Ministry of Health

National Guidelines for Voluntary Counseling and Testing

National AIDS and STD Control Programme (NASCOP)

in collaboration with the National AIDS Control Council

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Ministry of Health

Government of Kenya
Foreword

The burden of HIV/AIDS continues to pose a major challenge to Kenya’s health care system. Strong government intervention over the last 10 years has given rise to high level of awareness but without corresponding behaviour change. In addition to this, the impact of HIV/AIDS and its social economic consequences have undermined the nation’s resources. A situation like this demands an alternative and effective tool for behaviour change as well as caring, coping and supportive services within our health care system.

Voluntary confidential counseling and testing targets behaviour change. Knowing one’s HIV status empowers people to make informed decisions about their sexual lifestyle that would otherwise predispose individuals to HIV infection. The current Ministry of Health response to the HIV epidemic in its national strategic plan (1999–2004) includes the introduction of voluntary counseling and testing into the public health care system. Most of the people who are infected are not aware of their HIV status. (In reference to the Kenya Demographic Health Survey of 1998, only 15% of the Kenyans knew their HIV status and about 67% indicated that they would like to take a HIV test.)

Research in many countries has shown that people who know their sero-status, whether HIV negative or HIV positive, drastically change their behaviour. One of the government’s major strategies is to make voluntary counseling and testing services available, to target the majority of the population not yet infected and identify early those who are infected for proper care services. The expansion of the voluntary counseling and testing in Kenya will ensure that such vital services are made available and accessible to Kenyans.

The Ministry of Health recognizes the need for comprehensive and standardized voluntary counseling and testing operations in Kenya. A multidisciplinary team representing public health workers, physicians, social workers counselors and laboratory experts has developed these VCT guidelines. This team solicited inputs from a wide range of experts such as NGOs, donors, support groups for people living with AIDS, and the private sector. It is hoped that these guidelines will serve as a ‘blueprint’ for the introduction of these services and will help health workers and counselors establish and maintain high-quality VCT services in Kenya.

We expect that all providers, in both public and private, including mission facilities, will use these guidelines. They will be reviewed from time to time and any feedback from the users will be greatly welcomed.

Dr Richard O. Muga, OGW, DSM
Director of Medical Services
Executive summary

When the Government of Kenya declared that AIDS is a national disaster and included voluntary counseling and testing (VCT) in the National Strategic Framework for the Prevention of HIV/AIDS in Kenya, it became imperative that guidelines be developed to standardize the delivery of this service and to assure its high quality and confidentiality.

The VCT guidelines are for use by all who are providing or intend to provide VCT services, whether integrated with other facilities or as a stand-alone service. They are a useful tool for supervisors and for monitoring and evaluating services.

The guidelines are presented in four sections: Operational procedures for VCT services; HIV test-related counseling; HIV testing; Record-keeping, data management, monitoring and evaluation. They are followed by a bibliography of relevant reading material and appendices on confidentiality, ethics, human rights, and preventive TB therapy.

The section on Operational procedures spells out who takes the coordinating role for the VCT services in the district and the roles of the Ministry of Health, the National AIDS Control Council and the National VCT Technical Committee.

Because most VCT services are being offered in an already established health service infrastructure, the guidelines spell out the need to have a VCT registration desk so that clients who need only that service easily have access to it. Because using these services is voluntary, the consent of the client to have the counseling and testing must be informed. The service provider must ensure that there is no coercion.

It is essential that confidentiality be maintained through strict controls when conducting HIV counseling and testing. However, when VCT is an entry point for other medical services, it is important for the counselor to explain the need to use the client’s name when referring him or her but to emphasize that confidentiality is still maintained. HIV results should be disclosed only to the client and ideally do not need to be given out as a certificate.

The standard minimum age for HIV testing is 18 years, but the guidelines add another category of ‘mature minors’ who can give consent for VCT, although the counselor should make an independent decision as to whether the minor is mature enough to receive VCT services. In the case of children, the welfare of the child is the primary concern.

Counselors in VCT sites should be familiar with additional follow-up services available and should be able to make specific referrals based on a client’s needs. Such referrals include, but are not limited to, detection and treatment of STIs, screening of tuberculosis, family planning services, preventive therapy for opportunistic infections, post-test clubs for ongoing psychological support, and support programmes for behavioural change.

Section 2 gives guidelines on HIV test-related counseling and what should be covered during pre-test and post-test counseling. It discusses special circumstances
for VCT services like premarital HIV counseling and testing, couple counseling and adolescent counseling.

Section 3, which gives guidelines for the HIV testing, recommends use of simple rapid HIV test kits that can give results within 30 minutes or less and have been approved by the Government of Kenya. Serial testing, in which any positive sample is confirmed by another test, is the minimum requirement. Parallel testing, however, in which different whole blood tests are run simultaneously on a specimen, should be used whenever possible. When the test results are discordant, a venous sample should be requested from the client for additional testing at a reference lab.

Because of the window period, during which the virus might not show up in a blood test, clients who test HIV negative but have had recent risky behaviour should be encouraged to return for additional testing within three months to make sure they are truly uninfected.

It is recommended that all HIV testing for VCT be done by a laboratory technician, but in settings where this is not possible and where clients may prefer only the counselor to know, the counselor may conduct the HIV test under the supervision of a lab technician. All precautions against blood contamination should be observed. For quality assurance, between 3 and 5% of all specimens should be retested at a reference laboratory.

The national Ministry of Health system for collection and analysis of VCT data should be followed for collecting and recording data, using the standard collection instrument. Each VCT site should submit the completed data forms to the district health information office, where data are entered and tabulated for onward transmission to the National AIDS and STD Control Programme (NASCOP) and the provincial medical office. The VCT database is used to monitor and evaluate VCT services at each site.

The National Guidelines for Voluntary Counseling and Testing is intended to contribute to providing quality services in the country and to be a guide for those undertaking general supervision of service delivery at a VCT site or within the district.

The guidelines is the product of the concerted efforts of the Ministry of Health, NASCOP, the National AIDS Control Council, and both local and international organizations involved in the fight against AIDS in Kenya.
Voluntary Counseling and Testing

Voluntary Counseling and Testing
- VCT services should be completely voluntary and requested by the client
- Informed consent is always required.
- Confidentiality must always be maintained.
  - Anonymous services (no names) can be provided.

Voluntary Counseling and Testing
- Pre-test and post-test counseling is always required.
- Counseling should emphasize behaviour change and prevention.
- Couple counseling is recommended.
- Counselors should refer clients to other appropriate services if needed.

Voluntary Counseling and Testing
- Simple, rapid, whole blood tests for same-day or same-hour results are recommended.
- Serial testing is the minimum standard: one screening test for all clients and a confirmatory test for positive samples.
- Parallel testing is preferred: two different types of rapid test on all clients.
- Testing should be done by a laboratory technician if possible.
- Counselors may conduct simple rapid tests if trained and supervised by a qualified laboratory technologist.

Who should provide VCT?
- All VCT providers must be trained in VCT counseling and service delivery.
- VCT counselors should be carefully selected and their duties adjusted so they can concentrate on VCT services.
- VCT counselors should abide by a code of conduct and ethics.

Who should receive VCT?
- Anyone serious about behaviour change should receive counseling.
- Those with more than one sexual partner should seek counseling.
- Those diagnosed with a sexually transmitted disease or tuberculosis need counseling.
- Anyone 18 and over can freely request VCT.
- Couples before starting a relationship, before marriage, for pregnancy planning should seek counseling.
- Youth between 15 and 18 can be served if they are a 'mature minor' already engaged in risky behaviour. Counselors need to judge carefully.
- Children under 15 should be served only with parental consent and only if there is a clear benefit to the child.
Introduction

Voluntary counseling and HIV testing (VCT) is an essential component of an effective response to the AIDS epidemic. The Government of Kenya is fully committed to encouraging the provision of VCT services throughout Kenya, so that all Kenyans who wish to know their HIV serostatus have access to these services. The purpose of these guidelines is to provide national standards so that high-quality VCT services are available.

Numerous research projects in Africa, including an important one in Kenya, have demonstrated that VCT and knowledge of serostatus encourages clients to reduce risky behaviour, and thus VCT is important in any HIV prevention effort. (See bibliography on page 24.) Research has also found that VCT is a cost-effective method of prevention. Furthermore, it can be an entry point for providing other services, such as detecting and treating tuberculosis, preventing other opportunistic infections in HIV-infected persons, and preventing mother-to-child HIV infection. VCT services can serve as the entry point for long-term supportive services for clients who learn they are HIV infected, and it can assist HIV-positive clients adopt behaviour that does not transmit HIV to their sexual partners or infants. HIV-positive clients can also be assisted to begin the process of informing their sexual partners, families and children about their HIV status and can be referred for services to help them make appropriate plans for the future.

