to high-risk behaviour in a year or so?

♦ Should nurse counsellors be allowed to perform rapid HIV testing for both VCT and PMTCT programmes if laboratory personnel are not available?

♦ What are the essential elements of a successful support group and who should join one? AIDS support groups are sprouting up in many countries, with significant funding from donors, but what are the short- and long-term benefits of belonging to one?

♦ How can VCT services be made to appeal to young people? How can the practice of getting tested before marriage or pregnancy be encouraged?

♦ What type of VCT service is suitable for especially vulnerable or distinct populations such as university and college students, lorry drivers, the military?

♦ Does making VCT available within a community also encourage PMTCT?
Appendix 1. Country profiles

Kenya

Current status of VCT policies

- Sessional Paper No. 4 of 1997 on AIDS in Kenya provides the framework for HIV/AIDS response
- The national HIV/AIDS strategic plan outlines VCT initiatives to be undertaken

Policy implementation

- A VCT technical working group was started in October 2000 to coordinate and support implementation
- Kenya has no HIV/AIDS policy document; however, the government has focused on creating an environment in which VCT services can be set up with interested partners

VCT guidelines—current status

- Kenya has developed and is using its first set of comprehensive national VCT guidelines and training curriculum
- Guidelines were developed under the auspices of the technical working group on VCT and have been widely disseminated

VCT service delivery models

- VCT is implemented by CDC, FHI, the Kenya Association of Professional Counsellors (KAPC), the Kibera Community Self-Help Project (KICOSHEP), the Liverpool School of Tropical Medicine VCT Project, MSF and NASCOP. CDC, KAPC and the Liverpool Project provide counsellor training

Free standing

- All CDC, KAPC and KICOSHEP sites are free standing. Only HIV testing and post-test referrals are offered. The Liverpool project has one stand-alone site and is setting up another

Integrated services

- All government and 12 of the Liverpool project sites are integrated within health centres and clinics

Counsellor training

- Counselling training is now standardized across CDC, FHI, KAPC, Kenyatta National Hospital, Liverpool and NASCOP programmes
- A counsellor supervision course has been developed to support and increase the quality of counsellor performance
**HIV testing**
- Rapid tests are used in all VCT sites
- Non-laboratory staff, that is, counsellors, are conducting HIV rapid tests in VCT sites

**Strategies to promote VCT uptake**
- Accelerated scaling up supported by the government of Kenya, CDC and USAID
- Dissemination of guidelines to improve quality of service
- Community mobilization programmes
- Outreach and mobile services
- Promotions
- National VCT communication campaign by PSI
- Training of additional counsellors and laboratory technicians
- Registration and accreditation of VCT sites and VCT counsellors to ensure minimum standards

**Key policy issues**

**General VCT service provision**
- Ensure informed consent, addressing issues of disclosure, measures to protect confidentiality
- Provide effective post test support

**HIV counselling**
- Institute measures for assuring counselling quality, including counsellor supervision
- Expand current capacity for counselling. Government to lobby for legal recognition of counselling as a profession

**HIV testing**
- Minimum standards for mandatory, diagnostic and surveillance or research testing
- Logistical management to ensure countrywide availability of adequate test kits and supplies

**Research issues**
- Ongoing evaluation and recommendation of rapid test kits as more and more become available
- Increasing women’s access to VCT, especially in rural areas

**Unique features**
- Government of Kenya (GOK) actively involved in planning and promoting VCT. GOK has also identified funding to support expanding VCT programme to at least five sites in each of Kenya’s 74 districts (minimum of 370 sites) over five years. Districts funded directly for VCT
Multiple donors scaling up VCT implementation simultaneously in various parts of the country to achieve national coverage. Kenya had 74 sites as of June 2002, up from 3 in January 2001

- Standardized data collection system field tested and to be instituted nationwide
- Standardized national VCT training curriculum developed and implemented by all major organizations training VCT counsellors
- VCT site accreditation system implemented by NASCOP to enforce minimum standards of service
- KICOSHEP has one direct site located within a church

