Many organizations and individuals have worked together with the Ministry of Health to advocate for quality in voluntary counselling and testing. Liverpool VCT has been working in implementing quality assured VCT since 1998 and the lessons learnt from this practical experience in a resource-poor setting are shared in this manual.

This resource pack presents how we conduct QA at Liverpool VCT and in the sites which we assist. It is a method that has worked for us and a model that others may find helpful to borrow from. I hope you find it a helpful and user friendly resource.

Dr Miriam Taegtmeyer,
Director,
LVCT
INTRODUCTION

Putting Quality on the Agenda for VCT in Kenya

The Kenya National HIV/AIDS Strategic Plan 2000-2005 was developed to provide policy and an institutional framework to implement HIV/AIDS prevention and control interventions. A key aspect of this large-scale effort is providing accessible and affordable testing centres that offer a high quality of service. The establishment of voluntary counselling and testing (VCT) centres in every district of Kenya is a priority in the government’s fight against HIV/AIDS, with a commitment to open an average of five sites in every district by the end of 2004.

Kenyan government commitment to the scale-up of VCT has been unprecedented in sub-Saharan Africa. At national level, a VCT task force was convened to address issues of writing guidelines, advocacy, site registration, logistics, and quality. The National Guidelines for VCT are used as a basis for setting minimum standards. Sites wishing to access free test kits procured by the government must meet these standards and receive a registration code before opening. In June 2002 a mass media campaign was launched to promote services and by December 2002 over 115 VCT sites had been registered in six provinces in Kenya. More details about registration and accreditation of sites can be found in Section 1.5 of this resource pack.

Voluntary Counselling And Testing

VCT is a service aimed at the asymptomatic individual who wants to know their HIV status. Those who wish to get tested for HIV go to a site voluntarily and are offered pre-test counselling, on-site testing, and post-test counselling. VCT services have been shown to prevent the transmission of HIV through education, promotion of behaviour change, and provision of an entry point to care for those who find out they are infected with HIV. Currently VCT is offered in many settings including NGOs, CBOs, governmental and mission hospitals, health centres and stand-alone sites. Sites located in health facilities and actively making and receiving referrals to other health services in the facility are sometimes called “integrated sites” as without the referral pattern they would merely be “co-located”. Sites set in a non-medical environment such as residential areas, a shopping arcade or religious building are often called “stand alone sites”.

Implementing Quality Assurance in VCT

In 1998, the Liverpool School of Tropical Medicine started the Liverpool VCT Pilot Project in Thika and Nairobi Districts, Kenya to test the feasibility and acceptability of VCT with an integrated quality assurance system. This pilot was scaled-up from three to thirty sites in 2001 and comprehensive quality assurance systems were scaled up alongside VCT. Valuable lessons were learnt about ownership of services, the setting of achievable goals, working within available resources and about continuous quality improvement at health facility and district level. Counsellors, laboratory technologists and other health centre staff were able to establish and maintain high quality services at low cost through working within a system that provided support structures, acknowledged and valued quality and recognised improvement. The desire for quality improvement is now integral to the provision of the service.

ACRONYMS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
</tr>
<tr>
<td>ARV</td>
<td>Antiretrovirals</td>
</tr>
<tr>
<td>CDC</td>
<td>Centers for Disease Control and Prevention</td>
</tr>
<tr>
<td>CBO</td>
<td>Community-Based Organisation</td>
</tr>
<tr>
<td>CO</td>
<td>Clinical Officer</td>
</tr>
<tr>
<td>DASCO</td>
<td>District AIDS STI Coordinator</td>
</tr>
<tr>
<td>DHMT</td>
<td>District Health Management Team</td>
</tr>
<tr>
<td>DFiD</td>
<td>Department for International Development, UK</td>
</tr>
<tr>
<td>DMoH</td>
<td>District Medical Officer of Health</td>
</tr>
<tr>
<td>DPHN</td>
<td>District Public Health Nurse</td>
</tr>
<tr>
<td>DPHO</td>
<td>District Public Health Officer</td>
</tr>
<tr>
<td>DSRS</td>
<td>Department of Standards and Regulatory Services</td>
</tr>
<tr>
<td>EQAS</td>
<td>External Quality Assessment Scheme</td>
</tr>
<tr>
<td>GoK</td>
<td>Government of Kenya</td>
</tr>
<tr>
<td>HIS</td>
<td>Health Information System</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>KEN</td>
<td>Kenya Enrolled Nurse</td>
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<tr>
<td>KQM</td>
<td>Kenya Quality Model</td>
</tr>
<tr>
<td>LVCT</td>
<td>Liverpool VCT and Care, Kenya</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>NASCOP</td>
<td>National AIDS and STD Control Programme</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Governmental Organisation</td>
</tr>
<tr>
<td>PHT</td>
<td>Public Health Technician</td>
</tr>
<tr>
<td>QA</td>
<td>Quality Assurance</td>
</tr>
<tr>
<td>SOPs</td>
<td>Standard Operating Procedures</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
</tr>
<tr>
<td>VCT</td>
<td>Voluntary Counselling and Testing</td>
</tr>
<tr>
<td>WB</td>
<td>World Bank</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
</tr>
</tbody>
</table>
To obtain a coherent, functioning QA system which addresses national, district, health facility, individual practitioner and community concerns it is vital that quality is ... below sets out some of the key activities/responsibilities in relation to assuring quality VCT services at each level.

Using these Resources for Training
The resource pack can be used as reference manual for facilitators and participants in organising quality assurance workshops and activities and can also be used as a guideline for those unable to participate in training. It has been designed to be totally flexible and has been divided into 2 sections.

Section 1 sets out the roles and responsibilities for implementing quality assurance from community up to national level.

Section 2 covers the core concepts of quality assurance training.

Tables and figures have been included to aid training and where possible practical examples and case studies from Kenya have been used to illustrate how QA tools and techniques can be used and implemented.

We strongly suggest that teams (from health facilities and VCT stand-alone sites) as opposed to individuals should be trained and that the key components of training focus on Section 2. Training workshops should be interspersed with periods of implementation so that the teams have the opportunity to implement their newly learnt skills in their facilities, and also have the opportunity to come back together to share experiences and lessons learnt.

Who this Resource Pack is Targeted at
This pack is targeted at district health management teams, health centre staff and VCT stand-alone site staff to raise awareness about the importance of quality assurance in every day work situations. It describes how to plan and establish QA at facility level so that it becomes part of the routine health care and VCT delivery system. It has been purposely designed for health facilities, since direct improvements in the quality of VCT services can only be realised by the direct providers of care (those who make the decisions with the client). By focusing on hospitals, health centres and stand-alone sites this resource pack aims to promote local ownership of quality assurance. Since VCT delivery is based on team work, the QA system described supports an interdisciplinary team approach for working on quality-related problems, involving other care and support services within a health facility and not just VCT alone. This approach has proved to be highly effective in the pilot programme.

SECTION 1: ROLES AND RESPONSIBILITIES FOR IMPLEMENTING QA

To obtain a coherent, functioning QA system which addresses national, district, health facility, individual practitioner and community concerns it is vital that quality is monitored and improved at each level with the active involvement of all stakeholders. This assumes well-defined roles and responsibilities in relation to QA. The table below sets out some of the key activities/responsibilities in relation to assuring quality VCT services at each level.

Table 1: Roles and Responsibilities

<table>
<thead>
<tr>
<th>LEVEL</th>
<th>COUNSELLING</th>
<th>TESTING</th>
<th>RECORDS</th>
<th>SUPPLIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 COMMUNITY</td>
<td>• Advocacy through health centre committees • Feedback through community meetings • Conducting client exit interviews with service users</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.2 COUNSELLOR &amp; LABORATORY TECHNICIAN</td>
<td>• Attending group and individual supervision • Monitoring own performance (self-reflection forms) • Adhering to standard operating procedures • Collecting of samples for quality control (10%) • Accurately completing laboratory records and National VCT data forms • Timely ordering of new test kits and reagents • Use of in-date kits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.3 FACILITY (QA TEAM)</td>
<td>• Participating in regular QA team meetings • Monitoring and analysis of client quality (exit interviews) • Completing and analysing monthly VCT statistics • Routine analysis, identification and solution of quality problems • Giving feedback to community, service users and other facility staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.4 DISTRICT (DHMT)</td>
<td>• Counselor support supervision • Laboratory supervisory visits • Submission of aggregated data • Collecting and ordering of test kits &amp; consumables • DHMT supervisory visits • DASCO/VCT Coordinator supervisory visits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.5 NATIONAL (NASCP/DSRS)</td>
<td>• Mandatory registration of VCT sites • Voluntary accreditation of VCT sites • Set National Standards • National reference laboratory quality control • National data base updated • Procurement • Storage &amp; distribution (KEMSA)</td>
<td></td>
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</tr>
</tbody>
</table>
1.1 Community Involvement
A locally owned QA programme that involves the community is far more likely to benefit the community. The health care system is not a configuration of providers only, clients and the wider community are an integral component. In fact clients are the first to notice a quality service and tell others about it. The QA team at facility level should therefore invite a local community volunteer to be an active member of their team.

One way of involving the community is to get them involved in monitoring client perceptions of quality. This can be done through questionnaires immediately after the client has experienced the service. Such client exit interviews are generally conducted by a community volunteer stationed just outside the health centre, perhaps at the gate or in the shade of a nearby tree. This set-up allows those who have used the services to give honest opinions and feedback. Such interviews and also group discussions have outlined community priorities and have shown that community fears for their VCT sites continue to be about confidentiality. Clients also mention the judgemental attitudes of health care workers and their concerns about overcrowded facilities and long waiting times.

Client exit interviews are one simple way in which the voice of community members can be heard directly by facility staff and service providers. In small rural settings where providers and clients come from the same area and know each other there will be a lot of interest generated by client exit interviews. Both interviewees and the wider community will be expecting feedback. Improvements made by the QA team as a results of the feedback will be observed and monitored with pride.

A communities responsibility might include such things as:
- advocacy through health centre committees,
- feedback through community meetings
- conducting client exit interviews with service users.

1.2 What is the Role of the Individual in Quality?
Responsibility for quality rests with every individual VCT counsellor or service provider. This ownership of the QA process by service providers remains the secret to success in turning policy on quality of care into practice. It requires that individuals internalise the concepts of quality and quality assurance and practice it in all their daily work. The responsibilities of the individual counsellor include:
- Actively participating in counselling support supervision
- Monitoring own performance
- Adhering to standard operating procedures and national guidelines on HIV testing
- Maintaining accurate records
- Ordering of supplies

Actively participating in counselling support supervision
Counselling support supervision is an essential ethical requirement for all practising counsellors. It is the key to the development and sustainability of quality counselling services. Counsellors need it not only to survive but also to thrive in what can be a deeply rewarding role, yet one that can be professionally isolating, frustrating and emotionally draining.

The value of support supervision in dealing with stress
Stress is something that all counsellors experience and they need to be aware of their own stress levels and take breaks or get support when they are experiencing stress. Sources of stress for counsellors can include working with people affected by HIV, management and organisational difficulties and personal and home issues. Stress levels can be reduced in many ways. Some are simple and can be done alone. Simply talking to someone like a supervisor or a group of peers can make a big difference.

Presenting client issues for supervision
Recording and presenting clients for supervision may be done as a verbal report or as a summary from notes. In some settings audio or even videotaping sessions is an option. Where this is difficult or inappropriate live supervision can take place, where the supervisor actually observes the session (see appendix on Observed Practice). Figure 1 below describes how issues should be presented for supervision. Anything that has posed challenges in a counselling session is appropriate for supervision. This may include issues with the client, with the management of a VCT site or personal issues. The more a counsellor takes to supervision the more aware he/she will become of their counselling practice and the better they will be.