Many persons come for VCT services because they have signs and symptoms typically associated with HIV disease. Some will learn that they are HIV negative and can benefit by being referred for additional diagnostic investigations. But it is important to remember that most persons requesting the services will learn that they are not HIV infected. This information, and the counseling that accompanies it, can be a powerful catalyst for behaviour change so that the client can remain uninfected. VCT services can help clients make informed decisions about marriage, pregnancy and sexual relationships. They can provide the opportunity for receiving additional services, such as legal assistance, family planning, and detecting and treating other sexually transmitted diseases.

Overall, VCT services can help decrease the anxiety, stigma, and sense of hopelessness associated with fearing that one has AIDS. Clients who learn their serostatus and receive specific counseling based on their test results report an increased sense of hope in facing their situation openly and with adequate information. It has been said that ‘knowledge is power,’ and in the case of AIDS, a person’s knowledge of their own HIV status is a powerful weapon in the national effort to respond to the epidemic.

The following guidelines are intended to assist all facilities providing VCT services in Kenya, including Government of Kenya hospitals and health centres, private, mission, and NGO hospitals and health centres. These guidelines are also intended to cover VCT services provided by what is called ‘free-standing’ or ‘stand-alone’ VCT sites, which offer VCT services as their main service and are not part of an existing health facility. These stand-alone sites are often operated by NGOs. These
guidelines are not intended to cover the testing procedures for clinical care, such as for hospitalized in-patients; routine testing situations, such as the testing of prospective blood donors or pregnant women; or mandatory testing during medical exams for employment, insurance, international travel and so forth. Separate guidelines for these situations are being developed.
Section 1
Guidelines for operational procedures for VCT services

**National and local overview of VCT services**

- The Ministry of Health AIDS Control Unit (MOH/ACU), in coordination with the National AIDS Control Council (NACC), shall convene monthly meetings of the National VCT Technical Task Force to ensure national and local coordination of VCT services in Kenya.
- Every provincial health management team and district health management team (DHMT) should select one person to be the coordinator of VCT services for that area. In some cases, this may be the district AIDS and STI coordinator, but other persons concerned about HIV and AIDS may be selected. The VCT coordinator is responsible for ensuring that these national guidelines are followed and that all VCT standards are met.
- The district VCT coordinator should convene a regular meeting of VCT service providers in the district to review experiences, resolve any problems encountered in the delivery of VCT, and make plans for additional expansion of VCT services in the district. This meeting should be monthly if possible, or bimonthly at a minimum.
- A national VCT supervisory checklist involving such issues as supply of test kits, allocation of counselors and confidentiality of record keeping shall be used by the VCT coordinator in each district.

**General guidelines for provision of VCT services**

Registration and client flow: When patients or VCT clients request VCT, whether in a health facility or in a free-standing VCT site, they should be referred to the VCT registration desk. The receptionist should be trained to explain procedures to the client and explain how long the person will wait, although the receptionist should not engage in any counseling and should refer any questions to the counselor. Educational materials about VCT and HIV, such as posters, brochures, and video shows, should be available while the client waits to see a counselor.

Waiting period: All VCT sites should endeavour to provide same-day or even same-hour results to clients. This can be accomplished by using the latest generation of test kits. Clients should be able to receive their results within two hours; however, clients should not be pressured into receiving same-day results if they are reluctant to do so. During the pre-test counseling session, clients should be informed that their results will be ready within one to two hours, and they should be encouraged to stay at the VCT site for their results and post-test counseling. When a counselor determines that a client is not ready to receive same-day results, or if a client declines them, the counselor should encourage the client to return on another day to
be tested and to receive the results. (More discussion of same-day testing can be found in Section 3, ‘Guidelines for HIV testing for VCT sites’.)

Informed decision making: In both free-standing VCT sites and those integrated within health facilities, all efforts must be made to ensure that clients understand that an HIV test is to be performed. Although patients in health facilities may not request the test themselves, pre-test counseling should be provided to all clients, and VCT clients should make an informed decision about accepting an HIV test. Those who agree to a test or request a test should give informed consent to the testing procedures. Even if recommended by the health worker, clients may decline an HIV test.

Informed consent: VCT sites should endeavour to document that all persons being tested have voluntarily and freely consented to being tested. The most important aspect of informed consent occurs within the pre-test counseling session, when the counselor should explain the procedure and make sure that the client is requesting VCT without any coercion. If possible, a form should be used documenting that the client has given informed consent to the procedure. When anonymous testing is used, clients are usually not required to sign their name to an informed consent document, and in these cases clients should be asked to mark an ‘X’ on the form or have their fingerprint taken on the form if they are willing to do so.

Confidentiality and anonymity: It is essential that confidentiality be maintained when conducting HIV testing of any type. This can be achieved in two ways. One is through strict confidentiality, maintaining very strict controls over access to the client’s name and test results, and releasing results to others, such as other health workers, only if the client agrees. The other method is to practice anonymity, which is the method used when no names are taken, and only code numbers are used. In most countries with VCT programmes, it has been found that more clients will request VCT when their names are not recorded and anonymity is practised, and thus it is recommended that anonymous procedures be used at VCT sites in Kenya.

However, when VCT services are an entry point for other medical services, such as the prevention of mother-to-child transmission, TB treatment and prevention, or prevention and treatment of opportunistic infections and other sexually transmitted diseases, it may be in the best interests of the client for the name to be taken so that appropriate referrals can be made. However, VCT clients should be given the opportunity to decline a referral if they do not want their name and HIV status to be disclosed. Regardless of whether a code number or the actual name is used, the same standards of confidentiality must be maintained.

Confidential procedures: VCT sites, especially those located within health centres and hospitals, should ensure that clients requesting VCT services are not readily identified to the public or by other patients using the health centre by the fact that they have requested VCT. Confidentiality in VCT services involves not only using code numbers but also managing the waiting room and client-flow procedures in such a way to maintain confidentiality of the testing.
Disclosure of VCT results: In general, HIV test results should be disclosed only to the client. Refer to additional discussion on disclosure of test results in appendix 1, ‘Confidentiality in VCT sites’.

Written results: VCT sites should not provide written results. In general, voluntary counseling and testing sites and centres should not be used for mandatory testing, such as for pre-employment, insurance, educational or travel-related testing. The focus in VCT sites should be to help persons make better decisions about their sexual behaviour and to reduce risk of HIV transmission. For this reason, it should not be necessary for a VCT site to give written results, especially to HIV-negative clients. Clients requesting testing for official reasons such as employment or to obtain a visa should be referred to a laboratory for this type of testing. However, these clients can be encouraged to first learn their serostatus at the VCT site, with the understanding that they will need to be tested again at an official laboratory to receive written, certified results.

Confidential record keeping: Clients’ records must be stored securely. Only personnel with a direct responsibility for client’s medical condition should have access to the records. All personnel with access to medical records on which HIV test results are recorded should be trained in procedures to maintain confidentiality of HIV test results.

Minimum age: Anyone 18 years of age and above requesting VCT should be considered able to give full, informed consent. Young people under 18 who are married, pregnant, parents, engaged in behaviour that puts them at risk or are child sex workers should be considered ‘mature minors’ who can give consent for VCT, although the counselor should make an independent assessment of the minor’s maturity to receive VCT services. The counselor should also bear in mind the availability of follow-up support services. It is highly recommended that testing of minors under 18 who are not mature minors, especially those under 15, should be done with the knowledge and participation of their parents or guardians. Counselors providing services to adolescents and minors should receive additional training on the unique issues relating to HIV testing and counseling for youth. VCT sites should work to ensure that there are appropriate support services for minors who have received VCT.

Testing of children: When children who are brought to a VCT site for testing, the counselor should meet with the parents or guardians to determine the reasons for testing. The welfare of the child should be the primary concern when considering testing a child. Counseling should be provided to the parent or guardian, and referral for testing the child should be made to appropriate medical or child welfare services.