**Malawi**

**CURRENT STATUS OF VCT POLICIES**

- VCT has been identified as a basis for change of sexual life for preventing HIV infection and prolonging the life of the affected
- A draft national HIV/AIDS policy in Malawi is being developed and has evolved from the national HIV/AIDS strategic framework for 2000–2004. The document analyses six (out of eight) policy areas: 1) Multisectoral approach; 2) Human resources in the face of HIV and AIDS; 3) HIV testing and disclosure; 4) Orphans, gender status of women, widows and widowers; 5) Sex, sexuality and condoms; and 6) Sex industry. The two remaining policy areas that need to be addressed are 7) Biomedical issues as they relate to HIV (care and treatment of patients, PMTCT, safe blood supply, and so on) and 8) Legal and legislative review (ethics, human rights and the constitution)
- A consultative approach to development of the national HIV/AIDS strategic framework for 2000–2004 was adopted

**POLICY IMPLEMENTATION**

- The national HIV/AIDS strategic framework for 2000–2004 was launched at national level by President Bakili Muluzi
- VCT was implemented in 1992 by MACRO, ahead of HIV/AIDS policy development

**VCT GUIDELINES—CURRENT STATUS**

- The National AIDS Council (NAC) is actively involved in development of guidelines
- Government ministries and all donors working in HIV/AIDS in Malawi are represented in the technical working group on HIV/AIDS, which has
spearheaded the development of the draft VCT guidelines under NAC’s leadership
- The guidelines will be finalized after they have been tested for six months (June–December 2002)
- Guidelines were developed as VCT implementation progressed

**Scope and areas defined in VCT guidelines**
- Guiding principles for the provision of VCT services
- Essential requirements for setting up VCT services
- VCT models; human resources
- VCT service provision
- Laboratories and HIV testing
- Support services and links
- Administrative management of VCT sites and services
- Monitoring and evaluation

**Guidelines not yet in use as they are still in draft form**
- Draft PMTCT guidelines that have been developed were to be finalized in June 2002
- Content areas for PMTCT guidelines are 1) IEC for PMTCT; 2) PMTCT service delivery; 3) Infant feeding practices; 4) Voluntary counselling and testing; 5) ARVs for PMTCT; and 6) Social support

**VCT SERVICE DELIVERY MODELS**

**Free standing**
- MACRO, an NGO, has three sites in Blantyre, Lilongwe and Mzuzu urban areas
- Full-time counsellors
- Offer free services for anonymous counselling, HIV testing, syphilis testing, family planning services, post-test clubs and IEC outreach programmes
- The Lilongwe MACRO site offers STI syndromic management, TB referral services, provision of cotrimoxazole preventive therapy to TB clients, provision of isoniazid preventive therapy to HIV-positive clients
- MACRO has monitoring and evaluation system in place with 40,806 clients seen in 2001, almost double the 21,400 clients seen in 2000

**Integrated services**
- Integrated services are provided at Lilongwe Hospital and three district hospitals
- VCT services also provided by other organizations: MSF France, MSF Greece, MSF Luxembourg and Save the Children UK
- 7 out of 27 districts have access to integrated VCT services
- Fewer clients seen
- PMTCT programmes are being piloted in 8 districts

**Counsellor training**
- Counselling training not standardized
- VCT counselling training manual still to be developed
**HIV testing**

- Diagnostic testing carried out in hospitals with minimal counselling
- Mandatory testing in cases of rape
- NGOs using rapid HIV tests; government sites use Elisa tests
- Protocol for rapid HIV testing not standardized for the country
- Severe shortage of Elisa tests in hospitals affecting assurance of quality

**STRATEGIES TO PROMOTE VCT UPTAKE**

- Strengthen existing services in terms of capacity: staff, space and equipment
- Open additional sites at central level and expand to lower levels of health care—district hospitals, rural hospitals and health centres
- Provide communities with mobile VCT outreach programmes
- Set targets for each year

**KEY POLICY ISSUES**

**General VCT service provision**

- Strengthen post-test support
- Ensure availability of ARVs to the general population
- Expand the PMTCT programme