Figure 1
- Identification: first name only, age, sex, first impression, physical appearance
- any other information about the client but which does not identify them
- summary of how the client presented the problem
- contract summary
- counsellor’s question or issues for supervision
- focus should be on the client: client’s account of problem situation, problem definition, counsellor’s assessment of client’s problem, counselling plan
- focus should be on the process: skills used and how used, relationships between counsellor and client, evaluation of the process

A customer is the most important visitor on our premises.
He is not dependent on us.
We are dependent on him.
He is not an interruption to our work.
He is the purpose of it.
He is not an outsider on our business.
He is a part of it.
We are not doing him a favour by serving him.
He is doing us a favour by giving us an opportunity to do so.”
Mahatma Gandhi

“Communities must act concertedly to exercise their rights and bear their responsibilities”
Avedis Donabedian

Acknowledgments

Case example:
In rural Kenya many primary health care centres have health centre committees comprised of community members who not only take decisions about the local health centre, but also have access to some of the cost sharing funds collected at the health centre to spend on the improvement of the local facility. QA teams found that working with the health centre committee was an ideal way of giving feedback and implementing change plans. Examples of how QA systems have helped health centre committees make local improvements are:
- hiring of a gardener with health centre committee funds to improve the waste disposal, entrance cleanliness and plant flowers around the health centre
- sacking of a watchman whose attitude to VCT clients was inquisitive and off-putting
- provision of a bench for a waiting area and furniture for a counselling room from cost sharing funds

SECTION 1 ROLES AND RESPONSIBILITIES FOR IMPLEMENTING QA

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Standard operating procedures for rapid testing

The availability of excellent HIV test kits does not automatically guarantee reliable results. Adherence to standard operating procedures is paramount to obtaining quality and reliable results. Critical analysis of each of the steps involved from client identification, sample collection, testing, interpretation of results and recording to kit storage must be carried out to ensure achievement of quality-controlled ‘products’. Providing quality results will increase the good reputation of the testing site and lead to an increase in demand for the service.

There are many different types of rapid HIV tests on the market available for both blood and oral fluid. Each test kit comes with precise instructions, which must be followed if an accurate result is to be obtained. Test kits and the reagents that come with them have specific storage requirements and temperatures, expiry dates must be recorded and adhered to and correct amounts of reagents and timings of testing must be adhered to.

Both tests currently used for parallel testing in Kenya - Determine and Unigold - involve the use of whole blood, obtained through pricking the finger of the client with a lancet. Four drops of blood are withdrawn for testing using a pipette and two drops placed in the correct place on each kit. Reagent is then added in the correct volumes and a timer or watch set to ensure the results are read at exactly 15 minutes when both test will have had adequate time to run and still be stable. The choice of testing algorithms and test kits has been discussed in more detail later in this section.

Competence at finger-pricking, pipetting and testing is assessed during training and during observed practice. Service providers who are unable to successfully collect fourteen drops (four for the test kits and ten for QC and EQA) are either retrained, or failing that, discontinued from practicing.

SECTION 1 ROLES AND RESPONSIBILITIES FOR IMPLEMENTING QA
1.3 How Can the Whole Health Facility be Involved?

Workshops, research projects and national level interventions often fail to recognise the local knowledge and expertise in the health facility. A quality assurance programme that involves the health centre is different. It establishes a system to allow the health centre staff to sit together and decide for themselves what their own quality concerns are and how they plan to work on them. It allows the health centre to collect, analyse and act on their own data without having to hand it upwards to provincial and national level. It allows the health centres to have their own feedback and communicate directly with the community without having to wait for national feedback - often in an unfamiliar format. There is no need to massage the figures or make the data look better - it is presented for the use of the facility itself.

Such QA systems developed by facility-based staff are more likely to respond to local priorities and are far more likely to bring about the kind of quality improvements that can directly influence service quality. The QA team should be responsible for implementing QA by:

- Promoting QA awareness
- Continuously monitoring, assessing and improving quality
- Analysing and using QA data at facility level
- Developing and implementing QA change plans
- Involving the community in QA

How to train and implement such a system at health facility level is outlined in detail in section 2.

Promoting QA awareness

In integrated VCT sites (ie situated within an existing health facility), implementation of QA should be across all services and not just VCT. Otherwise from both client and provider perspectives, services may become disjointed and standards may vary widely. This will be unsatisfactory to clients but also frustrating for staff.

Continuously monitoring, assessing and improving quality

The QA cycle described in section 2 is designed to be implemented on a regular basis and it is health facilities that arrange for client exit interviews to be conducted, volunteers from the community to be contacted and the cycle to be completed for presentation to the district at the QA workshops. Health centres in which QA has become part of the system will have a QA team that meets regularly often take the initiative in starting to conduct interviews.

Analysing and using QA data at facility level

Unlike so much of the other data collected in health centres the data collected in client exit interviews is designed for analysis and action at the facility level. The primary data should be kept and analysed at the site for referring back to and for comparison over a change period. The initial QA training workshop may need to involve some basic maths as analysis through pie charts, bar graphs and line graphs will allow the QA team to quickly pick up on problem areas and design appropriate change plans. Often action has already been taken by the time they come to present the data at the follow up QA workshop.

Data collection and record keeping

Importance of collecting data is not only to measure demand and prioritise interventions through determining the characteristics of clients, but also to assure the quality and confidentiality of services. It is essential that confidentiality be maintained when conducting HIV testing of any type. Confidentiality can be achieved in two ways.

One way is through maintaining very strict control of access to the client’s name and test results, releasing results only to others, such as health workers, if the client agrees. The other method is to practice anonymity, when no names are taken and only codes are used. It is common experience that more clients will request VCT when their names are not recorded and anonymity is practised and ensured.

It is recommended that anonymous procedures be used at VCT sites. However, it should be noted that confidentiality in VCT services involves not only using codes but also managing the waiting room and client flow and also ensuring that VCT clients are not readily identified by public or other patients using the health facilities.

The coding system adopted for Kenya is explained in the Appendices and a copy of the National VCT data farm has also been attached.

Ordering of Supplies

The individual counsellor also has a role to play in the timely ordering of supplies. Accurate records and sensible predictions of client flow, based on mobilisation activities and experience, should help the counsellor alert their supervisors and facility in-charges at least one month before HIV test kits run out at a particular site. If for example a site regularly sees 40 clients in a week it should have 160 kits in stock.

"...in fact since implementing QA, it has helped to improve on our hospital a lot. See like cleanliness, everybody was complaining about the cleanliness and especially the toilets; this is no more. We are confident that we can work on the other problems as well."

Thika QA meeting Dec 2002

SECTION 1 ROLES AND RESPONSIBILITIES FOR IMPLEMENTING QA

Quality Assurance Resource Pack for Voluntary Counselling and Testing service providers
Developing and implementing quality change plans

Client feedback must be translated into action points of QA systems to work and improvements be made. A description of drawing up quality assurance change plans and a sample plan are given at the end of section 2 of this resource pack.

Involving the community in QA

More important even than presenting their data at district QA workshops, the health facility has the responsibility of presenting the results of the client exit interviews back to the community. Many choose to do this through community meetings and chiefs’ barazas, through posters on notice boards and through the health centre committee. In addition some health facilities and stand alone VCT sites have opened suggestions boxes so clients can make suggestions at any time, not just when the client exit interviews are being conducted.

1.4 A District-led Approach to Implementation

A District Health Management Team (DHMT) that has full ownership of quality in its district will plan comprehensively and include VCT as part of a package of HIV care services alongside HIV care clinics, post rape services, prevention of mother to child transmission and others. At this level the DHMT hold the key to successful execution of QA in guiding and supporting health facilities to provide high quality, client-centred services. Districts should be encouraged to develop their own quality assurance initiatives that are part of their annual work plan. Care should be taken to ensure that these initiatives are guided by national policies with nationally agreed standards and indicators of quality of care. District involvement in the QA process is vital for ensuring sustainability in the long term. The district responsibilities for VCT include:

- Supporting consistent goals for quality across the district (counselling, testing, supplies and care)
- Providing support supervision and VCT laboratory supervision
- Encouraging high performance and promoting best practice through data and records
- Facilitating QA training and continuing education

Role of the DASCO/VCT coordinators

The coordination role of the DASCO provides an umbrella for the whole district. From the onset of service implementation the District AIDS and STD Coordinator (DASCO) may be appointed as the district VCT coordinator. When setting up new services the VCT coordinator together with the DHMT members is responsible for site selection, selection of supervisors from amongst existing staff and the interviewing and release of staff to train and practice as VCT counsellors.
Role of the VCT counsellor supervisor

The importance of counselling support supervision to the individual counsellor in preventing burn out and maintaining quality is explained in more detail in section 1.1. This support supervision of VCT counsellors at district level should be clearly distinguished from the role of the DASCO/VCT coordinator. Methods of support supervision are laid out in figure 2 overleaf. A district may select one or several of these methods. Group supervision is the most common form of supervision used for VCT counsellors in Kenya.

Whether a DHMT selects individual or group supervision one of its first tasks is to select and release from other duties one VCT supervisor for every ten VCT counsellors it plans to train (as set out in the National VCT Guidelines). The selection of supervisors should be through internal advertising and interview. As set out in the National VCT guidelines the post holder should be a diploma holder or above who is based at the district hospital or equivalent. VCT counsellor supervisors are intended to be practicing senior counsellors. In districts where this is not possible it is important that they are selected and trained six months to a year prior to their supervisees.

The supervisors also take on the additional roles of administration (such as receiving reports and collecting and distributing data forms) and of continuing education. Figure 3 overleaf (taken from the National Training Manual for VCT counsellors) outlines the functions of supervision in quality assurance.

---

**Figure 2: Methods of supervision**

The various forms of supervision all have their own strengths and weaknesses.

- **One-to-one or individual supervision:** Involves one supervisor and one supervisee. It offers an opportunity for the supervisee to hear about and experience a particular counselling approach and offers a non-confrontative environment. However, it can become difficult if the supervisory relationship breaks down. There is also input from only one person, the supervisor.

- **Group supervision:** May comprise peers or may be a group with a designated leader. It provides a supportive atmosphere and emotional support for peers, especially for new counsellors. Experience for learning in the group, however, may not be sufficient, if the group is large some members may not get the opportunity to present their concerns, and group dynamics may interfere with learning.

- **Peer supervision:** This involves spending time with a colleague discussing your own work in a structured, confidential manner. This is usually available to counsellors and does not involve extra travelling time. Counsellors can learn from the experiences of their colleagues and are more likely to understand the concerns and stresses of their co-workers. If the counsellors have little experience, peer supervision can be limited.

- **Self-supervision:** Involves counsellors monitoring or assessing their own counselling work. It creates a reflective forum in which supervisees are able to examine their own work, evaluate it and move towards different interventions. It builds confidence in a counsellor’s own reflection. However, the counsellor may miss significant factors in their relationship with clients or may not be in touch with what is happening within themselves.

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**Figure 3: Functions of supervision**

**Educational:** The counsellor trainee is given a regular opportunity to receive feedback, develop new understandings and receive information. The counsellor is helped to integrate theory and practice and to develop competent practice.

**Supportive:** The counsellor trainee is able to share dilemmas, be validated on work performance and deal with personal distress evoked by clients.

**Management:** Ensures quality of work. Counsellor trainee is helped to plan work and use resources.
District Laboratory supervision for VCT

The district laboratory, represented on the DHMT, has a key role in supervision of all HIV testing that occurs in the district. Ultimately the laboratory in-charge is responsible for the accuracy of all test results. A laboratory technologist trained in rapid testing for HIV and also in VCT counselling is the ideal person to oversee testing in VCT sites. Regular supportive visits allow for systems and procedural errors to be spotted early and for additional training of the individual should there be need. In addition it allows for better explanation of the role of the filter papers, the importance of external quality assurance of testing and direct feedback from the regional laboratory.

A checklist can be an objective and useful tool for laboratory supervision as long as it is intended for providing support rather than fault finding. An example of a laboratory supervisors’ tool has been included in the appendices. Such a checklist enables supervisors to check the same areas on each visit, treat each site the same and see where improvements have been made between visits.