Persons of unsound mind: Persons who request VCT services but are found to be of unsound mind should be offered counseling but not testing. This includes persons under the influence of alcohol or illegal drugs and persons who are mentally impaired. Such persons cannot give true informed consent for testing when they are of unsound mind. They may be given counseling, and if appropriate, asked to return for VCT when they are no longer mentally impaired.
Partner notification: All VCT clients, both HIV positive and HIV negative, should be encouraged to inform their sexual partners of their test results. The counselor should encourage all clients to bring in their partner or partners for couple counseling and testing. Learning HIV test results together is the best way for partners to learn of each other’s status. Especially for HIV-positive clients who are reluctant or fearful about disclosing their results, the counselor should offer additional, ongoing counseling to help the client inform partners. If the client requests, a counselor may inform a sexual partner of the client about the test results, in the presence of the client.

Confidential referrals: Counselors in VCT sites should be familiar with additional, follow-up services available in their communities and should be able to make specific referrals, based on the client’s needs. When VCT services are an entry point for other services, such as the prevention of mother-to-child transmission, early detection, prevention and treatment of opportunistic infections including TB, and home-based care, it is usually preferable to give the client’s name. This can be problematic in a VCT site that observes anonymous VCT. The counselor should ensure that the client understands the reasons for giving the client’s name on the referral letter, and clients should consent to giving their name to the providers of additional services. Referrals to other services should be based on the client’s specific needs, life situation and test results. VCT counselors should ensure that organizations to which they refer and release the client’s name and test results are practising careful procedures for confidentiality of test results. When possible, such referral letters should be addressed to a specific provider of additional services who can be trusted to observe confidentiality and who is known to treat HIV-positive persons with respect and consideration. Clients should be given the opportunity to decline a referral if they do not wish their name and status to be disclosed. Regardless of whether a code number or the actual name is used, the same standards of confidentiality must be maintained.

Detection and treatment of other STIs: VCT services should take an active role in detecting and treating other sexually transmitted infections (STIs) and diseases (STDs). It is highly recommended that STI screening be offered to all VCT clients, and when possible, syphilis testing should be performed on the same blood sample as that used for HIV testing. If possible, on-site syphilis treatment should be offered immediately to any VCT client testing positive for syphilis. During registration, VCT clients should be informed about STI services available on site, and should be informed that both HIV and syphilis testing will be performed. The counselor should also inform the client that syphilis testing will occur, and the importance and benefits of being tested for syphilis. Clients should have the opportunity to refuse syphilis testing if they object to it.

Tuberculosis screening and referral: All VCT sites should maintain close links with the local TB control office, and all HIV-positive VCT clients should receive counseling and health education about the risks of TB. TB screening should be provided as soon as possible to all HIV-positive VCT clients. Screening for TB should follow the National Leprosy and TB Programme guidelines and any cases identified should be put on treatment as required. TB preventive therapy for HIV-positive clients should be provided following the WHO/UNAIDS 1998 Guidelines for TB Preventive Therapy.
(appendix 4). Staff of the TB control programme should be trained in maintaining confidentiality of HIV test results and the importance of maintaining a respectful attitude to all TB and HIV clients.

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

Preventive therapy for opportunistic infections: National guidelines for the management of HIV-positive patients should be followed for preventive therapy for opportunistic infections.

Networks of referral agencies and support services: VCT providers should actively work to ensure that they become part of existing networks of relevant services. If they do not exist, the VCT site should work to develop such networks, services and directories of services to ensure that VCT clients can receive ongoing supportive services. In addition to the services listed above, VCT clients may also need referral to agencies and organizations involved in treating alcohol and drug dependency, providing mental health services, and offering legal assistance. Some VCT clients, especially those who are HIV positive, may also benefit from ongoing group or individual therapy and other services, such as supportive counseling, nutritional education and food supplementation. Although the VCT site may not be able to provide all of these services directly, the VCT site manager and counselors should take an active role in ensuring that these services are available to VCT clients in need of supportive and ongoing services. A two-way referral system with agencies providing these services should be encouraged between the VCT site, existing PWA support groups in the VCT site catchment area, and regular meetings between these agencies should be encouraged.

Mobile outreach VCT: For special populations, such as pastoralists, or in remote rural areas with limited health facilities, mobile VCT services should be considered. Agencies providing mobile VCT should ensure that there are adequate follow-up services. Creative and innovative approaches to providing follow-up services may be required in these situations. Mobile VCT services should consider an integrated package of primary health services, including STD detection and treatment, child health screening and antenatal care.
VCT and human rights: Increasingly it is recognized that public health often provides an added and compelling justification for safeguarding human rights. In the context of HIV/AIDS, an environment in which human rights are respected ensures that vulnerability to HIV/AIDS is reduced, those infected with and affected by HIV/AIDS live a life of dignity without discrimination, and the personal and societal impact of HIV infection is alleviated. One aspect of the interdependence of human rights and public health is demonstrated by the fact that people will not seek voluntary HIV counseling and testing, treatment and support if they risk exposure and discrimination. HIV/AIDS often affects certain populations more—for example, drug users, prisoners, sex workers, men who have sex with men, refugees and displaced persons and migrant workers. Lack of human rights protection makes it difficult for such groups to avoid infection and to cope with HIV if affected.

Staffing and management of VCT sites

Management of VCT sites: VCT sites located within health centres or hospitals should be managed by the person in charge of the clinic or department where the VCT services are provided. VCT sites that operate as stand-alone sites should be managed by the director or person in charge of the site. A team approach to management, involving counselors, laboratory technicians and others involved in providing the VCT service, is encouraged.

VCT team training and building: The emphasis in all VCT sites should be on building a strong, multidisciplinary, multisectoral team for VCT services. The team should include the site manager, counselors, laboratory technicians, receptionists, volunteers, and if possible, persons living with HIV/AIDS. Including representatives of local organizations that provide related HIV/AIDS services in the community and other community organizations and leaders should be considered.

Selection of VCT counselors and recommended staffing

- A minimum of two staff per VCT site should be selected to serve as VCT counselors.
- Volunteer VCT counselors may participate in providing VCT services, but there should be at least one employed VCT counselor per site. Volunteers should be interviewed before they are assigned and should receive the same training and supervision as employed VCT providers and counselors. VCT site managers should assign the volunteers clear and regular duties and working hours.
- The management of the VCT site should participate in selecting those to be trained as VCT counselors. Those selected should be seriously interested in providing VCT services and should be patient, understanding, respectful of clients and genuine in their attitude.
- The VCT site management should be willing to allow those selected to devote most of their time to providing VCT services.
- In selecting counselors, those who are HIV positive should not be discriminated against because of their serostatus.
VCT counselors do not necessarily require prior training as health workers; they may be teachers, social workers, community workers and volunteer AIDS workers. Laboratory technicians or technologists involved in VCT testing may also be trained in VCT counseling if they are interested in counseling and have the recommended qualities. It is preferable and encouraged that those selected at VCT providers and counselors be willing to get tested themselves, voluntarily, both for their own personal risk-reduction planning and to understand VCT as a consumer. However, being tested should not be mandatory for selection as a VCT counselor.

Training of VCT counselors

Health workers and others selected to provide VCT counseling must take the VCT Counselor Course of three weeks or 124 hours. Counselors who meet certain qualifications may be trained in a shorter course that focuses on specific VCT counseling, risk-reduction counseling, use of rapid whole-blood tests, and management of VCT services. All staff selected to serve as VCT counselors should receive adequate training so that they are qualified to perform the work. Plans should be in place for ongoing training so that VCT counselors know that they will receive continuous, ongoing training to improve their skills. All VCT counselors should be trained using the National VCT training guidelines and curriculum prepared and approved by NACC, NASCOP/ACU-Ministry of Health and the Kenya Association of Professional Counselors (KAPC). These guidelines should be used for all VCT-related training in Kenya.

Selection and training of personnel to conduct testing

Two persons per site should be trained in conducting the simple, rapid tests recommended for VCT purposes. If possible, at least one should be a laboratory technician. In low-volume sites that do not justify assigning or employing a full-time laboratory technician or in those settings in which there are no laboratory technicians, counselors may be trained in conducting the simple, rapid tests. It is recommended that counselors selected for training in conducting the tests be health workers (nurses) when possible. When counselors conduct the testing, they should be supervised regularly by a trained laboratory technician or technologist. When the numbers of VCT clients warrant, a laboratory technician should be assigned to conduct the testing for VCT purposes. Regardless of which personnel actually conduct the tests, the VCT site should ensure that all clients receive their results as quickly as possible, within one hour if possible, and on a same-day basis as a routine. Appropriate staff should be trained in conducting the testing to ensure that this goal is achieved.