**HIV counselling**

- Demand for VCT services high
- Lack of standardized VCT counselling training manuals
- Lack of finalized VCT guidelines
- Counsellors in integrated sites who are not full time
- Need to strengthen counselling quality assurance measures

**HIV testing**

- Lack of standardization of testing protocol
- Severe shortage of Elisa test kits countrywide

**RESEARCH ISSUES**

- Reasons why Malawi women make little use of VCT services
- Factors contributing to decision to test being taken by clients well before they come to the VCT centre

**UNIQUE FEATURES**

- National AIDS Council’s leadership role for 1) government and donor coordination through the technical working group on HIV/AIDS and 2) development of policy and guidelines, which will result in standardizing services and improving quality of services provided
- Successful integration of MACRO’s services—STI syndromic management, TB referral services, provision of cotrimoxazole preventive therapy to TB clients, provision of isoniazid preventive therapy to HIV-positive clients, family planning
– Rapid testing for syphilis at MACRO sites
– Development of PMTCT guidelines

Uganda

CURRENT STATUS OF VCT POLICIES
– A national HIV testing policy was developed in 1993 to provide guidance on HIV testing in general
– A national health policy that includes HIV/AIDS was developed in 1999 and approved by the cabinet
– A national HIV/AIDS policy developed by the Uganda AIDS Commission in March 2001 is still in draft form
– Consultations are ongoing at the AIDS Control Programme to develop a national VCT policy that will incorporate emerging issues such as minors, private sector counselling and testing, and quality assurance
– A consultative approach to developing the national HIV/AIDS strategic framework for 2000–2004 was adopted

POLICY IMPLEMENTATION
– VCT has been implemented since 1991 by AIDS Information Centre (AIC), which operates a direct site in the major urban centres of four districts in Uganda, and 17 other indirect sites in as many districts. The Ministry of Health initiated two pilots in 1998 and begun scaling up in 2001
– VCT is incorporated in the 2000–2004 strategic framework for the control of HIV/AIDS
– VCT is an integral component of the national five-year strategic plan for the health sector, which has targets for increased access to VCT services in the general population
– A core team of 17 key stakeholders has been formed to coordinate VCT implementation. Members are drawn from UN agencies, donors, relevant government units and implementing NGOs and are scheduled to meet quarterly under the chairmanship of the Uganda AIDS Commission

VCT GUIDELINES—CURRENT STATUS
– TASO, AIC, Mild May, and AIDS Control Programme (ACP) have developed guidelines to support their specific processes for HIV/AIDS counselling and VCT implementation, with financial and technical support from partners. The AIM project, funded by USAID/CDC, is designed to strengthen HIV/AIDS services at district level with VCT as a priority intervention. It has collected, collated and reviewed all existing guidelines on training, IEC and counselling on behalf of ACP. The material was peer reviewed in a poster presentation at the HIV/AIDS conference in Barcelona in July 2002, now is to be field tested in selected sites and finalized. These guidelines will assist in standardizing and improving the quality of VCT in general and counselling in particular
– PMTCT steering committee has developed guidelines for providing services

VCT SERVICE DELIVERY MODELS

Direct
– AIC manages five direct sites in each of the major urban areas in four districts. These sites provide VCT, syphilis testing, STI syndromic management, family planning, TB prophylaxis, treatment for some opportunistic infections, and condoms

Integrated services
– All government and AIC ‘indirect’ sites are integrated sites, managed in partnership with district health teams. AIC and ACP provide training, monitoring and supervision, and supplies

Counsellor training
– Counselling training is not standardized across AIC, TASO and MOH programmes
– AIC is conducting VCT counsellor training for national and regional clients
– TASO training is more focused on ongoing care and support; AIC focuses more on prevention
– The VCT counselling training team for government sites is assembled from across AIC, TASO, Mild May and other partners as needed

HIV testing
– Protocol for rapid HIV testing is not standardized for the country; for example, ACP, AIC and private laboratories all use different protocols
– Supplies are erratic, including confirmatory tests; in particular this affects assuring the quality of testing in integrated sites