The structural and infrastructural requirements of a laboratory for HIV testing are included in the checklist in some detail: lockable cabinets, bench space, illumination, access to water and room privacy being some examples. The laboratory supervisor also checks supplies and storage, adherence to bio safety standards and record keeping. In addition the process of adhering to standard operating procedures is best observed at the site with the consent of a client. The person conducting the test may be observed in sample collection, in adherence to test procedures and universal safety precautions.

Record keeping and data analysis

While detailed laboratory registers and individual client data forms provide useful information for the site the district usually finds it is more useful to have the data in an aggregated format on a monthly basis. A number of simple monthly reporting formats are available and one is included in the appendices as an example. It was designed to help sites report to the district level while also meeting national reporting requirements from NASCOP and from donor agencies. The value of aggregated data is that it allows simple analysis of trends at a glance. For example client flow may have picked up or dropped off, the gender balance of clients may have altered or the number of people testing HIV positive risen significantly. All of these would have implications for programme design and mobilisation of services: could it be that mobilisation is only targeting healthy young men? Or primarily sick older women? etc. They may also reflect opening times, counsellor availability or accessibility. It is therefore the district team that should be the first to know the trends, consider the causes and take appropriate action. This data allows districts to identify poorly performing facilities, which need extra support and also to recognise high performance thereby promoting best practice across the district.

Supplies and logistics at district level

Once a VCT site has opened in a district it is important that clients find it open and fully functioning at all the advertised times. Clearly one key factor in this is the presence of test kits in accordance with national guidelines.

Each district is responsible through its district laboratory services to ensure a continuous in-date supply of test kits for the purposes of all HIV testing in the district (VCT, diagnostic, routine screening of blood for transfusion etc). Kits are normally collected on a monthly basis by the laboratory in-charge from the provincial KEMSA (Kenya Medical Supplies Authority) depot. The district therefore needs accurate returns and predictions from the VCT and laboratory supervisors to allow the timely ordering of kits from the provincial stores. As stock-outs, transport and distribution problems are not infrequent it is recommend-ed that a buffer stock is maintained at the district store. Accusations and concerns over theft and selling of test kits are likely to occur and the accurate keeping of records at the site including laboratory registers, national data forms and aggregated data will make for a transparent system whereby individual counsellors and laboratory technologists can account for all the kits they have used.

Facilitating QA training

Key members of the DHMT should arrange for and actively participate in quality assurance training for the facilities (as described in section 2) and give and receive feedback on the successes and challenges of implementing quality assurance in their district. Both stand-alone and integrated VCT sites should be invited by the district to the quality assurance training programme as all ultimately fall under the coordination of the District AIDS and STD coordinator. Regular QA trainings are vital for ensuring effective communications between primary and secondary level facilities and for exchanging ideas and experiences.
There is considerable confusion about the aims and roles of HIV testing in Kenya. To address this, the VCT taskforce has come up with working definitions as follows:

- **Mandatory testing (MCT)** is that which occurs for pre-employment, visas, insurance etc.
- **Routine testing (RCT)** is recommended for patients presenting with certain conditions, such as pregnant women, STI patients and TB suspects. The patient can decline the test. This form of testing is not yet common in Kenya.
- **Diagnostic testing (DCT)** is for purposes of changes in management for treatment of the symptomatic patients.
- **Voluntary testing (VCT)** is aimed at the asymptomatic individual wishing to know status in order to make a lifestyle change.

**Registration And Accreditation**

In order to ensure compliance with the National VCT guidelines registration and accreditation schemes can be instituted for the evaluation of VCT sites. There are two levels of evaluation:

1. The first stage of Compulsory Registration will require an on-site visit to assess the site against minimum structural standards. This responsibility rests with NASCOP and the Department of Health Management Teams. Once inspected sites are given a site code, are able to pick up test kits form a central store and submit data to the national data base. Unregistered sites are unable to access free test kits and may be stopped from practicing as VCT sites.

2. The second stage is Voluntary Accreditation that will require an annual survey to assess VCT services against a wider set of minimum standards (structure-process-outcome). The VCT logo developed for the mass media campaign can be linked to provision of quality VCT services (quality seal).

Figure 4 sets out the registration accreditation process.

1.5 The Role of National Level in Assuring Quality VCT

With the establishment of the Department of Standards and Regulatory Services (DSRS) in January 2001 a national level framework for assuring and improving quality has been designed under the Kenya Quality Management (KQM). This has firmly put quality on the National agenda. In relation to VCT, national guidelines for Voluntary Counselling and Testing have been established which provide clear guidance to all providers of the minimum standards expected. More challenging is the implementation of them, to ensure that both public providers and also private, NGO, CBO providers etc. conform to these standards. Therefore the role of national level is to advocate the importance of quality improvement strategies, and facilitate them by an equitable allocation of resources (human, material and financial). National level can support district development by requiring quality of service provision to be included in the training curriculum of all health personnel and that a culture of quality is fostered within the health service community, both public and private. Responsibilities at national level therefore include:

- Providing guidelines and standards for VCT services, training and supportive care services
- Regulating quality of service delivery through mandatory registration and voluntary accreditation of all VCT sites.
- Choosing test kits and establishing a National Reference Laboratory for the external quality control of rapid testing for HIV
- Procuring and distributing supplies

Establishing the VCT guidelines and Training Manual

The Kenya National Guidelines for VCT were established in 2001 as the result of work by a wide group of stakeholders forming the National VCT taskforce under the umbrella of NASCOP. The consultative process was multi-sectoral and professional counselors, laboratory technologists, epidemiologists, physicians, and community activists shared ideas and approaches to VCT. A multi-sectoral, multi-disciplinary approach to writing guidelines for AIDS services in Kenya enabled the building of a national consensus about VCT services, and provided a model for other multi-sectoral AIDS activities and national guideline development. Out of the guidelines the need for a standardised training format arose and a training manual was developed to include the training curriculum of all health personnel and that a culture of quality is fostered within the health service community, both public and private. Responsibilities at national level therefore include:

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- Regulating quality of service delivery through mandatory registration and voluntary accreditation of all VCT sites.
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Figure 4 sets out the registration accreditation process.
The role of the National Reference Laboratory

The quality of rapid test results may be affected by a number of factors including environmental factors, decomposition of reagents or kits, interfering substances or technician bias. Technicians may make mistakes in the assay procedure, in the interpretation of results or in their documentation. Currently, 10% of samples are saved on filter paper as dried blood spots and validated in a reference lab and it is the responsibility of the reference laboratory to analyse these and provide timely feedback.

3. Supervision and training of laboratory supervisors

Wherever HIV testing is carried out a district laboratory supervisor should supervise the technician (or operator trained in rapid testing) on a regular basis. A sample supervision tool has been provided in the appendices to this manual. In order to ensure national standards are maintained the laboratory supervisors should be trained together on the same curriculum. Some may also qualify for training in the training of rapid testing.

4. Inspection for registration and accreditation

Each team sent to register or voluntarily accredit VCT sites should have at least one representative of the laboratory services present to assess aspects of bio-safety, standard operating procedures, supplies and stock as well as adherence to quality control measures.

Supplies, procurement and distribution of HIV test kits

Keeping the responsibility for procurement of HIV test kits at national level in Kenya has made a positive impact on quality assurance measures. The central purchasing and distribution of kits free of charge to registered VCT sites is a strong incentive for a site to become and remain registered.

Case Study:

Results from a pilot study of site registration and accreditation conducted between November 2001 and May 2002 in Kenya have shown that it is feasible to assess quality of VCT services against the national VCT guidelines using an external assessment team. Subsequent to the study site registration has been made mandatory in Kenya and site codes issued from NASCOP prior to a site being able to offer services.

In the study the registration/accreditation tools were used by external assessors, however these tools could also have been used as self-assessment tools for VCT sites and in fact would be useful checklists for ensuring that sites have complied with the National VCT guidelines. Use of the tool would also ensure that sites are fully prepared before an external assessment takes place. Independent government bodies usually operate registration / accreditation schemes. In this pilot NASCOP were responsible for the registration programme and NASCOP/DSRS for the accreditation programme. Whilst there are obvious advantages in keeping the programme “in-house”, credibility of the programme may have been strengthened if an independent body conducted this programme. The most important criteria for a successful programme like this was that the assessors received a thorough orientation in the application of the National VCT guidelines and conducted assessments in a supportive manner as opposed to an inspection visit.

Figure 4 Registration/Accreditation Schematic

The schematic below sets out the registration/accreditation process.

- New site
- Registered site
- Accredited site
- Apply registration
- Apply accreditation
- Pass
- Fail
- Fail twice
- Site closed until problem remedied
- 1 month correction
- 3 month correction
- Fail twice
- Pass
- Fail

The quality of rapid test results may be affected by a number of factors including environmental factors, decomposition of reagents or kits, interfering substances or technician bias. Technicians may make mistakes in the assay procedure, in the interpretation of results or in their documentation. Currently, 10% of samples are saved on filter paper as dried blood spots and validated in a reference lab and it is the responsibility of the reference laboratory to analyse these and provide timely feedback.

1. Choice of test kits

Rapid tests used for VCT should be both highly sensitive and highly specific (see glossary for definitions) allowing for accurate results. The tests should be evaluated for sensitivity and specificity in a Kenyan laboratory using samples from HIV positive and HIV negative Kenyan residents.

2. Validation

As with other testing methods, rigorous quality measures are therefore enacted at VCT sites to regulate the accuracy and precision of test kits and their operators. The normal practice is for between 5% and 10% of all clients’ samples to be validated in this manner. In addition filter papers collected from discordant couples and indeterminate results should be submitted with a note indicating the reason for submission. Results from the reference lab are intended for feedback to service providers not to the clients. Such an external quality assessment scheme is able to recognise reagent, kit or instrument damage. It is also able to provide information on staff quality and to quickly identify poor methods and replace them with reliable ones. Determining the acceptability of results on each run enhances the public reputation of a laboratory and the demand for its services. At the same time the encouraging of good laboratory practice and adherence to standard operating procedures reduces costs and the number of repeat tests required.

Choice of Test Kits And External Quality Control Of Rapid Testing

The national level has a key role to play in the choice of HIV testing methods and algorithms as well as in establishing a national reference laboratory for the analysis of samples sent for external quality control.

The Kenyan guidelines recommend the use of traditional long ELISAs done in a lab setting for mandatory, routine and diagnostic testing where ‘patients’ may be issued with written results. Increasingly however, even in hospitals with laboratory and ELISA capabilities, the more expensive rapid tests (which are simpler and quicker to operate) are being used.

In adherence to the guidelines, VCT sites in Kenya currently utilize parallel testing algorithms with two rapid blood-based HIV tests to ascertain clients’ HIV status.

The Kenyan guidelines recommend the use of traditional long ELISAs done in a lab setting for mandatory, routine and diagnostic testing where ‘patients’ may be issued with written results. Increasingly however, even in hospitals with laboratory and ELISA capabilities, the more expensive rapid tests (which are simpler and quicker to operate) are being used.

Serial testing (an initial screening test, followed by a confirmatory test for positive samples) is the minimum standard, parallel testing (the simultaneous conduction of two different rapid tests on one sample) is advised.

SECTION 1 ROLES AND RESPONSIBILITIES FOR IMPLEMENTING QA
Procurement and distribution methods are complex and beyond the scope of a resource pack aimed at the health facility level. The distribution of test kits to the VCT sites is a task sometimes contracted out by governments to specialised independent or parastatal agencies. Distribution must take into account stock management (when what will be needed where), geographical access, transportation and storage requirements and security. The bullets below outline some of the necessary steps in procurement:

- A quantification exercise to determine commodity requirements (consumption versus morbidity)
- Selection of the most suitable procurement method
- Development of supplier pre-qualification criteria
- Initiation of the tendering process (review and/or revise contracts/delivery schedules/supplier performance monitoring system)
- Ensuring of test kit quality through appropriate policies and practices

Even with a well-defined QA system, satisfying all stakeholders is never easy. The diagram below shows the proposed structure for QA as a district-led approach.