Training of ancillary staff: All staff and volunteers involved with the VCT site, including the receptionist, drivers, medical records officers and secretaries should receive basic introductory training in the role and purpose of VCT, how services are delivered, basic communication skills and the need to observe strict standards of
confidentiality, not only for results but also regarding who has requested VCT services.

**Support supervision of VCT counselors**

- VCT counselors should have access to regular support supervision, with at least one supervisory session every two to four weeks. Sessions may be provided in a group setting with other VCT counselors, although every counselor should have access to one-to-one support supervision when needed. Ideally, the group supervisory sessions should involve no more than 10 VCT counselors.
- All programmes or projects providing VCT should make appropriate arrangements and allocate resources for supervision of VCT counselors.
- At least two support supervisory counselors should be selected per district. If possible, they should have the following qualifications:
  - minimum of the nationally recognized certificate course in counseling and additional training in VCT related counseling
  - minimum of six months experience in VCT counseling
  - should be a practicing counselor in their daily work
  - should have the same interpersonal skills and qualities of a counselor, and should be patient, understanding, respectful of clients, and genuine
  - should have adequate administrative and management skills
- Those selected as supervisory counselors should be in a position to actually work as a supervisory counselor. Those persons already in positions of management and those with many duties already should not be selected as supervisory counselors.
- Those selected as supervisory counselors should receive a course in support supervision and be interested in furthering their own training in counseling.
- The primary responsibilities of these support supervisors will be to provide emotional support and professional feedback and guidance to VCT providers. Their role will not be to provide administrative supervision.
- These VCT support supervisors may be Ministry of Health or NGO staff. The district VCT coordinator should oversee that support supervision is provided in each district.
- General problems that the support supervisors identify in administering or managing VCT sites will be reported to the district VCT coordinator.

**Professional advancement:** VCT providers who demonstrate interest and skills in VCT work should be given the opportunity take the certificate counselor training course. Beyond that, VCT counselors should continue to have opportunities for advancement in their field, such as additional training in counseling, supervision and VCT centre management.

**Recognition of the value of counseling work:** VCT site management, the DHMT, and all those involved in providing VCT services should recognize the value and importance of counseling work. Other health professionals should treat VCT counselors as respected professionals and integral members of the health team at each site.
Counseling rooms: Each VCT site should provide adequate space for VCT services. Counseling rooms should be private, quiet, well lit and ventilated, and supplied with presentable furniture, with a minimum of a small desk and three chairs. More chairs should be provided if the demand for VCT necessitates group pre-test counseling.

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

Occupational risks: Every measure should be taken to reduce the risk of occupational transmission of blood-borne diseases and TB. If adequately trained and appropriately supervised, VCT counselors may be asked to draw blood and conduct simple, rapid HIV tests. Counselors who perform this work should do so only after thorough training in these tasks. Protective material, especially gloves, should always be provided. Counseling rooms should be well ventilated. It is desirable that VCT staff receive hepatitis B immunization. VCT service providers should follow the national guidelines on post-exposure prophylaxis for HIV.

Periodic medical screening of VCT providers: Recognizing that VCT providers, including counselors, laboratory technicians, receptionists and volunteers, may be exposed to other diseases in the course of their work, efforts should be made to ensure that VCT providers receive routine preventive health screening, especially for TB. They should be trained in measures they can take to reduce their exposure to communicable diseases. They should have ready access to HIV testing and TB screening. VCT providers who are HIV positive should be provided access to preventive services such as TB preventive therapy, medication to prevent opportunistic infections, and ongoing medical support.

Psychological support of VCT counselors: Recognizing that VCT counseling is often stressful, all VCT sites should put in place measures to provide psychological support for VCT counselors, such as regular support supervision sessions. HIV-positive counselors should have access to additional support to assist in dealing with psychological issues that occur as a result of their work. All VCT counselors and supervisors should have ongoing opportunities for personal growth and self-awareness to improve the quality of their performance.

Regular meetings: VCT sites should schedule regular meetings (weekly or biweekly) to discuss issues relating to VCT services, site management, community referrals, and so forth. Time should be set aside so that all counselors and other VCT support staff, including the person in charge of the facility, laboratory technicians, record clerks and receptionists can attend such meetings together. These meetings
may also be used to provide in-service training for staff. Additionally, it is recommended that a monthly meeting be held with representatives of all VCT sites in a district, to discuss issues relating to providing VCT services in the district. All district VCT supervisors should attend these monthly meetings.

Time: VCT counselors should not work in excess of 40 hours weekly. If counselors work late hours or on weekends to accommodate clients, their work schedule should be adjusted.

Workload: VCT counselors should ideally see no more than 10 VCT clients per day. However, it must be recognized that at times, there may be large numbers of clients requesting VCT services. If the workload on a particular day is more demanding than this, the counselors' supervisor should make arrangements for adequate recuperative time. VCT sites where counselors regularly must see more than 10 clients daily should arrange for additional counselors to be trained and assigned to work in the site.

Specific guidelines for VCT sites located within health facilities

Confidentiality: In health facilities offering VCT services, it may be more practical to use name-based confidential record-keeping rather than use anonymous systems as are used in stand-alone or free-standing VCT sites. If names are used, every effort must be made to ensure that the records are confidential and that only counselors and health-care providers who have a need to know the test results have access to them. The purpose of taking names is to facilitate referral for other services, such as prevention of mother-to-child transmission or TB screening and is not for the purpose of identifying persons with HIV infection.

Fees and cost sharing: When possible, it is recommended that VCT services be provided free of charge, especially in low-income communities. An affordable fee may be charged to enhance the sustainability of VCT services, but the fee should not be a barrier to access to services. If a health facility charges a fee, it should be approved by the facility management. If it is a government facility, the fee should be approved by the District Health Management Board and the District AIDS Control Committee, and guided by national policies. The fee should be posted clearly so clients know in advance what it will be, and receipts should be given. If a fee is charged, discounts or waivers should be put in place to render free services for clients unable to pay. Free days may also be considered as a way of attracting clients for whom a fee would represent a barrier to using VCT.
Specific guidelines for stand-alone VCT sites

Anonymous procedures: At free-standing VCT sites, it is recommended that anonymous procedures be used and no names taken. Code numbers should be used to identify the VCT client.

Fees and cost sharing: Free-standing VCT sites may charge a fee if approved by the agency running the site. If a fee is charged, the fee should be posted clearly so clients know in advance what it will be, and receipts should be given. If a fee is charged, measures such as free days should be put in place to offer free services for clients unable to pay. Counselors should be able to waive the fee if they determine that the client is unable to pay but that there will be a personal or public health benefit if the test is provided. The District Health Management Team and the District AIDS Control Committee should actively discourage overcharging.
Section 2
Guidelines for HIV test-related counseling

Pre-test or test-decision counseling guidelines

General information about VCT should be provided to groups in the course of general health education talks, such as those held at health centres and antenatal clinics (ANCs). Individual pre-test counseling or counseling on the decision to take the test should be provided to all those requesting VCT, including those involved in providing VCT or other health services.

If demand at a VCT site is very high, group pre-test counseling can be provided if the following conditions are met:

- All clients consent to having pre-test counseling as a group.
- Measures for privacy are adequate.
- No more than six people are placed in a group.
- When possible, efforts should be made to compose groups of clients with similar ages and of the same sex.

Issues to be discussed in the pre-test or test-decision session include:

- basic facts about HIV infection and AIDS
- meaning of an HIV test, including the window period
- reasons why the client is requesting VCT
- HIV testing procedures at the site, including whether or not written results will be given

Since rapid tests give same-day results, a prevention counseling session should be held while the test is developing. Issues to be discussed include:

- basic HIV prevention
- personal risk assessment
- client's readiness to learn serostatus
- client's intentions after learning test results
- exploration of what the client might do if the test is positive, and the possible ways of coping with a HIV-positive result
- exploration of what the client might do if the test is negative and possible ways of staying uninfected
- exploration of behaviour change
- client's reproductive intentions and the role of family planning
- exploration of potential support from family and friends
- condom use, including condom demonstration
- any special needs discussed by the client
Post-test counseling guidelines

Readiness for results: Before disclosing the test results, the counselor should ensure that the client is truly willing and ready to receive the results and understands what both positive and negative test results mean.