STRATEGIES TO PROMOTE VCT UPTAKE

– Planned expansion by both ACP and AIC from 12 to all 56 districts
– Use of VCT outreach services from ‘static’ centres to rural communities
– Community mobilization programmes
– Piloting of promotional model (social marketing) of VCT by AIC in conjunction with commercial marketing strategies
– Training of additional counsellors and laboratory technicians
– Instituting quarterly supervisory visits to MOH sites

KEY POLICY ISSUES

General VCT service provision
– Building capacity of districts to provide high-quality VCT services
– Policy and coordination to guide and streamline scaling-up process
– Lack of clarity on age of consent for services and testing of children
- AIC to develop and document its own set of internal policies based on
the need to address emerging issues

**HIV counselling**
- Demand for VCT services high
- Lack of standardized VCT counselling training manuals
- Lack of finalized comprehensive VCT guidelines
- Counsellors in integrated sites who are only part time, with most assigned additional duties
- Need to strengthen quality-assurance measures for counselling

**HIV testing**
- Lack of standardization of testing protocols and policies across the country
- No standardized evaluation of test kits for national use
- Logistical management to ensure availability of adequate test kits and supplies countrywide

**Research issues**
- Effectiveness and sustainability of group counselling
- Impact of social marketing on VCT uptake, especially couples, because of high discordant rates seen by AIC
- Increasing uptake of VCT among the youth (over 50% of population is below 15 years)

**Unique features**
- Government and donor coordination on HIV/AIDS through the technical working group of the core team of 17 stakeholders
- Three-tier counselling structure with counsellors, counsellor assistants and community aides trained and deployed at district, health centre and community levels, respectively, in every district. A new cadre of counselling supervisors (one per district) is being established. This counselling capacity is complemented by others at NGOs like TASO and AIC
- Successful integration of services by AIC and ACP: STI syndromic management, TB referral services, provision of preventive therapy to TB and HIV-positive clients, family planning. Rapid testing for syphilis provided at all AIC direct sites
- Implementation of VCT decentralized to district authorities through the district health management team

**Zambia**

**Current status of VCT policies**
- The HIV/AIDS/STD/TB strategic framework for 2001–2003 outlines the priority subpopulations that are vulnerable to HIV infection as follows: orphans and street children, youth in and out of school, young girls,
widows and widowers, commercial sex workers, truck drivers and their assistants, migrant and seasonal workers, cross-border traders, fishermen and fish traders, uniformed personnel, prisoners, refugees and displaced people. Those most vulnerable to the impact of HIV are PLWHA and orphans

- VCT is stated as one of the priority interventions
- A consultative approach was adopted towards developing the HIV/AIDS/STD/TB strategic framework for 2001–2003
- A draft national HIV/AIDS/STD/TB policy is being developed to guide individual and collective actions against HIV/AIDS/STD and TB. The document addresses the following broad areas: situation analysis at global and national levels; vision, guiding principles and objectives of the policy; policy measures that need to be in place; implementation framework

**POLICY IMPLEMENTATION**

- VCT was implemented in 1991, ahead of developing HIV/AIDS/STD/TB policy

**VCT GUIDELINES—CURRENT STATUS**

- National VCT guidelines not yet in place
- Government plans to use existing guidelines in the country to draw up the national guidelines
- Kara Counselling and Training Trust has VCT guidelines for its own use. Areas covered are guidance on hours open; referrals; reception; pretest counselling; HIV testing; post-test counselling and giving of results; follow-up support; dealing with special groups such as couples, young people, pregnant women and children; management of the VCT centre; fees for VCT services; supervision and support; written records; dealing with difficult client behaviour; monitoring and evaluation

**VCT SERVICE DELIVERY MODELS**

*Integrated services*

- Integrated services are in 57 sites throughout the country with a total of 185,892 clients seen between 1999 and 2001, 85% of whom were counselled and tested
- Kara Counselling and Training Trust has four integrated sites
- PMTCT programmes are being piloted in six sites
- First PMTCT site has been operational since March 2000
- Between 2000 and 2001, 4669 clients were seen and 65% tested

*Direct*

- Kara Counselling and Training Trust has two direct sites
- Society for Family Health has one New Start HIV counselling and testing centre, begun in March 2002; 1344 clients had been seen by end of April 2002, 94% of whom received counselling and testing
- Counsellors are full-time
– A small fee is charged to those who can pay