SECTION 2: TRAINING MATERIALS FOR IMPLEMENTING QUALITY ASSURANCE

Training and capacity building is a major component of any QA programme. To avoid costly training and having little impact, certain critical factors that the districts and training facilitators must take into account when conducting QA training include:

- Training of interdisciplinary teams as opposed to selected individuals - training teams rather than individuals is far more likely to lead to long term sustainability of QA and avoid the problem of high staff turnover.
- Explicitly defined selection criteria - only those people who have the power to implement their newly gained skills should participate. Equally important is their capacity and willingness to learn and implement new skills.
- Context specific learning materials - all training materials used should reflect as much as possible the context of the local situation, otherwise key messages will be lost.
- Participatory techniques and problem solving exercises - participants must be given practical examples under the supervision of training facilitators to ensure that core concepts are understood. The teaching should be pitched according to ability. For example in the data analysis section it may be necessary to cover some aspects of basic maths.
- Emphasis on the development of locally defined tools - if management tools are locally defined and developed, they will reflect local concerns and thus local ownership will be high.
- Stimulation of both creativity and logical thinking - opportunities for personnel to systematically analyse local problems and develop solutions are rare due to the competing demands of day-to-day management responsibilities. It is vital that in training workshops participants are given the opportunity and time to do this.
- Workshops interspersed with periods of action learning - unless participants commit to implement their newly learnt skills in their own work environment, capacity building will have no impact.
- Supportive supervision - during implementation periods of newly developed tools and skills, it is vital that supportive supervision is given to personnel to guide them in their newly learnt methods and techniques.
- Support of senior personnel - participation of senior personnel in training programmes contributes greatly to staff motivation and long term sustainability of new initiatives.

All the tools and examples that are described in this section have been developed and tested in Kenya. During pre-testing of this resource pack training was conducted by experienced individuals who are familiar with and have seen the QA cycle work in practice. The resources presented here assume that trainers will have a certain level of training and QA experience for them to effectively impart QA concepts to health facilities. One-off isolated workshops are unlikely to have the impact of a carefully designed, low-cost, flexible training programme.

This section describes:

2.1 Core concepts around quality and the quality assurance cycle
2.2 Methods for problem identification, analysis, and solution
2.3 Action planning

The section refers to ‘tools’ or questionnaires for monitoring the quality of VCT and curative services. Samples of the tools used by LVCT can be found in the appendices of this resource pack.
2.1 Core concepts around quality and the quality assurance cycle

What is quality?

Quality means different things to different people. It might mean reputation, durability of a product, right price, prompt service, high standard, friendly reception, availability of services and many other things.

General definitions

General definitions of quality normally include the following
- achievement of standards or targets
- consideration of client needs and expectations
- consideration of available resources (financial, human and time)
- recognition that there is always room for improvement and that targets and standards must be reviewed

What is quality of care?

“Quality of care does not mean sophisticated or exclusive care, but is concerned with fully meeting the needs of those who need the service most, at the lowest cost to the organisation, within the limits set by higher authorities.”

Why is it important to be concerned about quality of care?

The client’s perspective is very important because if we do not provide services which the client wants and if our standards are lower than other institutions, then they will go elsewhere where for health services or they will only turn to us in emergencies. If we are seriously concerned about quality of care at facility level it will help us achieve many things such as:
- higher standards
- client satisfaction
- methods for assessing our services
- better relations between our fellow workers, clients and the communities we serve
- increased patronage and reputation of our institutions
- staff satisfaction.

If we don’t take quality seriously, clients will start to and continue to use private facilities. Poor quality health services can waste money, waste time and even waste lives. Therefore the main reasons for why quality is important are:
- concern for high standards
- improve our reputation
- reduce the cost of poor quality (wastage)
- increase client satisfaction
- improve staff satisfaction and development

Who does it benefit?

If we improve the quality of health services in our institutions, both clients and staff will become more satisfied. More clients will want to use our services, we will develop a reputation for high quality services and we will attract more money for investment in our facilities and then be able to improve even more. Thus it benefits
1. Community
2. Clients
3. Staff
4. Institution

Who should be involved?

High quality health services does not mean luxury or “high-tech” services. Attention to quality is essential for all countries whatever their resource levels. Improvements in quality can occur without excessive additional resources. Everybody has a responsibility for quality, from national down to individual level.

Is it something new?

No, but health professionals concern with quality has been typically limited to clinical care of individual patients based on technical standards set by the professionals themselves. It has not been focused on the client, but rather the illness. Also what is required is a planned approach where quality is reviewed continuously and the focus is on the whole of health service delivery, not just elements of it.

Dimensions of quality

Quality of care is comprised of different dimensions such as access, efficiency, social acceptability and effectiveness. Quality assurance might look at just one of these dimensions or may look at all of them. Examples of factors that may be important to monitor include:
- Waiting time to see the counsellor
- How staff communicate with patients
- Cleanliness of the facilities
- Staff attitude
- Drug availability
- Proper diagnosis and treatment

Different points of view about quality

Depending on whether you are a client, the community a professional or a manager will depend on what aspects you think are the most important to measure and improve.

The client

It is very important that health services meet the client’s perceived needs and expectations. Satisfied clients are more likely to comply with treatment and to continue to use the services. But it is important to note that clients do not always know what is best for them. Maybe because they are ill informed or they are too ill to make decisions.

Client Quality = what the client expects from health services

The health care provider

Trained professionals such as doctors, nurses, counselors, laboratory technicians, pharmacists and others are expected to provide the best care by virtue of their professional skills. Services rendered by professionals can be defined through professional standards. Professional quality is about technical competence, which maybe our clients are not technically qualified or too ill to assess. But it is important to note that sometimes professionals may not make the best decisions and may waste resources, resources that could have been used to treat other clients.

Professional Quality = whether services meet the needs as defined by professional standards.
2.2 Methods for problem identification, analysis and solution

1. Planning for Quality Assurance
   - preparing for QA in the Health Facility
   - determine scope of programme
   - forming an interdisciplinary QA team

Determining the scope of QA effort at the facility level is extremely important. Facilities should guard against over ambition. A simple, well-focused approach is far more likely to succeed than trying to tackle all quality problems at once. Interdisciplinary QA teams represent the best mechanism for driving the QA process and at least some of the team members should have managerial responsibility to take decisions that can directly influence service quality. The QA team should be responsible for implementing QA by:
   - Promoting QA awareness
   - Continuously monitoring, assessing and improving quality
   - Analysing and using QA data at facility level
   - Developing and implementing quality action plans
   - Involving the community in QA

Suggested membership of the QA team is described in the table below.

<table>
<thead>
<tr>
<th>Integrated Site</th>
<th>Stand-alone site</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical officer/in-charge</td>
<td>Manager</td>
</tr>
<tr>
<td>Nursing officer</td>
<td>Senior counsellor</td>
</tr>
<tr>
<td>Care officer</td>
<td>Junior counsellor</td>
</tr>
<tr>
<td>Public health technician</td>
<td>Laboratory technician</td>
</tr>
<tr>
<td>Counselor</td>
<td>Technician</td>
</tr>
<tr>
<td>Laboratory technician</td>
<td>Receptor</td>
</tr>
<tr>
<td>Drug dispenser</td>
<td></td>
</tr>
<tr>
<td>Receptionist</td>
<td></td>
</tr>
</tbody>
</table>

What is Quality Assurance?
Quality Assurance is a systematic and planned approach to assessing, monitoring and improving the quality of health services on a continuous basis. It promotes confidence, improves communications and allows clearer understanding of community needs and expectations.

1. Quality Assurance is oriented towards meeting the needs and expectations of the patient and the community
2. Quality Assurance focuses on the way we work (how we deliver health services)
3. Quality Assurance employs standards to ensure an acceptable level of quality of care
4. Quality assurance uses data to analyse how we are working and delivering health services in accord with these standards
5. Quality assurance encourages an interdisciplinary team approach to problem solving and quality improvement

The Quality Assurance Cycle
In practice Quality Assurance is a continuous process and the quality assurance cycle can be used to guide your activities. There are various different stages in the cycle which are explained.

Figure 6 the QA cycle

1. Plan for QA
   - Setting standards should be applicable and feasible

   Standards describe the desired and achievable level of performance. We need to have agreed standards so that we can monitor our performance against these standards and know how well we are performing and whether in fact we are reaching the desired standards. Standardization covers two distinct aspects:
   - 1. The development of guidelines for practice (standard operating procedures)
   - 2. Standardization of services, staffing levels, equipment and supplies across health facilities

In Section 1.5 accreditation and registration tools are described which are based on the national VCT guidelines which set out standards of care which all VCT sites should be working towards.

3. Monitor quality of services
   - Select indicators (aspects of the service to be measured)
   - Select information source (client, health centre registers etc.)
   - Design data collection system (client questionnaires, checklists etc.)
   - Implement monitoring
   - Calculate results from data collection

Whilst we all have personal views on the level of quality we provide and receive, the only true way we can find out how we are performing is through measurement which will require the collection of data. We have to be clear on:
   - What it is that we want to monitor - selection of indicators (aspects of the service to be measured)
   - Where we can find this information - identification of information source (client, health centre registers etc.)
   - How we can collect it - Design and implementation of data collection system (client questionnaires, checklists etc.)

No one method can capture all the information we need to know and all methods have both strengths and weaknesses. Normally it is sensible to collect data from various sources and then as a team we can analyse and interpret the findings. Some methods used for monitoring quality include:
   - Records review
   - Supervision
   - Questionnaires/exit interviews
   - Suggestion box
   - Self assessment
   - Observation
   - Analysis of routine data

To get a true picture of quality it will normally be important to use several of these methods described. In Section 1.2 tools that have been used for self assessment and observation are described and in Section 1.5 accreditation and registration tools are described which are based on inspection, observation, record review and staff interview. In this section examples are given of how exit interviews and collection of routine data can be used for monitoring quality of both VCT and curative services.

Client Exit Interviews
It is of vital importance that our services are tailored towards the needs of our clients. Client exit interviews can be used for measuring client perceptions and satisfaction with particular aspects of the service or the service in general. A satisfied client is more likely to listen, comply with treatment and advice and provide complete and accurate information in relation to their concerns and/or sickness. Exit interviews are a rapid way of assessing client perceptions of our services on a routine basis. The community can be involved in the administering of the questionnaires. We believe that clients are more likely to describe how they really feel about services to a community volunteer rather than to a member of staff. By interviewing 100 clients every 6-9 months we can get an idea of how users feel about our services. Client exit interview tools for both curative and VCT services and instructions on how to use the tools are in the appendix.
Routine Data

We can also monitor quality of service provision through the collection and analysis of routine data. In the appendix is the monthly summary sheet for VCT services. By recording accurately all activities we can analyse this data to provide useful information in relation to client flow, gender, age, testing positive and negative, false positives, condom distribution etc. When results from routine data collection are analysed in conjunction with exit interview results, observation and self assessment it provides us with a more complete picture of current levels of quality.

4. Team action for quality improvement

- identify and prioritise quality problems (from monitoring information)
- analyse/understand what is causing the problem
- suggest solutions
- make an action plan to overcome the problem
- implement the solution

A lot of effort goes into monitoring quality, however this must be supported by analysis and identification of quality problems, such that problems can be understood and solutions formulated and implemented. To do this well we need to be systematic in how we tackle these problems and we can use QA tools to help us in team action for quality improvement.

Identifying the problem using results from QA monitoring

Interpreting the results from QA monitoring is a very important part of the quality assurance cycle. You will find it very helpful to either produce graphs or to put the results in a table. This allows you to see visually how you are performing over time and to make comparisons quickly and easily between different sets of QA data that you have collected.

For results from the client exit interviews we recommend that you use bar charts. This will help you to see quickly and easily how you are performing in relation to client satisfaction. If some of the percentages are very low it suggests that these are priority areas that should be addressed to understand why they received such low scores. Also if scores have decreased this should be a real cause of concern. You may also find that when comparing the percentages they have remained the same when you were expecting an improvement or that in some cases things have improved, but not enough!