Giving test results: The results should be available to the client the same day, and every effort should be made to reduce the waiting time for the client. The counselor should give the test results calmly, in a quiet, private setting. Every opportunity should be given to allow the client to express their feelings about the test results and any other personal issue. There should be ample time for the client to ask questions about the meaning of the test results and any other issues. One-to-one or couple counseling can be used to give results, depending on the clients’ preference. Clients may specifically request that a family member, friend or other supportive person be in the room when they receive results, although the counselor should make sure that this is what the client truly wants.

Positive living: All HIV-positive clients should be counseled about ‘living positively with HIV’, which includes maintaining a positive attitude, avoiding additional exposure to the virus and other STIs, taking good care of themselves medically, eating a good diet, joining PLWHA (persons living with HIV/AIDS) organizations and other social support groups.

Risk-reduction planning: Every post-test counseling session should include the development of a risk-reduction plan specific to the client’s test results and personal life situation. The counselor should help the client understand the importance of avoiding future risky exposure to HIV.

Window period: Clients who test negative but whose behaviour has recently been risky or who know they have been exposed to HIV should be encouraged to return for additional testing within three months to make sure that they are truly uninfected. The counselor should explain about the window period, and make sure that these at-risk but currently HIV negative clients understand the importance of follow-up testing. Clients who may be in the window period should be encouraged to reduce their risk during this period. However, HIV negative clients with no recent possible exposure to HIV do not need to be told to come for confirmatory testing.

Partner notification: The counselor should encourage the client to bring in their partner (or partners) for couple counseling and testing. See the page 4 paragraph ‘Partner notification’ for more discussion of this topic.

Family planning counseling and education: Information on family planning, its role for both HIV-positive and HIV-negative clients, and how to have access to services should be included in VCT counseling sessions. If possible, family-planning services should be provided at VCT sites. If the client is negative, during post-test counseling the counselor should encourage good reproductive behaviour that promotes good health. The counselor should reinforce the client’s use of family planning, if already using a method, and additionally counsel for condom use, if the client is at risk of HIV/AIDS. If the HIV-negative client does not wish to become pregnant but is not
using a family-planning method, she should be referred to an appropriate family-planning service.

If the client is HIV positive and female, the risks of pregnancy should be clearly explained and she should be made aware of risks to herself and to the unborn child if a pregnancy is carried to term. The counselor should know where to refer the client for a full range of family-planning methods, including long-term or permanent methods. It is important to ensure that the client understands the choices available and can make her own decision.

Condom education and distribution: Condom education, demonstration and distribution should be part of every post-test counseling session, and all clients, both HIV positive and HIV negative, should be given condoms during the post-test session. The dual protection against HIV and against unwanted pregnancies should be emphasized. However, clients who refuse condoms should not be coerced to receive them.

Additional counseling sessions: VCT clients, both HIV positive and HIV negative, should be encouraged to return for additional counseling and prevention education. It should be recognized that many VCT clients need time to absorb their results, and additional counseling sessions may be beneficial for all clients. VCT centres should have an open-door policy for their clients for ongoing supportive counseling. Such additional counseling should deal with both health and non-health issues, including legal and workplace problems the client may encounter.

Referrals: The counselor should make appropriate referrals to additional services as needed, such as medical, social, legal, spiritual and psychological support if the counselor determines that these services would be helpful. Especially for clients who are HIV positive, post-test support services should include treatment services for TB, opportunistic infections and other sexually transmitted diseases. See paragraphs ‘Confidential referrals’ (p. 5), ‘Tuberculosis screening and referral’ (p. 5) and ‘Networks of referral agencies and support services’ (p. 6).

Special circumstances for VCT services

Premarital VCT services

Premarital VCT should be encouraged in all sectors of society but should remain voluntary. Confidentiality of results should be maintained.

It is preferred and recommended that premarital VCT occur with the couple receiving their results together. However, no VCT client should be coerced to reveal results to a prospective marital partner. If the clients are reluctant to reveal the results to each other, individual VCT should be encouraged as a first step, with the hope that the couple will later request couple VCT or that the couple will reveal results to each other before they marry. A thorough discussion should take place in the pre-test counseling session about the potential implications of test results on marriage decisions.
Efforts should be made to protect the rights of individuals and couples who are HIV positive, and to prevent negative outcomes for HIV-positive individuals and discordant couples (couples where one partner is positive and one negative) as a result of premarital VCT.

Additional counseling services are recommended, both individual and couple sessions, for those who test HIV positive during premarital VCT. For couples who are either discordant or both HIV positive and intend to have children, the counselor should explain methods to reduce the risk of mother-to-child transmission and where such services are available.

It is recommended that HIV-negative couples receive counseling on how to avoid HIV infection in the future, including discussions of positive patterns of sexual life within marriage. Religious leaders including pastors and imams should be educated about the benefits of premarital VCT, location of the services, and how to discuss premarital VCT with couples, families and the community. Education about premarital VCT will emphasize that the role of religious leaders is to encourage couples to know their serostatus, not to regulate who is allowed to marry.

Written HIV results will not be provided to those requesting premarital VCT. With consent, HIV test results will be revealed to the couple together so that they learn their own serostatus and that of the intended marital partner. Religious leaders and the community will be educated about the fact that written results are not provided and that they should rely on what the couple voluntarily informs them of their VCT results.

**Adolescents and VCT**

Adolescents are a special group. They are starting sexual activities and can be guided into safe practices. Adolescents should be encouraged to delay their sexual debut and practise abstinence. Those already engaging in sexual intercourse should be advised to discontinue sexual activity, engage in less risky practices or use condoms. All those involved in providing VCT to adolescents should be aware that adolescent girls are more vulnerable biologically and socially to HIV transmission. The considerably higher rates of HIV infection in young women should alert counselors to the special circumstances and needs of young girls. The VCT counselor should also consider the particular vulnerability of the girl child involved in commercial sex work.

**Adolescent-friendly VCT sites:** Both the staff and the site should be ‘adolescent friendly’, understanding, non-judgemental and accepting of adolescent language, dress and behaviour. All VCT staff should be respectful of the feelings and emotional turmoil that adolescents commonly experience. When possible, youth drop-in VCT centres should be established, and existing youth drop-in centres should be encouraged to add VCT services on site.

**Links with other agencies:** VCT sites should make contacts with schools, community centres and so forth. Outreach to sites where youth are present should be made to explain the role and value of VCT.
Referral to youth network: VCT sites should compile a register of the local youth network so that adolescents may be referred for other activities. VCT providers should work to ensure that adequate youth-friendly services are available.

Age of consent: Please refer to paragraph 'Minimum age' (p. 4) for a discussion of age of consent for adolescents.

Condoms: Condoms should be easily available in the VCT site, and the counselor should provide condom education and demonstration during all counseling sessions unless the client specifically refuses. Adolescents who decline the offer should not be coerced. Both free and socially marketed condoms should be available, and VCT sites may consider selling condoms as a form of income generation. When available, female condoms should also be provided.

**Couple counseling and VCT**

Couple counseling should be encouraged, not only for those planning to get married, but also for those already in a relationship who wish to make informed decisions about having children, selection of family planning methods and generally for those who want to work on their relationships and plan their future. Couples should not be coerced into being counseled together but should be given opportunity to make informed decisions about it. Confidentiality is important, and couples should be informed about what it covers and its limits.

The counselor should attentively listen to the couple as they explain why they have come for the test. Each partner in the couple should be given equal opportunity to talk and ask questions, and the counselor should be non-judgemental and respectful in responding to the couple. Couples should be given the relevant and accurate facts about HIV/AIDS to help them make informed decisions.

They should be helped to explore the implications their test results may have on their relationship, marriage, sex life, family planning and plans for childbearing. Partners in a couple should be given the opportunity for individual sessions as some may find it threatening to explore their current or past sexually risky behaviour in the presence of their partner. Couples should also explore together the practicability of any changes in their sexual practice like abstinence, condom use or non-penetrative sex.

Sharing results: Couples who come together for VCT should be given their results together, unless they express a preference to receive the results separately. A client’s status should not be disclosed to their partner without their consent. Counselors should ensure that both members of the couple have come voluntarily. If the counselor is concerned that one member of the couple has been coerced, the counselor should encourage the couple to return when they are both ready for VCT. Couples should be encouraged and supported to take the responsibility of discussing the implications of the results on their relationship. They should be encouraged to openly disclose their results to other relevant persons, such as their children, the family, the doctor or nurse, and they should explore the implications of doing this.