_Counsellor training_
– Counselling training is carried out by Ministry of Health, Zambia Counselling Council, and Kara Counselling and Training Trust

_HIV testing_
– Diagnostic testing carried out in hospitals, with minimal counselling
– Both government and NGOs use rapid HIV tests for VCT
– Protocol for rapid HIV testing not standardized throughout the country

_STRATEGIES TO PROMOTE VCT UPTAKE_
– Formation of the National HIV/AIDS/STD/TB Council, which is to coordinate all HIV/AIDS activities
– Increased involvement of the Central Board of Health, district health management boards and local communities
– Increased funding for community sensitization, mobilization and outreach activities
– Inclusion of a third rapid test as a tie-breaker
– Implementation of decentralized quality control for testing
– Expansion of VCT to all 72 districts

_KEY POLICY ISSUES_

_Generic VCT service provision_
– Standardizing data collection throughout the country
– Strengthening data management
– Addressing stigma for PMTCT programmes
– Strengthening post-test support

_HIV counselling_
– Demand for VCT services high
– Lack of national VCT guidelines
– Counselling to be considered a profession
– Counsellors in integrated sites who are only part time
– Need for stress management retreats

_HIV testing_
– Lack of standardized testing protocol for the country

_RESEARCH ISSUES_
– Factors contributing to decline in HIV prevalence among 15- to 19-year olds

_UNIQUE FEATURES_
– Changes in cultural practices such as ritual cleansing
– Scaling up of services to the present 57 sites
– Coordination of VCT activities through the Zambia VCT Partnership
– Partnerships in counsellor training and community mobilization
– Counsellor supervisor training

Zimbabwe

CURRENT STATUS OF VCT POLICIES

The national HIV/AIDS policy was developed in 1999 and approved by President Mugabe in 2000. It was developed through a broad consultative process and sets down overall guiding principles on issues related to HIV/AIDS.

– VCT is an important intervention for HIV/AIDS prevention and control that should be made accessible to the general public
– Access to information and counselling for informed consent to HIV testing should be ensured as a fundamental human right
– Mandatory testing is also addressed under human rights, identifying specific risk groups that include pregnant women, infants, prisoners and engaged couples

Key strategies for implementing the above policies are also defined.

POLICY IMPLEMENTATION

A national strategic framework 2000–2004 was also developed in 1999 to guide implementing the national HIV/AIDS policy. This framework was the result of consulting with stakeholders, reviewing performance under the medium-term plans 1 and 2, and identifying priority issues and gaps to be addressed in the future. However, the framework does not set out specific targets for VCT, which is highlighted primarily within the context of PMTCT.

VCT GUIDELINES—CURRENT STATUS

National guidelines not yet in place. Guidelines within the New Start VCT programme are currently used as the standard for providing VCT services. They are . . .

– pre- and post-test counselling guides, based on the CDC voluntary counselling and testing guides
– Group information giving sessions
– VCT outreach activities
– HIV testing
– The New Start centre operating procedure manual gives guidance on VCT service provision at site level. Areas covered in the document are policy issues; VCT site management issues; VCT site operational issues including client flow; monitoring and evaluation; procedures in opening VCT sites; counselling process for pre- and post-test counselling, couple counselling; confidentiality; counselling quality assurance and counsellor
VCT SERVICE DELIVERY MODELS

The main VCT service delivery mechanism is through the socially marketed New Start centres under the Ministry of Health and Child Welfare, receiving technical assistance from PSI Zimbabwe.

Integrated services
- Integrated services are mainly in 10 integrated New Start centres found in the 10 provinces of the country. These have served 47% of the total 77,113 clients seen since March 1999 when the first New Start centre was opened. About 97% of these clients have received counselling and testing.
- The Zimbabwe AIDS Prevention and Support Organisation (ZAPSO) is an NGO offering VCT services in three integrated sites. Since the first site opened in November 1998, 17,465 clients have been seen from both the integrated and free-standing sites with about 51% of clients having received counselling and testing.
- Since the first pilot site was opened in 1999, 29 PMTCT sites have become fully operational with nevirapine being given to all eligible pregnant women using an opt-in strategy. The programme has just entered the expansion phase in which the emphasis is on training counsellors, setting up logistics systems for rapid test kits and drugs, and setting up the monitoring and evaluation component of the programme.