Figure 7: Data from two cycles of QA in Thika District hospital

Remember when you are comparing your data sets, look out for where:

- percentages are low
- percentages have decreased
- percentages have remained the same
- percentages have improved but still not satisfactory

For analysis of routine data you may find that tables, pie charts and line graphs help you to analyse client throughput and outcomes.

Example of Problem Identification

Data collected from QA monitoring can also be analysed in tabular form. Below are selected results from the QA exit interview for curative care.

Figure 8 line graph of client exit interviews used in problem identification

Remember when you are comparing your data sets, look out for where:

- percentages are low
- percentages have decreased
- percentages have remained the same
- percentages have improved but still not satisfactory

Using the above rules you would probably identify the two most important problems as:

- Waiting time – (decreased by 10%)
- Diagnosis – (score has remained the same and is low)
Prioritising the Problem

Once you have identified the problems it is important that you do not try and tackle every problem at the same time. Instead you must decide which problems have priority. This will help you to decide which problem to tackle first as a team. You can do this by looking at each of the identified problems and considering how serious the problem is in relation to the well-being of the client. Which problem will have the greatest impact by tackling it first? It is also important to consider if you have the resources to overcome the problem - this can be in relation to staffing levels, equipment, time, drugs and money. You should also consider the feasibility of tackling such a problem - how easy is it for us to tackle the problem? Maybe the identified problem is something that you do not have control over. If this is the case it is important to discuss it with your supervisors at district level.

Remember when you are prioritising problems consider:

- seriousness of the problem in relation to client well-being
- resource constraints - financial, manpower, material
- feasibility - is it a problem you can tackle at facility level?

If you are having difficulties in deciding on what problem to tackle first a useful tool for priority setting is the matrix.

| Priority setting Example |

We use priority setting so that we tackle the most important problem first. For the 3 selected problem areas we now have to decide which is the most important (the problem we will tackle first). For this we can use a matrix and the criteria for priority setting.

Remember when you are prioritising problems consider:

<table>
<thead>
<tr>
<th>How Serious?</th>
<th>Time</th>
<th>Diagnosis</th>
<th>Drug availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very serious = 3</td>
<td>1</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Quite serious = 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not serious = 1</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How many resources?</th>
<th>Time</th>
<th>Diagnosis</th>
<th>Drug availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Few resources = 3</td>
<td>2</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Average resources = 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A lot of resources = 1</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How easy?</th>
<th>Time</th>
<th>Diagnosis</th>
<th>Drug availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very easy = 3</td>
<td>2</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Quite easy = 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not easy = 1</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

TOTAL 5 9 4

If you are having difficulties in deciding on what problem to tackle first a useful tool for priority setting is the matrix.

<table>
<thead>
<tr>
<th>Table 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waiting Time</td>
</tr>
<tr>
<td>How Serious?</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>How many resources?</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>How easy?</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>TOTAL 5</td>
</tr>
</tbody>
</table>

Sum the score for each problem and identify the problem with the highest score. Top priority is Diagnosis.

Defining the problem

Once you have identified and prioritised the problems it is important to formulate a full statement that clarifies the nature of the quality problem. Often we think we have identified the problem but in fact we have not expressed it very clearly. Problems should directly relate to specific processes or activities so that the improvement effort is well focused and measurable. When writing the problem statement, it should be expressed a simply as possibly, avoiding jargon and abbreviations that may not be understood by everyone. It should be written precisely and clearly - try and describe the problem in as few words as possible. Finally you should quantify the problem in numbers and/or percentages - in this way everyone will be clear about the extent of the problem.

Remember when defining the problem, the problem statement should be:

- simple, precise, quantified

<table>
<thead>
<tr>
<th>Table 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor problem statement</td>
</tr>
<tr>
<td>Patients are not examined</td>
</tr>
<tr>
<td>Staff are rude</td>
</tr>
<tr>
<td>Too many interruptions</td>
</tr>
<tr>
<td>We need more staff</td>
</tr>
<tr>
<td>Queue jumping</td>
</tr>
</tbody>
</table>

Below are examples of problem statements:

2.3 Action Planning Identifying whom will work on the problem

Once the problem has been fully defined, appropriate people should be assigned to work on the problem. Make sure that as members of the QA team, you DO NOT take all the responsibility. Involve the other health centre staff who are directly involved in the activities which relate to the problem you are working on. This ensures the involvement of those most knowledgeable about the process. Normally it will help if it is a multi-disciplinary group of people working on the problem to ensure that all parts of the problem are understood.

Analysing and studying the problem

Problem analysis will help you understand what is causing the problem. Most problems are NOT caused by a single factor but have many underlying causes. As you analyse your problems and look at their different causes, it is very important that you are honest with yourselves and that you list all the different causes for why the particular problem is occurring. To structure your thinking you can use the problem tree technique.
Deciding on and implementing the solution
The choice of solution must depend on resources available and what is practical. Once the team has chosen the solution, implementing it requires careful planning, and must be written into a QA change plan. Firstly taking into account your selected problem you should set a target for what you are aiming for – by how much do you expect to improve the situation. Remember it is important to be realistic when setting targets. If they are too ambitious you will only be disappointed when you do not meet the target. The next step will involve identifying the principal activities you will need to conduct to implement your chosen solution. For each activity you must be clear of the resource requirements, be realistic about the timescale for conducting each activity, assign persons responsible for each activity and set out exactly how they will monitor (evidence) that the activity has been completed. Once you have agreed the QA change plan with the rest of the health centre staff you are ready to implement it! Figure 10 on the next page is an example of a QA change plan.

Remember, when you prepare your QA change plan:
specify clearly roles and responsibilities for each activity
do not always assign all activities to the same persons, decide on who is/are the most appropriate persons
make time allowances for unexpected activities that may be imposed on you
ensure plans are realistic and flexible

5. Evaluate Action
- evaluate whether you have overcome the problem

Once the solution has been implemented the team should evaluate whether the solution was implemented correctly and whether it resolved the problem it was designed to address. The team can check this by reviewing the monitoring mechanisms described in the problem solution action plan and checking whether the agreed target was attained. Once the solution has proved to be effective, new problems can be identified through your QA measures such as client exit interviews, self assessment etc. and so the cycle is completed.
**APPENDICES**

**Preparation for testing**

Get all materials ready.
- For Determine kits
  - Label strip.
  - Peel off foil cover from strip.
  - Get chase buffer ready.

For Uni-Gold kits
- Peel cover from device.
- Label device.
- Get wash buffer ready.
- Remember that parallel testing should be done.

**Fingerprick procedure**

- Develop rapport with client.
- Let client choose finger.
- Sterilize site.
- Prick finger (puncture skin).
- Wipe off first drop of blood.
- Collect drops of blood (using Uni-Gold pipettes).
- Stop the bleeding.

For Determine assay
- Add two drops of whole blood to the sample pad of the strip (indicated by arrows).
- Let blood soak in.
- Add 2 drops of wash buffer.
- Allow to run for 15 minutes.
- Interpret results.

For Uni-Gold assay
- Add 2 drops of whole blood to the sample part of the device.
- Let blood soak in.
- Add 2 drops of wash buffer.
- Allow to run for 10 minutes.
- Interpret results.

**Safety precautions**

Always wear a pair of gloves when performing any procedure.
- Remember: a new pair of gloves for each client.
- Disinfect bench top as required.
- Dispose of all waste appropriately.

**Good laboratory practice — do’s and don’ts**

- Gloves: wear them always when handling blood.
- Gown: wear as protective clothing and when it becomes contaminated, decontaminate with appropriate disinfectant.
- Spills: decontaminate immediately with appropriate disinfectant.
- Lab space: clean lab floor twice daily. Keep the lab clean and neat.
- Eating, drinking and smoking are prohibited in the lab.
- Pipetting: do not use your mouth to pipette.
- Hand washing: testing staff should wash hands when leaving the lab and after handling specimens.
- Visitors, especially children, should not be allowed in the testing area.
- Waste disposal: dispose of infectious material according to the standards of your health facility.
  - Always classify your waste into —
    - non-contaminated waste and paper waste
    - contaminated waste for incineration
    - sharps

**COUNSELOR SELF ASSESSMENT FORM (LIVERPOOL VCT PROJECT)**

**Score range:** 0-4

0 = very poor; 1 = unsatisfactory; 2 = satisfactory; 3 = good; 4 = excellent

1. Did I explain to the client what to expect in the session?
2. Did the client speak as much or more than I did?
3. Did I perform a risk assessment?
4. Did I help the client come up with a risk reduction plan?
5. Did the client understand the meaning of the test results?
6. Did I feel comfortable giving the result?
7. Did I assess the availability of the client’s social support?
8. Did I discuss referral options with the client?
9. Did I discuss disclosure of test results with the client?
10. Did the client determine an immediate plan of action?
11. Did I deal with the client’s emotional reactions?
12. Did I deal with my own emotional reactions?
13. Did I give adequate time to the client?
14. Did I conduct a client center session?

**DATE:**

**HIV RESULT:**

Neg □ □ □ Pos □ □ □ N/A □ □ □
Guidelines for observed practice

General points
- It is expected that every VCT trainee will attend practice and be supervised by observation for at least 2 days or a minimum of 6 and a maximum of 8 clients within 1 month after the training. The trainees should be informed before the end of the month if the trainee is unlikely to complete the practice in time.
- The supervision is a continuation of learning and therefore should be taken seriously by all trainees.
- Observers should keep records of their observations and discuss these with the trainee after each observed session.
- These records will be produced at the end of the practice and used as evidence of the trainee’s progress.
- On reaching the site...
  ✓ The observer informs the trainee to the VCT centre and gives the trainee a counsellor code. This is important as it makes the trainee feel welcome.
  ✔ The observer takes the trainee through the VCT protocol. This is generally discussing with the trainee the main objectives for each protocol component and the VCT procedures, including lab procedures particular to the site. Trainees should be fully competent to collect samples before the observed practice.
  ✓ The observer explains to the client that training is in process and asks if the client has any objections to having an observer in the session. The client should be able to ask the trainee to leave at any stage.

Observation of experienced counsellor in session
- The observer then has one or two real sessions with a client while the trainee observes.
- The trainee should be placed in a position that does not distract the client.
- The trainee should not talk or interrupt the session in any way.
- After the session the observer and the trainee discuss the session and clarify any issues.

Observation of the trainee in session
- The trainee then gets the first client and the observer sits in to observe. It is important that the observer sits out of the way of the trainee and does not distract the client.
- Ideally the observer should not disrupt the session in any way.
- The trainee should not refer to the observer unless it is crucial.
- The observer should make notes on the observation checklist (following).
- If the observer feels the trainee is floundering or making mistakes, the observer may intervene in the session as necessary. If the trainee is unsuccessful in collecting the sample in the second attempt the observer should intervene.
- Afterwards, observer and trainee discuss the session and the observer gives the trainee feedback. It should be remembered that this is not an assessment but part of the learning. Feedback should be constructive and given in a supportive manner.
- After the feedback the trainee may take another client and be supervised in the same way. Should the observer feel the trainee is not yet ready, the observer should tell the trainee, giving reasons, and give the trainee the opportunity to observe further sessions.
- When the observer feels confident that the trainee is ready and competent enough, the observer may leave the trainee alone to see one or two clients. The observer should remain ready to help the trainee should the trainee require help. After each session the observer should check on how the trainee is doing and discuss the sessions.
- Throughout all the observation process, the observer must maintain confidentiality. This creates an atmosphere in which the trainee can develop confidence and learn by example from the observer about confidentiality.
- While counselling a minimum of six clients, the trainee should be observed at least four times including the last session before finishing the practice. Where possible, the person who observes the last session should be the one who has been observing the trainee. In this way the observation of the last session takes on the form of an exam.
- After seeing six clients, should the observer feel that the trainee is not yet ready or competent enough to provide VCT services, the observer may discuss this with the trainers and include this in the report on the trainee.

Observed practice form

Date: ________ Venue: ________ Trainee: ________
Observer: ________ Session no.: ________ VCT centre: ________

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

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

Session: Start time: ___:___ Stop time: ___:___
Observer: _______________ Session date: ___/___/___
### LABORATORY SUPERVISION TOOL

Supervisory tool for external assessment of rapid HIV testing procedures in both integrated and stand-alone VCT sites.