Referral: Couples, both HIV positive and HIV negative, should be referred for medical, social, legal, spiritual and psychological support if the counselor determines
that these services would be helpful. Marital counseling may also be helpful for these couples, and the counselor should be aware of any providers of marital counseling in the area to facilitate referral. Information about preventing mother-to-child transmission (PMCT) programmes should be provided when appropriate.

**Discordant couples**

Counseling procedures: Procedures should provide a safe and trusting environment where the couple can feel free to express their feelings. The counseling should maintain confidentiality and encourage the couple to disclose their HIV status to each other. The counselor should not take sides and should be respectful and understanding if conflicts or arguments arise between the couple during the session. There is need to discuss the window period and need for retesting, especially of the HIV-negative partner. Relevant and accurate information about HIV/AIDS should be given and the couple helped to make informed decisions regarding their health, family planning, childbearing and safer sex.

Disclosure: There is need to be patient and understanding with the partner who is HIV positive and is reluctant to disclose to the partner at first. Most people if supported and helped to explore the costs and the benefits of disclosure to their partner usually disclose in the end.

Prevention of further transmission: The counseling session should include discussion of the role of consistent condom use in preventing HIV transmission to the uninfected member of the couple. These couples should be taught that inconsistent condom use provides much less protection than using condoms every time they have sex. For couples that refuse to use condoms, abstinence should be discussed.

Referral: The counselor should make referrals for medical, psychological, social and spiritual support for all discordant couples. If available, marital and family counseling may also be of benefit.

**Testing during pregnancy and to prevent mother-to-child transmission of HIV**

VCT service sites, especially those in health facilities, may serve as the entry point for antenatal mothers to be screened for HIV, and then enrolled in PMCT programmes. In this situation, the mother’s name and HIV test information may be recorded on her card. Strict procedures for maintaining confidentiality of test results must be observed in this setting, as otherwise mothers may decline HIV testing and thus forgo the opportunity for preventing mother-to-child transmission. Unlike the situation in stand-alone VCT sites, pregnant women may have come to the site for regular ANC services and may not be expecting or requesting HIV testing. The counselor must ensure that the mother thoroughly understands the benefits and risks of HIV testing and understands the additional services she will receive if HIV positive. To the extent possible, mothers should be offered the opportunity to learn their test results immediately, although they should also be given the opportunity to learn their test results on the next ANC visit if they are not ready to receive results. VCT counselors in a PMCT or ANC setting should follow the national PMCT guidelines.
Other special circumstances

Request for testing only: When clients request testing but decline counseling, the counselor will explain that VCT services are provided as a package including both counseling and testing. The benefits of counseling should be explained, and the client should be encouraged to return when the client has more time and is ready to accept the full package of counseling and testing together.

Request for counseling only: Some clients may request counseling only and decline to be tested. This service should be provided without any pressure or coercion for testing.

Repeat testing: Clients should be encouraged to disclose if they have been to other centres for HIV testing. The reasons for seeking repeat testing should be explored with clients who have been tested elsewhere. Clients who seek repeated testing should be counseled about the reasons they continue to seek testing, and unnecessary repeat testing should be discouraged.

Quality assurance for counseling services

Tools should be developed to assess the quality of VCT counseling services, such as client exit interviews to assess client satisfaction, counselor self-assessment tools, supervisory sessions and other methods to assure the high quality of VCT services. Such tools should be used regularly to assess and monitor the quality of counseling provided to VCT clients. The VCT site manager shall be responsible for ensuring the quality of VCT services.
Section 3
Guidelines for HIV testing

Recommended types of tests: HIV testing at present may be done using whole blood, serum, plasma or oral fluids. Currently, it is recommended that rapid, whole-blood tests be used as much as possible with approved, rapid, simple tests that give results in less than 30 minutes. It is preferable that clients be informed of test results on a same-day basis. Hospitals and health centres that can perform same-day ELISA testing may continue to use these types of tests. Traditional, machine-read ELISA tests should be reserved for the hospitalized in-patient.

Recommended test kits: It is recommended that rapid test kits used for VCT testing meet the following specifications: be approved by the government, be rapid with simple procedures, be a whole-blood test, do not require electricity to run, and require refrigeration only in hot climatic conditions.

Non-blood sample testing: As additional tests are developed and available, NASCOP in collaboration with the National Public Health Laboratories (NPHL) and the Kenya Medical Research Institute (KEMRI) will evaluate the performance of tests using oral fluids or urine. Such tests will not be introduced for VCT purposes until pilot testing has been done, both to confirm laboratory performance and to assess client response to such testing methods.

Approval of new test kits: As new HIV test kits are developed and available, the normal procedures for approval for new test kits will be followed. The Office of the Director of Medical Services, Ministry of Health, will issue certificates of approval for HIV test kits based on the recommendation of NPHL and NASCOP/ACU-Ministry of Health after the relevant advisory technical committee has completed its evaluation. Procedures for approval of new test kits are available from NASCOP/ACU-Ministry of Health and the National AIDS Control Council.

Testing algorithms

- **Serial testing**: One screening test may be used and then all positive samples should be confirmed with a different rapid test. When whole-blood tests are used, this may mean drawing two fingerprick blood samples from clients or an additional fingerprick sample for those who test positive or indeterminate on the first test. Every effort should be made to ensure confidentiality of this process so that other clients and staff cannot guess at a client’s serostatus on the basis of who is asked for a second fingerprick.

- **Parallel testing**: Whenever possible, two different whole-blood tests should be used for every VCT client. Using this method, all results will be confirmed, both HIV positive and HIV negative.

- **Discordant results**: When there is discrepancy between the first two HIV tests, a third, different test should be performed immediately, if such a test is available. In addition, all clients who have discordant results on the first two tests should be asked for a venous sample for additional testing at a referral laboratory for
confirmatory testing. The counselor should ask the client if they are willing to give their name and contact information to ensure that the client learns the results of the additional tests. In addition, these clients should be asked to return for repeat testing after three months. Every VCT centre should have a system in place to send samples to a referral laboratory in the case of discordant results. A referral laboratory should have the capability to perform standard ELISA tests and at least two rapid tests.

Window period: Clients who test negative but have had recent risky behaviour or known exposure to HIV should be encouraged to return for additional testing within three months to make sure that they are truly uninfected. The counselor should explain about the window period and make sure that these at-risk but currently HIV-negative clients understand the importance of follow-up testing. However, HIV-negative clients with no recent possible exposure to HIV do not need to be told to come for confirmatory testing.

Test performance: It is recommended that all HIV testing for VCT be done by laboratory technologists or technicians. However, in some locations and settings this is not possible. In addition, some VCT clients may strongly prefer that only their counselor know their test results. If they are properly trained in testing procedures, and supervised by a laboratory technologist, nurses and counselors may perform simple, rapid tests for VCT purposes. All precautions to protect against blood contamination should be observed.

Supervision: Laboratory technologists trained in laboratory supervision should provide supervision to any staff performing HIV testing. Such supervision should occur at a minimum of once monthly, and more frequently if problems are identified.

Related testing: When possible, clients should be tested for syphilis in addition to HIV, using whole-blood syphilis tests if available. Clients should be informed that syphilis testing is available, but that they can refuse it. If a VCT client is syphilis positive, they should be treated immediately, if at all possible. Additional whole-blood testing for other STIs should be introduced when possible and available. All HIV-positive clients should be asked about cough and other symptoms of TB and referred for TB testing if necessary. It is recommended that NASCOP and the National TB Control Programme work together to extend TB testing (not only sputum) to all provinces.

It is recommended that between 3 and 5% of samples be retested at a laboratory certified to conduct quality-control testing. When possible, this quality-control testing for each district should be done at the relevant provincial general hospital. Results of quality control testing should be submitted to NASCOP/ACU-Ministry of Health and NPHL for national monitoring. In addition, results of the quality control testing should be shared with the DHMT in each district. Both HIV-positive and HIV-negative samples should be included in the sampling for quality control. The filter paper technique may be used to collect whole-blood samples if approved by the NPHL.
Safety precautions: Strict laboratory safety precautions should be followed based on recommendations adopted by NPHL, according to the level of the site. Each site should have on hand a site-appropriate guide on laboratory safety precautions.

Logistics

- Communication: Facilities for communication should be introduced between the VCT sites, the district VCT coordinators and NASCOP/ACU-Ministry of Health and NACC, so that those doing the HIV testing can request additional information and guidance from technical experts.

- Distribution of test kits: The Kenya Medical Supplies Agency shall be the agency to distribute HIV test kits. NPHL shall also maintain an emergency stock of rapid HIV test kits for distribution when needed.