Direct services
- Two New Start direct sites are now located in the two major cities. Since the first site was opened in October 2000, 40,847 clients have been seen. The second site was opened in August 2001.
- ZAPSO has three free-standing sites.
- Location in a busy part of the city, full-time counsellors and longer open hours are some of the hallmarks of this model of VCT service delivery.
- ZAPSO operates one such site in the capital city.

Counsellor training
- VCT counsellor training is carried out by PSI in conjunction with Ministry of Health and Child Welfare.
- The Zimbabwe HIV counselling training manual is used to guide training carried out as follows: five days of theory followed by three months of field attachment with supervision and another five days of experience-sharing before certification.

HIV testing
- Diagnostic testing carried out in hospitals with minimal counselling.
- Elisa testing mainly carried out in hospital settings while VCT centres use rapid test kits.
– Protocol for rapid testing has been standardized for the whole country, following an extensive evaluation of HIV rapid tests in country

**STRATEGIES TO PROMOTE VCT UPTAKE**

– Social marketing of VCT, with a small fee charged to those who can afford to pay
– Price promotions for different target groups, for example, Father’s Day
– Toll-free Youth Chat Line for discussion of reproductive health matters with youths and appropriate referral to New Start centres
– Use of HIV rapid tests
– VCT outreach activities to communities that do not have access to static VCT sites
– Scaling up of VCT services through the district health initiative, in which VCT service provision within the district hospital will be piloted, taking into account features of free-standing sites such as full-time staff
– Community mobilization activities to raise level of awareness of VCT

**Key policy issues**

– General: need to develop comprehensive VCT guidelines
– HIV counselling: external quality-assurance programme to be set up for counselling
– HIV testing: use of non-laboratory personnel to perform rapid HIV testing in VCT sites

**RESEARCH ISSUES**

– Do VCT clients sustain behaviour change beyond 12 months of receiving VCT services?

**UNIQUE FEATURES**

– Demand creation: social marketing of VCT services, VCT outreach, Youth Chat Line
– Mystery client surveys for VCT service quality control
– Standardized data management system
– Standardized HIV testing protocol for the country
### Appendix 2. Scope of national VCT guidelines

<table>
<thead>
<tr>
<th>VCT establishment and site management</th>
<th>Bot</th>
<th>Ken</th>
<th>Mal</th>
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<th>Sey</th>
<th>SA</th>
<th>Tz</th>
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<th>Zam</th>
<th>Zim</th>
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<td>VCT procedures and service provision</td>
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<td>Staffing and management</td>
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<td>Integrated sites</td>
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<td>Stand-alone sites</td>
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<td>Payment for VCT</td>
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<tr>
<td>Involvement of PLWHA</td>
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<tr>
<td>Support services and links</td>
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</table>

### Counselling

| Pretest                               | x   |     | x   |     | x   | x   | x   | x   |     |     |
| Post-test                             |     |     | x   |     | x   | x   | x   | x   |     |     |
| Premarital                            |     | x   |     |     |     |    |    |    |     |     |
| Adolescents                           | x   |     | x   |     | x   |     |     |     |     | x   |
| Couples                               |     |     | x   |     | x   |     |     |     |     | x   |
| Discordant                            |     |     |     | x   |     |     |     |     |     | x   |
| Pregnancy                             | x   |     |     | x   |     |     |     |     |     |     |
| Family                                |     |     |     |     |     |    |    |    |     |     |
| Group                                 |     |     |     |     |     |    |    |    |     |     |
| Outreach services                     |     |     |     |     |     |    |    |    |     |     |
| Other                                 |     |     |     |     |     |    |    |    |     |     |
| Quality assurance                     | x   |     | x   |     |     |    |    |    |     | x   |