<table>
<thead>
<tr>
<th>Facility Name:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site Code:</td>
<td></td>
</tr>
<tr>
<td>District:</td>
<td></td>
</tr>
</tbody>
</table>

**Designation of External Assessors:**

**No. Of Testing Personnel Present:**

**Purpose:**
To ensure that quality testing is maintained in all VCT sites

**Objectives:**
To assess the following:
1. Testing facility
2. Availability and use of test kits and disposal receptacles
3. Test kit storage
4. Skills in sample collection and testing
5. Interpretation of results
6. Adherence to testing protocols
7. Availability and use of disinfectants
8. Adherence to safety measures
9. Availability and use of ‘laboratory’ log books
10. Quality control measures in place
11. General staff interaction with regard to testing

#### a) SCORING SYSTEM

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Minimum standard not met; no demonstrated efforts; only excuses</td>
</tr>
<tr>
<td>4</td>
<td>Minimum standard not met; demonstrated efforts; visible commitment to improve</td>
</tr>
<tr>
<td>3</td>
<td>Minimum standard met; acceptable compliance with maximum standard</td>
</tr>
<tr>
<td>2</td>
<td>Minimum standard met; demonstrated effort to surpass the standard; visible commitment to do even better in future; maximum standard met in most aspects</td>
</tr>
<tr>
<td>1</td>
<td>Maximum standard met; hardly possible to improve any further; demonstrated positive trends over a longer period of time (to be agreed upon)</td>
</tr>
</tbody>
</table>

**Note:**
Some of the items to be assessed require either ‘yes’ or ‘no’ as answers. In such cases score 1=YES and 5=NO. Minimum standard is based on the location of the facility, the general layout, environment, and its general organization. The assessor may describe this at the end of the session.
b) TESTING STAFF PROFILE

Please complete table for each member of staff performing tests in the facility

<table>
<thead>
<tr>
<th>Name</th>
<th>Position/Laboratory technician or technologist, counselor or both</th>
<th>Completed recognised training on testing</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I STRUCTURE

1. Supervision
   1.1 Named internal supervisor available?
   1.2 List of staff performing tests available, including qualifications?
   1.3 Code numbers of staff performing tests available?

2. Infrastructure
   2.1 Adequate testing room/space available?
   2.2 Adequate illumination of testing area?
   2.3 Room adequately furnished (1 table, 3 chairs)?
   2.4 Room properly organized for testing?
   2.5 Lockable cabinet for storing kits available?
   2.6 Lockable cabinet for storing records?
   2.7 Lockable cabinet for storing filter papers samples?
   2.8 Safe water supply in testing room?

3. Supplies and Storage
   3.1 Monthly status-report on testing accessories (gloves, spirit, cotton wool, lancets, soap, disinfectants)?
   3.2 Uninterrupted and adequate supply of accessories?
   3.3 Stock-out experienced since last visit?
   3.4 Kits within expiry date?
   3.4.1 Determine
   3.4.2 Uni-Gold
   3.5 Stock at hand
   3.5.1 Determine
   3.5.2 Uni-Gold
   3.6 Kits stored at an appropriate temperature? (Fridge required if above 30 degrees)
   3.7 Uninterrupted and adequate supply of QC/QA materials (filter paper, glycine bags, dry racks, desiccants, humidity indicator cards, zip-lock bags)?

4. Safety in sample collection
   4.1 Disposal receptacle for dry waste available?
   4.2 Disposal receptacle for sharp implements available?
   4.3 Adequate amount of working strength disinfectant available?
   4.4 Adequate waste disposal system in place (incinerator or pit)?
   4.5 Addresses of contact people posted on wall visible to all staff?
   4.6 Adequate guidance on PEP
   4.7 Knows about where to get PEP
   4.8 Adequate waste disposal system in place (incinerator or pit)?

5. Records
   5.1 ‘Laboratory’ logbooks available?
   5.2 Records of expiry date and lot numbers of test kits available?
   5.3 All test results recorded?
   5.4 All test anomalies recorded?

6. Sample Collection and Client Care
   6.1 All requirements within reach?
   6.2 Initial rapport developed with client to explain whole process?
   6.3 Test devices opened (and labeled) in the presence of client?
   6.4 QC/QA appliances set and labeled in the presence of client?
   6.5 Client asked to make choice of finger?
   6.6 Proper swabbing of finger with spirit (alcohol) done?
   6.7 Fingerstick done correctly (check on site, orientation of lancet, depth)?
   6.8 First drop of blood wiped off (dry cotton wool used)?
   6.9 Washing of finger done correctly?
   6.10 Sample collected well?
   6.11 Bleeding stopped correctly (dry cotton wool used)?
   6.12 Client reassured all through the process?

7. Testing Procedures
   7.1 Determine
   7.1.1 Two drops of whole blood added?
   7.1.2 One drop of Chase buffer added?
   7.1.3 Minimum of 15 minutes allowed for results to develop?
   7.1.4 Results interpreted correctly?
   7.2 Uni-Gold
   7.2.1 Two drops of whole blood added?
   7.2.2 Two drops of Wash buffer added?
   7.2.3 Minimum of 10 minutes allowed for results to develop?
   7.2.4 Results interpreted correctly?

8. Handling of filter paper
   8.1 Gloves assessed for presence of powder before starting preparation?
   8.2 Circles on filter paper not touched?
   8.3 Filter paper labeled correctly?
   8.4 Filter paper placed in the proper orientation?
   8.5 Three (3) or more circles properly charged with blood?
   8.6 Location set aside for drying is adequate and convenient?

9. Safety in handling filter paper
   9.1 Working surfaces cleaned before work commenced?
   9.2 Arrangement of working surface in order?
   9.3 A new pair of gloves used per client?
   9.4 Disposal of all waste done promptly and correctly?
   9.5 Hands washed correctly after completion of process?

10. Continuous Quality Assessment
    10.1 Regular peer evaluation done within the facility (monthly)?
    10.2 Standardized procedures are printed and accessible to all testing staff?
    10.3 Does peer evaluation meeting identify weak points?
    10.4 All discordant result cases referred to reference laboratory?
    10.5 All filter paper samples sent for quality assurance to reference laboratory?
## III RESULTS

### 11. Performance

11.1 Average number of clients/counselor/day (<10 clients)?

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
</table>

11.2 % Done where getting blood was a problem (more than one prick)?

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
</table>

11.3 % Done where insufficient amount of blood obtained (not enough for both testing and to fill at least three circles on filter paper)?

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
</table>

11.4 Level of standardization of testing process

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
</table>

11.5 Reported cases of invalid results obtained

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
</table>

11.6 Levels of concordance with reference laboratory

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
</table>

### General comments:

__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

### Final score

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
</table>

---

### Quality Assurance Resource Pack for Voluntary Counselling and Testing service providers

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### SECTION 2 TRAINING MATERIALS FOR IMPLEMENTING QUALITY ASSURANCE
Record keeping and confidentiality

It is essential that confidentiality be maintained when conducting HIV testing of any type. Confidentiality can be achieved in two ways.

One way is through maintaining very strict control of access to the client’s name and test results, releasing results only to others, such as health workers, if the client agrees. The other method is to practice anonymity, when no names are taken and only codes are used. It is common experience that more clients will request VCT when their names are not recorded and anonymity is practised and ensured.

It is recommended that anonymous procedures be used at VCT sites. However, it should be noted that confidentiality in VCT services involves not only using codes but also managing the waiting room and client flow and also ensuring that VCT clients are not readily identified by public or other patients using the health facilities.

The following coding system has been adopted for district codes, site codes, counsellor and client codes.

District codes. Standardized codes from NASCOP include the province code as the first number.

Site codes. Standardized codes from NASCOP are added to the district code. New sites, such as private VCT sites and community-based organizations sites, need to be registered with NASCOP for a code.

Counsellor codes. Counsellors are given a 3-digit serial code number. For example, two counsellors at a site will simply be 001 and 002.

Client codes. Client codes are made up of the site code (5 digits), followed by the year (2 digits), followed by a serial number (4 digits). For example, the fifth client who comes to site 20601 (Thika District Hospital) in year 2004, will become 20601-04-0005. This allows a unique identifier for each client across the country.

Guidelines on how to fill the VCT form

Date: Date of VCT session in the format dd/mm/yyyy

Site Identifiers: Province, District & Site Codes, Site Type are pre-printed

Counselor Code: Enter your 3 digit counselor code

Return visit: Tick only one as appropriate

New client code: Tick only one as appropriate 0 (No) if Return Visit =1 or 1 (Yes) if Return Visit = 0 (or if old client code is lost)

Client code: 5 digit site code is pre-printed, enter 2 digit year (e.g. ‘03’) & 4 digit ID number

Partner code: Only for couple sessions, enter 5 digit site code, enter 2 digit years 4 digit ID number

Mothers maiden names: Clearly write down any two names offered

Sex: Tick in male or female box

Age: Clearly write down in the space provided, age in years (2 digits)

Occupation: Tick only one as appropriate (1st mentioned by client) and write details in the specify box

Education: Tick only one as appropriate

Marital status: Tick only one as appropriate

Client seen as: Tick only one as appropriate

Is the client pregnant (Women only): Tick only one as appropriate

What service does the client want today: Tick only one as appropriate

Reason for VCT today: Tick as many reasons as mentioned by client

How did client learn about VCT services: Tick as many responses as mentioned by client

Has the client ever had sex: Tick as only one as appropriate

Number of sex partners in the last 12m: Write down the appropriate number for each type of partner (zero if client never had sex or had no sex in the last 12m)

Condom use in previous 12 months: Tick only one as appropriate for each type of partner; tick ‘9’ if client ‘never had sex’ or ‘3’ if client had no sex in last 12m or ‘4’ if they don’t have a steady (non-steady) partner

Client used condom last time had sex: Tick only one as appropriate, tick ‘9’ if client ‘never had sex’ or ‘3’ if client had no sex in last 12m

If not tested today why not: Tick only one as appropriate

Client ever tested for HIV: Tick one as appropriate

HIV result today: Indicate test kit used (test 1=Determine; test 2=Unigold )

Tic only one as appropriate for the results of each test

Syphilis result today: Tick only one as appropriate

Couple discordant: Tick ‘0’ or ‘1’ for client came with sexual partner (couple) and ‘9’ if client came alone or in a group

Condoms given to client: Tick only one as appropriate. If yes, please indicate number given. Tick 8 if your agency does not distribute condoms

Client referred to: Tick all that apply - client may be referred to more than one place

Record keeping and confidentiality

It is essential that confidentiality be maintained when conducting HIV testing of any type. Confidentiality can be achieved in two ways.

One way is through maintaining very strict control of access to the client’s name and test results, releasing results only to others, such as health workers, if the client agrees. The other method is to practice anonymity, when no names are taken and only codes are used. It is common experience that more clients will request VCT when their names are not recorded and anonymity is practised and ensured.

It is recommended that anonymous procedures be used at VCT sites. However, it should be noted that confidentiality in VCT services involves not only using codes but also managing the waiting room and client flow and also ensuring that VCT clients are not readily identified by public or other patients using the health facilities.

The following coding system has been adopted for district codes, site codes, counsellor and client codes.

District codes. Standardized codes from NASCOP include the province code as the first number.

Site codes. Standardized codes from NASCOP are added to the district code. New sites, such as private VCT sites and community-based organizations sites, need to be registered with NASCOP for a code.

Counsellor codes. Counsellors are given a 3-digit serial code number. For example, two counsellors at a site will simply be 001 and 002.

Client codes. Client codes are made up of the site code (5 digits), followed by the year (2 digits), followed by a serial number (4 digits). For example, the fifth client who comes to site 20601 (Thika District Hospital) in year 2004, will become 20601-04-0005. This allows a unique identifier for each client across the country.
REGISTRATION SURVEY TOOL

For use by NASCOP to register and give site codes to new VCT Sites
(Not to be used for facilities providing routine diagnostic or mandatory HIV testing)

Assessment for registration of new sites
Registration is compulsory for all sites planning to provide VCT services. The registration assessment focuses on adequacy of existing structures (human resources, guidelines, infrastructure, safety issues and information systems) for delivery of VCT services.