- Storage of test kits: It is recommended that test kits that can be stored at room temperature be used as much as possible. If local climatic conditions require refrigeration of test kits, provision for a refrigerator and the cost of running it should be included in the project budget. Each VCT site should have a designated staff member in charge of ensuring that test kits are stored properly, and used before their expiration date.

- Disposal of sharps, used test kits, and other contaminated waste: Sharps (lancets or needles) should be disposed in a specially designed sharps container, or alternatively, in a plastic bottle with a hole cut that can be sealed when full. Used test kits and blood-contaminated materials should be placed in a separate container and incinerated or disposed of according to standard health facility practice.
Section 4
VCT record-keeping, data management, monitoring and evaluation

Data collection system: The national system for collection and analysis of VCT data should be followed. This system has been developed in collaboration with the existing health information system of the Ministry of Health.

Data collection instrument: A standard data collection instrument should be used at all VCT sites, including government and mission hospitals and health centres, NGOs, PLWHAs organizations, and private and commercial sites offering voluntary HIV counseling and testing. When using the VCT data form, counselors should inform the client that no names are recorded on the form to reassure the client of the confidentiality of the information.

Data recording: The counselor should fill out the VCT form in duplicate before the client leaves the counseling room. The counselor should ensure that filling out the form does not interfere with establishing rapport with the client, and does not interfere with an effective counseling session. The client may refuse to answer questions. At the end of each day, each counselor should check all the forms for that day to see if any items are missing. If there are any questions about how to fill out the form, the counselor should ask the supervisor or the district-level data manager for guidance.

Coding system: A standardized system of assigning codes to clients for identification purposes should be used. These codes are available from NASCOP. This is of particular importance in VCT sites where names are not recorded.

Record-keeping: For ease of data entry, the original of the data collection form should be sent to the District Health Information Office for data entry. A copy should be retained at the VCT site for record keeping. A standard filing system for VCT records should be developed and followed. All efforts must be maintained to keep VCT records confidential and stored in a secure room with lockable cabinets.

Data entry: Each VCT site should submit the data collection forms to the District Health Information Office, where data entry should occur. Submission of VCT data collection forms should be made as frequently as possible (weekly if possible) and no later than each month. This will ensure rapid data entry. The person in charge at each VCT site is responsible for ensuring that data collection forms are submitted in a timely fashion. A proper tracking system should be in place for recording when forms are sent to the District Health Information Office. Data collection forms may be collected from sites by the district VCT coordinator when possible. All data entry should be completed within one month at the latest (for example, all data on VCT clients in January should be entered by the end of February). Computers for data entry should be supplied to each District Health Information Office. In the situation where the VCT site has a computer and records staff, data entry should be done at
the site and a diskette sent to the District Health Information Office for compilation. Every time data are entered, they should be backed up on diskettes.

Data tabulation: At the end of each month, the district health information officer should produce a monthly summary in triplicate. The original should be sent to NASCOP/ACU-Ministry of Health, the VCT records officer, the duplicate be retained at the district health information office, and the triplicate sent to the provincial health information office. If needed, computers for data tabulation and analysis should be supplied to each provincial medical office and to NASCOP/ACU-Ministry of Health, in coordination with existing resources now being used for the ministry’s health information system.

Data transfer: To the extent possible, data on VCT clients should be sent electronically from the district to the Provincial Medical Health Information Office, the VCT coordinator, and NASCOP/ACU-Ministry of Health. When electronic transfer is not possible, the monthly returns should be saved on diskettes, which should be transferred in a secure fashion to the province and to NASCOP.

Supervision of data entry and management: Medical records officers trained in supervision should supervise the data entry officers. Such supervision should be carried out quarterly and more often if the need arises.

Data analysis and reporting: It is intended that VCT data be used for understanding VCT demand and utilization, for surveillance, and for improving management of VCT services. A software package should be developed and installed at all district health information offices, at provincial and national levels. Data analysis should be completed and submitted back to each VCT site, the district, the province, NASCOP/ACU-Ministry of Health and NACC. NASCOP/ACU-Ministry of Health will design feedback mechanisms to ensure that each level of services and management is informed on a quarterly basis regarding VCT services. VCT counselors should also be informed of the resulting VCT data for the sites at which they work. NACC should distribute VCT reports based on the data to relevant AIDS control units in various ministries and provinces.

Training of counselors, medical records officers, and laboratory technicians: All persons involved in data recording, data entry, data tabulation and analysis should be trained before this computerized data management system is introduced. Such training will be organized by NASCOP/ACU-Ministry of Health, working in collaboration with the provincial medical office and the district health management team.

Monitoring and evaluation: The VCT database should be used to monitor and evaluate VCT services at each site, in each district and province, and at a national level. NASCOP/ACU-Ministry of Health and NACC will develop a national monitoring and evaluation plan. Special studies may be required for specific issues, but in general the emphasis should be on using the VCT database as much as possible to maximize the use of this system.

Publication of VCT data: Any articles or publications based on VCT data must be submitted to NASCOP/ACU-Ministry of Health and NACC for clearance before
publication. This includes abstracts for national and international conferences. When appropriate, other national clearing mechanisms, such as the National VCT Committee and the National Council for Science and Technology, should also be engaged.
Selected references on voluntary counseling and testing


Appendices

Appendix 1: Confidentiality in VCT sites

Many people are afraid to seek HIV services because they fear stigma and discrimination from their families and community. VCT services should always preserve individual needs for confidentiality.

**Definition:** Confidentiality is when personal information about clients, whether obtained directly or indirectly, is not revealed without the client’s permission. This information includes biographical details that may permit the client and the client’s HIV test result to be identified.

Traditionally, counselors offer confidentiality because

- Confidentiality encourages a relationship in which clients can divulge to the counselor information and feelings normally kept to themselves, some of which are often taboo.
- Confidentiality helps clients admit that they have been involved in high-risk behaviour associated with sex, drugs and alcohol.
- Confidentiality permits clients to remain in control and divulge HIV serostatus to selected individuals, especially sexual partners and family members.
- Confidentiality should be apparent in all activities of the VCT site. All staff members of the site must observe it. The client can be helped to accept the guarantee of confidentiality by the continued emphasis that all staff members give it.
- Confidentiality should be there between client and counselor. Confidentiality needs to be explained and agreed upon between the counselor and the client. Clients respect counselors more when they know that they maintain confidentiality. The client will give the counselor privileged information and the counselor must maintain that confidentiality to safeguard the rights and welfare of the client.

The VCT counselor should keep the following points in mind:

- **Need for disclosure.** In the VCT setting, disclosure of HIV test results to any party other than the client should not occur. It should be noted that the *Sessional Paper No. 4 of 1997 on AIDS in Kenya* recommends: ‘Health care providers are allowed to disclose the HIV status of their patients to persons considered to be at risk of infection after the individual has been provided enough opportunity to disclose his HIV status to those concerned.’ If a VCT counselor feels that a VCT client is endangering the health of others or their own health, the counselor should consult with the counselor supervisor to make an appropriate plan of action for intensified counseling and interventions with the client.

- **Between counselors and parents or guardians.** When adolescents are tested, especially those under age 18, the counselor should encourage the young person to inform their parents or guardians about the test results. If the counselor determines that it is in the best interest of the adolescent for a parent or guardian
to know results, the counselor should assist the adolescent client in every way possible to disclose this information.

- *Between counselors and supervisor.* It is accepted that counseling practice can be improved when counselors are supervised. During supervision sessions counselors may discuss their caseload freely; however, the identity of the client should still be protected and it should not be possible for the supervisor to identify the client.

- *Between counselors and medical staff.* Differences in the way doctors and counselors regard confidentiality may lead to conflicts between them, which they should discuss. The medical team responsible for a client’s care may share confidential information and keep it in a client’s medical records, and counselors may not agree with this sharing.
Appendix 2: Code of ethics and practice for counselors of the Kenya Association of Professional Counselors

*Purpose*

The purpose of a code of ethics is 1) to establish and maintain standards for counselors and 2) to inform and protect members of the public seeking and using counseling services.