### Testing

| Testing protocol                      | x   |     | x   |     | x   | x   | x   | x   |     |     |
| Quality assurance                     | x   |     | x   |     |     |    |    |    |     | x   |

### Monitoring and evaluation

| Record keeping                        | x   | x   |     |     |     |    |    |    |     |     |
| Data management                       | x   | x   |     |     |     |    |    |    |     |     |

### Training

| Counselling                           | x   |     | x   |     |     |    |    |    |     |     |
| Testing                               | x   |     | x   |     |     |    |    |    |     |     |

In **Lesotho**, there were no VCT services as of March 2002. No data are available for **Mozambique, Namibia, Swaziland.**
## Abbreviations and acronyms

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
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<tbody>
<tr>
<td>ACP</td>
<td>AIDS Control Programme (Uganda)</td>
</tr>
<tr>
<td>AIC</td>
<td>AIDS Information Centre (Uganda)</td>
</tr>
<tr>
<td>AIDS</td>
<td>acquired immune deficiency syndrome</td>
</tr>
<tr>
<td>AIM</td>
<td>AIDS/HIV Integrated Model District Programme (Uganda)</td>
</tr>
<tr>
<td>ARV</td>
<td>antiretroviral drugs</td>
</tr>
<tr>
<td>CDC</td>
<td>Centers for Disease Control and Prevention</td>
</tr>
<tr>
<td>CRHCS</td>
<td>Commonwealth Regional Health Community Secretariat</td>
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<tr>
<td>DfID</td>
<td>Department for International Development (UK)</td>
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<tr>
<td>ECSA</td>
<td>east, central and southern Africa</td>
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<tr>
<td>FHI</td>
<td>Family Health International</td>
</tr>
<tr>
<td>FP</td>
<td>family planning</td>
</tr>
<tr>
<td>HIV</td>
<td>human immunodeficiency virus</td>
</tr>
<tr>
<td>IEC</td>
<td>information, education and communication</td>
</tr>
<tr>
<td>JICA</td>
<td>Japan International Cooperation Agency</td>
</tr>
<tr>
<td>KAPC</td>
<td>Kenya Association of Professional Counsellors</td>
</tr>
<tr>
<td>KICOSHEP</td>
<td>Kibera Community Self-Help Project (Kenya)</td>
</tr>
<tr>
<td>M&amp;E</td>
<td>monitoring and evaluation</td>
</tr>
<tr>
<td>MACRO</td>
<td>Malawi AIDS Counselling and Resource Organisation</td>
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<tr>
<td>MOH</td>
<td>Ministry of Health</td>
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<tr>
<td>MSF</td>
<td>Médecins sans Frontières</td>
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<tr>
<td>MTCT</td>
<td>Mother to Child Transmission</td>
</tr>
<tr>
<td>NASCOP</td>
<td>National AIDS Control Programme (Kenya)</td>
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<tr>
<td>NGO</td>
<td>non-governmental organization</td>
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<tr>
<td>Norad</td>
<td>Norwegian Agency for Development Cooperation</td>
</tr>
<tr>
<td>OI</td>
<td>opportunistic infection</td>
</tr>
<tr>
<td>PLWHA</td>
<td>People Living with HIV/AIDS</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention of Mother to Child Transmission</td>
</tr>
<tr>
<td>PSI</td>
<td>Population Services International</td>
</tr>
<tr>
<td>RHMC</td>
<td>Regional Health Ministers’ Conference</td>
</tr>
<tr>
<td>SADC</td>
<td>Southern African Development Community</td>
</tr>
<tr>
<td>STD</td>
<td>sexually transmitted disease</td>
</tr>
<tr>
<td>STI</td>
<td>sexually transmitted infection</td>
</tr>
<tr>
<td>TASO</td>
<td>The AIDS Support Organization (Uganda)</td>
</tr>
<tr>
<td>TB</td>
<td>tuberculosis</td>
</tr>
<tr>
<td>TBPT</td>
<td>tuberculosis prevention therapy</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
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<tr>
<td>VCT</td>
<td>Voluntary Counselling and Testing</td>
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<td>WHO</td>
<td>World Health Organization</td>
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