Facility Name: Date:
Site Code: Time started:
District: Time finished:
Facility Type: (please circle) SA / INT / COM
SA = Stand-Alone
INT = Integrated
COM = NGO/CBO
Assessors:
Staff interviewed:

Purpose:
To ensure compliance with minimum national VCT standards for registration.

Objectives:
1. Assess availability of trained personnel
2. Assess adherence to VCT and safety guidelines
3. Assess physical infrastructure for VCT service delivery.

a) STAFF SITE PROFILE
Please complete table for each member of staff working on VCT in the facility.

<table>
<thead>
<tr>
<th>Name</th>
<th>Position (supervisor, counsellor, lab technician, receptionist, etc.)</th>
<th>% time on VCT</th>
<th>Completed national VCT curriculum training</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
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<td>3</td>
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<td>4</td>
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<td>5</td>
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<td>9</td>
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<td>10</td>
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<td>11</td>
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<td>12</td>
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<td>13</td>
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<td>14</td>
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<td></td>
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<tr>
<td>15</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

b) SITE OPENING HOURS

<table>
<thead>
<tr>
<th>Days of the Week</th>
<th>Opening Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday - Friday</td>
<td></td>
</tr>
<tr>
<td>Saturday</td>
<td></td>
</tr>
<tr>
<td>Sunday</td>
<td></td>
</tr>
</tbody>
</table>

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### c) SCORING SYSTEM

<table>
<thead>
<tr>
<th></th>
<th>No</th>
<th>Minimum standard not met</th>
<th>Yes</th>
<th>Minimum standard met</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Human Resources</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Two VCT trained counsellors (in accordance with National VCT Guidelines) available?</td>
<td>Yes</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>2 Trained lab technician or counsellor able to do rapid tests available?</td>
<td>Yes</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>3 Internal administrative supervisor or in-charge available?</td>
<td>Yes</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>4 Trained counsellor-supervisor available?</td>
<td>Yes</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td><strong>Policy, Standards and Guidelines</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 National VCT guidelines easily accessible?</td>
<td>Yes</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>6 VCT counselling protocols available and on display?</td>
<td>Yes</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>7 VCT testing protocols available and on display?</td>
<td>Yes</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>8 Safety guidelines available and on display (including advice on needle stick injuries)?</td>
<td>Yes</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td><strong>Infrastructure</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 Adequate sign posting and directions for VCT rooms?</td>
<td>Yes</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>10 Door tags available (please enter/counselling in progress)?</td>
<td>Yes</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>11 Adequate counselling rooms available (well lit, spacious, ventilated, private)?</td>
<td>Yes</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>12 Room/s adequately equipped with 3 chairs, 1 table and separate testing surface?</td>
<td>Yes</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>13 Adequate waiting area (chairs and space)?</td>
<td>Yes</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>14 Room/s and waiting area well maintained and clean?</td>
<td>Yes</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>15 Secure lockable cupboard for storing client records available (counsellor access only)?</td>
<td>Yes</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>16 Provision for storing test kits at appropriate temperature?</td>
<td>Yes</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>17 Penile model available and on display?</td>
<td>Yes</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>18 Condoms freely available and on display?</td>
<td>Yes</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>19 Accessible clean toilets?</td>
<td>Yes</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td><strong>Safety</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20 Hand washing facilities in testing room or nearby?</td>
<td>Yes</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>21 Sharps container available for disposal of lancets and needles?</td>
<td>Yes</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>22 Separate bin in testing room for disposal of contaminated waste (gloves, cotton wool etc.)?</td>
<td>Yes</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>23 Pit or incinerator available for disposal of contaminated waste?</td>
<td>Yes</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td><strong>Records and Information System</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24 Client register available</td>
<td>Yes</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>25 System for anonymous client coding in place</td>
<td>Yes</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>26 Laboratory log book available</td>
<td>Yes</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>27 Referral system in place or being developed?</td>
<td>Yes</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>28 Quality assurance system for testing in place or being developed?</td>
<td>Yes</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>29 Quality assurance system for counselling in place or being developed?</td>
<td>Yes</td>
<td></td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

I hereby make a commitment to adhere to current VCT guidelines or any other guideline that may be introduced by NASCOP in future.

---

On-site supervisor / in-charge: _______________________________
Witnessed by assessor: _______________________________

---

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Version 2 (April 2002)
ANNUAL REGISTRATION AND VOLUNTARY ACCREDITATION SURVEY TOOL

For Assessment of VCT Sites
(Not to be used for facilities providing routine diagnostic or mandatory HIV testing)

Facility Name: Date:
Site Code: Time started:
District: Time finished:
Facility Type: (please circle) SA / INT / COM
SA = Stand-Alone
INT = Integrated
COM = CBO/NGO
Assessors:
Staff interviewed:

Purpose:
To ensure compliance with minimum national VCT standards and guidelines

Objectives:
1. Assess availability of staffing levels
2. Assess adherence to protocols
3. Assess availability of health education materials and condoms
4. Assess availability and use of record keeping formats
5. Assess availability of test kits and medical consumables
6. Assess adherence to staff roles and responsibilities
7. Assess general aspects of site operations

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C) SCORING SYSTEM

1. Minimum standard met; no efforts; only excuses
2. Minimum standard met; demonstrated efforts, visible commitment to change the situation
3. Minimum standard met; acceptable compliance with minimum standard
4. Minimum standard met; demonstrated effort to surpass the standard; visible commitment to do even better in future; maximum standard met in most aspects
5. Maximum standard met; hardly possible to improve any further; demonstrated positive trends over a longer period of time

I STRUCTURE
1. Leadership & Supervision
   1.1 Regular VCT site meetings (monthly)?
   1.2 Regular QA site meetings (bimonthly)?
   1.3 Named District VCT coordinator making supervisory visits?
   1.4 Named counsellor supervisor trained and available?
   1.5 Trained lab technician supervising systems for testing?
   1.6 Named internal administrative supervisor or in-charge supportive?

2. Human Resource Management
   2.1 List of VCT staff available including registration, qualifications etc.?
   2.2 Job descriptions of VCT staff available?
   2.3 Two VCT trained counsellors (in accordance with National VCT Guidelines) available?
   2.4 Receptionist or clerk available (oriented to VCT)
   2.5 Trained lab technician or counsellor able to do rapid tests available?
   2.6 Trained VCT site-manager available

3. Policy Standards and Guidelines
   3.1 National VCT guidelines easily accessible?
   3.2 VCT counselling protocols available and on display?
   3.3 VCT testing protocols available and on display?
   3.4 Safety guidelines available and on display (including advice on needle stick injuries)?

4. Infrastructure
   4.1 Facility registered to provide VCT services (site-code from NASCOP)?
   4.2 Adequate counselling room(s) available (well lit, spacious, ventilated, private)?
   4.3 Rooms adequately equipped with 3 chairs, 1 table and separate testing surface?
   4.4 Penile model available and on display?
   4.5 Lockable cupboard for storing client records available (counsellor access only)?
   4.6 Rooms and waiting area well maintained and clean?
   4.7 Adequate waiting area (chairs and space)?
   4.8 Accessible clean toilets?

5. Supplies and Storage
   5.1 Monthly status report on non-pharmaceuticals (gloves, syringes, condoms etc.)?
   5.2 Uninterrupted and adequate supply of non-pharmaceuticals (gloves, lancets, condoms, spirit, cotton wool, chlorine, detergent, disposable syringes)?
   5.3 Uninterrupted and adequate supply of rapid test kits in stock?
   5.4 Kits within expiry date?
   5.5 Kits stored at an appropriate temperature?

6. Safety
   6.1 All VCT staff received Hepatitis B immunisation?
   6.2 Hand washing facilities in testing room?
   6.3 Sharps container used for disposal of lancets and needles?
   6.4 Separate bin in testing room used for disposal of all contaminated waste (gloves etc.?)
   6.5 Pilot or incinerator used for final disposal of all contaminated waste?

R = Registration
A = Accreditation
D = Desirable

II PROCESS

7. Referral System
   7.1 Referral system in place and functioning?
   7.2 Referral directory/list available?
   7.3 Designated referral site for care and support?
   7.4 Post-test support available (PTC, PLWHA etc.)?

8. Records and Information System
   8.1 Uninterrupted and adequate supply of VCT data forms and client cards?
   8.2 Client register available and used?
   8.3 Laboratory log book available and used?
   8.4 System for anonymous client coding in place and functioning?
   8.5 Easily retrievable copies of quarterly reports sent to DHMT available?
   8.6 Written feedback from District easily accessible?

9. IEC Materials
   9.1 Signboards, signs, labels and directions for VCT rooms/s?
   9.2 Opening hours prominently displayed?
   9.3 Door tags used for privacy (please enter/counselling in progress)?
   9.4 Uninterrupted and adequate supply of VCT leaflets and posters?
   9.5 VCT leaflets on display and available for clients?
   9.6 Content of leaflet is clear and easy to understand?
   9.7 VCT posters prominently displayed?
   9.8 Content of poster is clear and easy to understand?
   9.9 Adequate supply of condoms freely available and on display?

10. Financial Management
    10.1 Fee charges prominently displayed?
    10.2 Records of accounts available?
    10.3 Clear policy and measures in place for clients unable to pay?

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Instructions for Conducting Client Exit Interview

Who do I Interview?
Using the Curative Care questionnaire, interview those who have come for curative care and not for any other reasons such as immunisation, antenatal care, TB, dressings etc.
If the patient is a child then interview the adult who has brought the child.
Using the counselling questionnaire, interview only those who have come for counselling services.

How many clients do I interview?
Interview 100 patients who come for curative care in order to obtain an accurate representation. Try and conduct 10 patient interviews per day over a 2-week period. If you normally have between 20 and 30 people attending the health centre then interview every second person that attends daily. If 30+ attend daily, then interview every third person, if 40+ attend daily then interview every fourth person.
Interview all those clients who come for counselling services over a 2-week period.

How often should we interview our clients?
We recommend that you collect this data once every 6 months so that you can assess your advances in improving quality.

Who should conduct the interview?
Make sure the same person interviews all the patients to ensure that the questions are always asked in the same way. Try and get an outsider e.g. a community volunteer or a member of staff from one of the other health centres that will not be known by the patients who use your health centre. If it is a member of staff conducting the interview it is better that he/she is not wearing their uniform.

When do I interview them?
Interview curative care patients as they leave the health centre, after they have collected their drugs.
For the counselling clients interview them immediately after they have seen the counsellor.
Each interview should take 5 minutes or less.
Number the questionnaires in consecutive order each day (starting from 1) and date them.

Where do I interview them?
Try and find a place that is quiet and away from the other patients and staff. Offer the patient somewhere to sit so that they feel comfortable during the interview.

Interview technique
• Ask the client if you may interview them.
• Explain briefly why you are interviewing them (read to them the introductory paragraph at the top of each questionnaire)
• Ask the questions exactly as they are written and only give further explanations if you feel they do not understand the question.
• Ask the questions very clearly and let the client decide their response. (Remember that it is the client’s perception of the service that we are measuring and not what you think their perception is! Do not try to influence the client’s answer.)
We are conducting a survey with users of our health centre to find out what you think about our services. This will help us improve quality to future clients. Your answers are strictly confidential and we thank you for your participation and honesty.