*The nature of counseling*

The overall aim of counseling is to provide an opportunity for clients to work towards living in a more satisfying and resourceful way. The objectives of each counseling relationship depend on the client’s needs. The client may be concerned with

- addressing and resolving specific problems
- making decisions
- coping with crises
- developing personal insight and knowledge
- working through feelings of conflict
- improving relationships with others

The counselor’s role is to help the client work in ways that respect the client’s values, personal resources and capacity for self-determination. In counseling, both the counselor and the client explicitly agree to enter into a counseling relationship. What distinguishes counseling from the use of counseling skills is the user’s intent. Counseling skills are used to enhance the performance of the counseled one’s functional role, as line manager, nurse, tutor, social worker, personnel officer, voluntary worker, and so on. The recipient of these skills will in turn perceive that they are used to that end.

*Code of ethics and practice:* Counselors uphold the basic values of integrity, impartiality and respect and apply the principles of autonomy, beneficence, avoidance of harm, justice and fidelity to specific situations. They have a responsibility to the clients, to themselves, their colleagues, the profession, members of other caring professions, the wider community and the law. They appropriately address issues of confidentiality, advertising, public statements, research and ethical decision-making.

*Ethical guidelines for counselors*

- Counselors need to be aware of what their own needs are, what they are getting from their work, and how their own behaviour and needs influence their clients. It is essential the counselor’s own needs not be met at the client’s expense.
- Counselors should have the training and experience necessary for the assessments they make and the interventions they attempt.
- Counselors need to become aware of the boundaries of their competence and seek qualified supervision or refer clients to other professionals when they recognize that they have reached their limit with a given client. They should make
themselves familiar with the resources in the community so that they can make appropriate referrals.

- Although practitioners know the ethical standards of their professional organizations, they are also aware that they must exercise their own judgement in applying these principles to particular cases. They realize that many problems have no clear-cut answers, and they accept the responsibility of searching for appropriate solutions.
- It is important for counselors to have some theoretical framework of behaviour change to guide them in their practice.
- Counselors need to recognize the importance of updating their knowledge and skills through various forms of continuing education.
- Counselors should avoid any relationships with clients that could be a threat to therapy.
- It is the counselor's responsibility to inform clients of any circumstances that are likely to affect the confidentiality of their relationship and of any other matters that may negatively influence the relationship.
- It is imperative that counselors be aware of their own values and attitudes, recognize the role that their belief system plays in their relationships with their clients, and avoid imposing their beliefs, either subtly or directly.
- It is important that counselors inform their clients about matters such as the goals of counseling, techniques and procedures that will be employed, possible risks associated with entering the relationship, and any other factors that are likely to affect the client's decision to begin therapy.
- Counselors must realize that they teach their clients through setting an example. Thus they should attempt to practise in their own lives what they encourage in their clients.
- Counselors bring their culture to the counseling relationship, and their client's cultural values also operate in the process. Counseling takes place in the context of the interaction of cultural backgrounds.
- Counselors need to learn how to think about and deal with ethical dilemmas, realizing that most ethical issues are complex and defy simple solutions. Willingness of a counselor to seek consultation is a sign of professional maturity.
Appendix 3: Human rights and VCT

**Human rights principles most relevant to VCT**

Following are the human rights every client should have and be made aware of:
- the right to privacy
- the right to non-discrimination, equal protection and equality before the law
- the right to found a family
- the right to the highest attainable standard of physical and mental health
- the right to informed consent before a medical procedure is carried out

**The right to privacy**

A person’s interest in their privacy is particularly compelling in the context of HIV/AIDS, because of the stigma and discrimination attached to the loss of privacy and confidentiality if HIV-positive status is disclosed. VCT services must therefore put adequate safeguards in place to ensure that no testing occurs without informed consent, that confidentiality is protected, particularly in health and social welfare settings, and that information on HIV status is not disclosed to third parties without the consent of the individual. Privacy is protected through observing confidentiality in carrying out HIV testing, disclosing results and keeping records.

The recognized exceptions to the rule of confidentiality in the context of HIV/AIDS are the following:
- where the unequivocal consent of the client is given
- where the information is to be given under compulsion of the law, for example, as material evidence in court proceedings
- where information is being shared among medical professional colleagues in a research or health-care setting
- where cultural and social traditions permit shared confidentiality in the family and the community
- in cases of anonymous and unlinked testing

The test results should be given to the client in person and privately to ensure confidentiality and adequate support. This includes all forms of testing, for all of the following persons:
- migrants, refugees, travellers
- military personnel
- pregnant women
- children who are being adopted, or subject to custody or access orders
- couples intending to marry
- people seeking insurance, bank loans, and so on
- participants in certain sports, such as boxing
- hospital patients, such as before surgery or where health-care workers have suffered needle-stick injuries
• inmates of institutions such as prisons and facilities for the mentally ill, developmentally disabled, or people with severe physical disabilities
• employees with a particular emphasis on certain occupations such as health-care workers, pilots, entertainers, truck drivers, fishermen
• people subject to punishment by criminal law, such as sex workers, injecting drug users and men who have sex with men

The right to non-discrimination, equal protection and equality before the law
Discrimination must not exist in a VCT setting, as it would deny intending clients access to VCT and thus deny them the opportunity for behavioural change and coping mechanisms.

The right to marry and found a family
Mandatory premarital testing and the requirement of AIDS-free certificates as a condition to solemnizing a marriage is discouraged. Similarly, coerced abortions and sterilization of HIV-infected women violates their right to found a family.

The right to the highest attainable standard of physical and mental health
Quality VCT can contribute to the physical and mental health of those who wish to know their HIV status. Quality VCT is an integral step for supportive medical care. It is characterized by
• quality information—from VCT promotion, the testing facility and health personnel
• informed consent
• pre- and post-test counseling

The right to informed consent before a medical procedure
It is a standard of medical practice that there should be informed consent before any medical procedure. The risks and benefits of the procedure should be explained to the client or patient to facilitate the process of informed consent.

Protecting human rights within a VCT site
In addition to the strict observance of pre- and post-test counseling, confidentiality and informed consent, protecting the human rights of VCT clients can be promoted through the adoption of an ethical code of conduct for all those involved with VCT services and the signing of an oath of confidentiality. Such a code of conduct should include a commitment to competence, consent, confidentiality, respect for people’s rights, professional conduct, and integrity towards clients.
Appendix 4: WHO/UNAIDS guidelines for preventive TB therapy

In February 1998, WHO and UNAIDS recommended that before preventive TB treatment the following are required:

- adequate capacity for HIV counseling
- sufficient trained health-care staff
- establishment of links between HIV care and the TB control system
- TB treatment services that have a high probability of curing cases of TB identified through preventive therapy services (such as less than 10% default or failure at end of treatment)

Preventive therapy should be used only when one can exclude active TB cases and have appropriate monitoring and follow-up. National TB programmes should participate in training, diagnosis of TB and treatment of TB cases, and they should assist in assessing for drug logistics and procurement.

Those who have a positive HIV test should receive

- **Counseling on TB**: people living with HIV are at risk of developing TB. They should be given health education and encouraged to seek early diagnosis and treatment of cough and other symptoms suggestive of TB.
- **Screening for active TB**: Preventive therapy is inadequate treatment for active TB and could lead to development of drug resistance. Until the validity of different screening tools or algorithms is established, it is recommended that a chest radiograph be examined for each person before considering preventive therapy treatment.
- **Targeting of those most likely to benefit**: preventive therapy is recommended for HIV-infected individuals who test positive on tuberculin skin tests do not have active tuberculosis. Where skin testing is not feasible, special target groups for PT are
  - those living in populations with a high prevalence of tuberculosis infection (estimated to be > 30%)
  - health-care workers
  - household contacts of TB patients
  - prisoners
  - miners
  - other selected groups at high risk of acquisition or transmission of TB
- **Provision of PT to those without active TB**: Isoniazid is the recommended drug; 5 mg/kg (max. 300 mg) may be given as daily, self-administered therapy for six months. Patients should be seen monthly and given only a one-month supply of medication at each visit.
- **Monitoring of adherence and toxicity**: Patients should be monitored at the routine visits for adherence to the treatment, drug toxicity and development of symptoms of TB. Active TB cases should be referred to the national TB programmes for
registration and treatment. Patients need to be educated about the symptoms of hepatitis and if it occurs to discontinue the drug promptly.

Evaluation of outcome: Programmes or centres that offer PT should assess its effectiveness regularly. This assessment should include attendance at scheduled appointments, adherence (number of persons started on preventive therapy and number completing it), toxicity and withdrawals from therapy because of toxicity, and the number of suspected TB cases found through screening and monitoring the therapy. Individual records should be maintained to document use of PT. Individual information should be aggregated for regular reports, which can be used by the TB programme to estimate future drug requirements.