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

1. How long did you wait before you saw the doctor?
   - [ ] < 30 mins
   - [ ] 30 mins – 1 hr
   - [ ] 1 hr – 2 hrs
   - [ ] > 2 hrs
   - [ ] N/A

2. How did the doctor welcome you?
   - [ ] Warm
   - [ ] Neutral
   - [ ] Cold

3. Did you feel the counsellor was confident in his/her role?
   - [ ] Yes
   - [ ] No
   - [ ] Not sure

4. Did the counsellor help you to feel free to talk about all your concerns and personal issues?
   - [ ] Yes
   - [ ] No
   - [ ] N/A

5. Did you feel the counsellor understood your concerns?
   - [ ] Yes
   - [ ] No
   - [ ] N/A

6. Did you feel the counsellor was respectful towards you?
   - [ ] Yes
   - [ ] No
   - [ ] N/A

7. Did you feel your personal issues would remain safe between you and the counsellor?
   - [ ] Yes
   - [ ] No
   - [ ] N/A

8. Did you feel your personal issues would remain safe between you and the counsellor?
   - [ ] Yes
   - [ ] No
   - [ ] N/A

9. Did you feel that you received all the necessary information you needed to know?
   - [ ] Yes
   - [ ] No
   - [ ] N/A

10. Did you have enough time with the counsellor?
    - [ ] Yes
    - [ ] No
    - [ ] N/A

11. Did you feel the counsellor listened to you?
    - [ ] Yes
    - [ ] No
    - [ ] N/A

12. Did you feel that your concerns were heard correctly?
    - [ ] Yes
    - [ ] No
    - [ ] N/A

13. Did you feel that your concerns were heard correctly?
    - [ ] Yes
    - [ ] No
    - [ ] N/A

14. Did you feel comfortable when your sample was taken?
    - [ ] Yes
    - [ ] No
    - [ ] N/A

15. Did you feel the counsellor was confident in his/her role?
    - [ ] Yes
    - [ ] No
    - [ ] Not sure

16. Did you feel the counsellor was confident in his/her role?
    - [ ] Yes
    - [ ] No
    - [ ] Not sure

17. Did you feel the counsellor was confident in his/her role?
    - [ ] Yes
    - [ ] No
    - [ ] Not sure

18. Did you feel the counsellor was confident in his/her role?
    - [ ] Yes
    - [ ] No
    - [ ] Not sure

19. Did you feel the counsellor was confident in his/her role?
    - [ ] Yes
    - [ ] No
    - [ ] Not sure

20. Did you feel the counsellor was confident in his/her role?
    - [ ] Yes
    - [ ] No
    - [ ] Not sure

21. Did you feel the counsellor was confident in his/her role?
    - [ ] Yes
    - [ ] No
    - [ ] Not sure

22. Did you feel the counsellor was confident in his/her role?
    - [ ] Yes
    - [ ] No
    - [ ] Not sure

23. Did you feel the counsellor was confident in his/her role?
    - [ ] Yes
    - [ ] No
    - [ ] Not sure

24. Did you feel the counsellor was confident in his/her role?
    - [ ] Yes
    - [ ] No
    - [ ] Not sure

25. Did you feel the counsellor was confident in his/her role?
    - [ ] Yes
    - [ ] No
    - [ ] Not sure

26. Did you feel the counsellor was confident in his/her role?
    - [ ] Yes
    - [ ] No
    - [ ] Not sure

27. Did you feel the counsellor was confident in his/her role?
    - [ ] Yes
    - [ ] No
    - [ ] Not sure

28. Did you feel the counsellor was confident in his/her role?
    - [ ] Yes
    - [ ] No
    - [ ] Not sure

29. Did you feel the counsellor was confident in his/her role?
    - [ ] Yes
    - [ ] No
    - [ ] Not sure

30. Did you feel the counsellor was confident in his/her role?
    - [ ] Yes
    - [ ] No
    - [ ] Not sure

31. Did you feel the counsellor was confident in his/her role?
    - [ ] Yes
    - [ ] No
    - [ ] Not sure

32. Did you feel the counsellor was confident in his/her role?
    - [ ] Yes
    - [ ] No
    - [ ] Not sure

33. Did you feel the counsellor was confident in his/her role?
    - [ ] Yes
    - [ ] No
    - [ ] Not sure

34. Did you feel the counsellor was confident in his/her role?
    - [ ] Yes
    - [ ] No
    - [ ] Not sure

35. Did you feel the counsellor was confident in his/her role?
    - [ ] Yes
    - [ ] No
    - [ ] Not sure

36. Did you feel the counsellor was confident in his/her role?
    - [ ] Yes
    - [ ] No
    - [ ] Not sure

37. Did you feel the counsellor was confident in his/her role?
    - [ ] Yes
    - [ ] No
    - [ ] Not sure

38. Did you feel the counsellor was confident in his/her role?
    - [ ] Yes
    - [ ] No
    - [ ] Not sure

39. Did you feel the counsellor was confident in his/her role?
    - [ ] Yes
    - [ ] No
    - [ ] Not sure

40. Did you feel the counsellor was confident in his/her role?
    - [ ] Yes
    - [ ] No
    - [ ] Not sure

41. Did you feel the counsellor was confident in his/her role?
    - [ ] Yes
    - [ ] No
    - [ ] Not sure

42. Did you feel the counsellor was confident in his/her role?
    - [ ] Yes
    - [ ] No
    - [ ] Not sure

43. Did you feel the counsellor was confident in his/her role?
    - [ ] Yes
    - [ ] No
    - [ ] Not sure

44. Did you feel the counsellor was confident in his/her role?
    - [ ] Yes
    - [ ] No
    - [ ] Not sure

45. Did you feel the counsellor was confident in his/her role?
    - [ ] Yes
    - [ ] No
    - [ ] Not sure

46. Did you feel the counsellor was confident in his/her role?
    - [ ] Yes
    - [ ] No
    - [ ] Not sure

47. Did you feel the counsellor was confident in his/her role?
    - [ ] Yes
    - [ ] No
    - [ ] Not sure

48. Did you feel the counsellor was confident in his/her role?
    - [ ] Yes
    - [ ] No
    - [ ] Not sure

49. Did you feel the counsellor was confident in his/her role?
    - [ ] Yes
    - [ ] No
    - [ ] Not sure

50. Did you feel the counsellor was confident in his/her role?
    - [ ] Yes
    - [ ] No
    - [ ] Not sure

51. Did you feel the counsellor was confident in his/her role?
    - [ ] Yes
    - [ ] No
    - [ ] Not sure

52. Did you feel the counsellor was confident in his/her role?
    - [ ] Yes
    - [ ] No
    - [ ] Not sure

53. Did you feel the counsellor was confident in his/her role?
    - [ ] Yes
    - [ ] No
    - [ ] Not sure

54. Did you feel the counsellor was confident in his/her role?
    - [ ] Yes
    - [ ] No
    - [ ] Not sure

55. Did you feel the counsellor was confident in his/her role?
    - [ ] Yes
    - [ ] No
    - [ ] Not sure

56. Did you feel the counsellor was confident in his/her role?
    - [ ] Yes
    - [ ] No
    - [ ] Not sure

57. Did you feel the counsellor was confident in his/her role?
    - [ ] Yes
    - [ ] No
    - [ ] Not sure

58. Did you feel the counsellor was confident in his/her role?
    - [ ] Yes
    - [ ] No
    - [ ] Not sure

59. Did you feel the counsellor was confident in his/her role?
    - [ ] Yes
    - [ ] No
    - [ ] Not sure

60. Did you feel the counsellor was confident in his/her role?
    - [ ] Yes
    - [ ] No
    - [ ] Not sure

Thank you very much for your patience and time!
### SUMMARY SHEET (Client Exit Interview - VCT)

<table>
<thead>
<tr>
<th>Site Code:</th>
<th>District:</th>
</tr>
</thead>
<tbody>
<tr>
<td>From:</td>
<td>To:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Aspects of service being assessed</th>
<th>Number</th>
<th>Total number responding (exclude NAs)</th>
<th>Percentage (number/total number) x 100</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Waiting less than 30 minutes to see the counsellor</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Welcome (Warm)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Explained what to expect</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Felt free</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Listened</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Understood personal issues</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Personal issues remain safe</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Discussed risk behaviour</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Discussed disclosure to partner</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>10. Discussed condom use</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Counsellor comfortable discussing issues</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Condom demonstration</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Blood sample taken</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Finger prick (once)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>15. Comfortable when sample taken</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Confidence of counsellor</td>
<td></td>
<td></td>
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<tr>
<td>17. Counsellor respectful</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. Counsellor genuine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. Counsellor non-judgemental</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. Privacy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. Time (just right)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. Received necessary information</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23. Room in convenient place</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24. Attitude of other health centre staff (very good)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25. Will recommend to others</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26. Overall satisfaction (excellent)</td>
<td></td>
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</tr>
</tbody>
</table>

### SUMMARY SHEET (Client Exit Interview - Curative)

<table>
<thead>
<tr>
<th>Health centre:</th>
<th>District:</th>
</tr>
</thead>
<tbody>
<tr>
<td>From:</td>
<td>To:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Aspects of service being assessed</th>
<th>Number</th>
<th>Total number responding (exclude NAs)</th>
<th>Percentage (number/total number) x 100</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Waiting less than 30 minutes to see the doctor</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. No unnecessary delays (No)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Being listened to</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Asked questions about your concerns</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Physical examination</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Felt comfortable</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Privacy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Told what you are suffering from</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Advice about your problem</td>
<td></td>
<td></td>
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<tr>
<td>10. Understood advice</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>11. Advice about when to return</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>12. Prescribed drugs/injections</td>
<td></td>
<td></td>
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<tr>
<td>13. Received all drugs/injections</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Advice about drug usage/injection</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Understood drug/injection advice</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Waiting less than 15 minutes to receive drugs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Receipt for all payments</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. Staff co-operation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. Attitude of doctor (very good)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. Attitude of person in pharmacy (very good)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. Attitude of reception staff (very good)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. Attitude of watchman (very good)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23. Cleanliness (very clean)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24. Overall satisfaction (excellent)</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
Quality Assurance Resource Pack for Voluntary Counselling and Testing service providers

National Guidelines


Books/ Manuals/Technical Reports

9. Woodward CA (2000) Issues in Health Service Delivery, Improving provider skills; Strategies for assisting health workers to modify and improve skills: Developing quality health care – a process of change. Discussion paper No 1, WHO/EIP/OSD/00.1

Relevant Journals:


Useful Web-Sites:

Http://www.isqua.net.au
Http://www.qaproject.org
Http://www.liv.ac.uk/fstm
Glossary of terms

Effectiveness
the extent to which something achieves its aim

Efficiency
delivering maximum services with minimum expenditure of resources

Equity
ensuring fairness and lack of discrimination in access to health

Health Services
all services designed to improve health and well-being

Indicator
aspect of service selected for measurement

Measurement
a numeric value given to an attribute which facilitates comparison with standards

Monitoring
observation and recording of events over time

Multi-disciplinary team
a group of people working together from different professions

Outcome
the end result of effect of care

Patient quality
what the patient expects from health services

Patient Satisfaction
extent to which patient expresses positive attitudes to health services in general

Process
all components of health care delivery including diagnosis, treatment, after care etc

Professional quality
whether health services meet the needs as defined by professional standards

Proficiency testing
known blood samples are sent from a reference laboratory to regional centres for testing. Results from these centres are compared against the gold standard

Quality
the degree of excellence or fitness for purpose of a service

Quality Action Team
a group of people working together to identify and implement procedures for quality improvement

Quality Assurance
a systematic and planned approach to assessing, monitoring and improving quality of health services within available resource constraints on a continuous basis

Quality Assurance Cycle
sequence of related activities comprising of appraisal, action and improvement

Quality Control of HIV test kits
measures included during each run to ensure the HIV tests are working properly

Quality System
defines the roles, responsibilities and procedures within an organisation in order to ensure that staff are able to and do carry out quality assurance

Sensitivity
a measure of the reliability of a screening test based on the proportion of people with a specific disease who react positively to the test. The higher the sensitivity the fewer false negatives

Specificity
the proportion of people free from disease who react negatively to the test. The higher the specificity the fewer the false positives.

Standard
specification of expected or desirable measurable attributes of a product or service

Standard Operating Procedures
are the instructions that come with each specific test. They must be adhered to for a result to be accurate and regarded as valid

Structure
availability and quality of human and physical resources

Target
statement of expected performance

Validation
The parallel testing of random resubmitted samples at a reference laboratory