

PREVENTING HIV, PROMOTING REPRODUCTIVE HEALTH

**INTEGRATING HIV
VOLUNTARY COUNSELLING
AND TESTING SERVICES INTO
REPRODUCTIVE HEALTH SETTINGS**

STEPWISE GUIDELINES FOR
PROGRAMME PLANNERS,
MANAGERS AND
SERVICE PROVIDERS

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Joint publication of IPPF South Asia Regional Office
and UNFPA



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FOREWORD

What is the purpose of this guide?

This guide aims to provide sexual and reproductive health (SRH) programme planners, managers, and providers with the information necessary to integrate voluntary counselling and testing (VCT) for HIV/AIDS within their services. VCT has been shown to be an effective strategy to facilitate behaviour change for HIV prevention. It offers an entry point for early care and support for those infected with HIV and prevention of mother to child transmission. VCT also plays a role in reducing stigma and discrimination. The cost of establishing VCT services within existing SRH settings is lower than establishing them in freestanding sites.

In particular, the guide considers integration within the context of family planning (FP) service provision. FP and VCT service provision have similar aims of reaching sexually active people and promoting safe and healthy sexuality, including the prevention of HIV, sexually transmitted infections (STIs), and unwanted pregnancy. FP settings offer specific opportunities for reaching women with VCT.



There is a continuum of possibilities for integrating VCT services in SRH settings, and this guide supports those considering integration to determine the appropriate VCT components to integrate, and to plan, implement, monitor and evaluate an integrated service. In conjunction with IPPF's UNFPA-supported publication, Programme Guidance on Counselling for STI/HIV Prevention in Sexual and Reproductive Health Settings, this guide supports those overseeing the management of FP, maternal and child health (MCH) or STI services who are considering VCT within their current service provision, as a move toward developing more holistic SRH services. The guide is relevant for both public sector and NGO sector service providers.

Four sites – two in the Ivory Coast and two in India – were involved in piloting the integration of VCT in their setting. Of these, three sites operate as NGO SRH clinics, while one site is based within a large public sector hospital. Their experiences, as well as those of three further IPPF member associations in Kenya, Rwanda, and Ethiopia with experience in integrating VCT in SRH settings and youth programmes have been used to inform this guide. In addition to these experiences, the guide draws on international literature of best practice in developing VCT services, and in integrating HIV services in SRH settings. For ease of reading, references to this literature are not included in the text, but are provided in the reference section.

How is this guide organised?

This guide provides a 'stepwise' approach for the integration of VCT.

Section 1 gives an introduction to VCT and its components and outlines the rationale for integrating VCT in SRH settings.

Section 2 details an assessment process, which assists those seeking to integrate services to determine how to integrate VCT services. This section will be useful for planners and managers.

Section 3 describes factors to consider when planning the integrated service. It is organised around the components of a VCT service including community education and mobilisation, counselling, testing, care and support, and resource needs. This

section will be useful for programme planners and managers.

Section 4 covers specific implementation issues related to the components of an integrated VCT service. This section will be useful to planners, managers and implementers.

Section 5 focuses on monitoring and evaluation. Although monitoring and evaluation are covered in this section, they are integral parts of planning and implementation. This section will be useful for planners, managers and implementers.

The Appendices contain checklists, sample monitoring tools, and further reference material to support the information in sections 1 to 5. Users of this guide are encouraged to adapt the checklists and tools to make them relevant for their site.

References to key documents are included. Most of these references are available through the internet.

ACRONYMS

ANC	Antenatal Care
AIBEF	Association Ivoirienne pour le Bien-Etre Familial
ARBEF	Association Rwandaise pour le Bien-Etre Familial
AIDS	Acquired Immunodeficiency Syndrome
ARV	Anti-Retroviral
CBD	Community Based Distributor
ELISA	Enzyme Linked Immunosorbent Assay
FGAE	Family Guidance Association of Ethiopia
FP	Family Planning
FPAI	Family Planning Association of India
FPAK	Family Planning Association of Kenya
IDU	Injecting Drug User
IEC	Information, Education, and Communication
IPPF	International Planned Parenthood Federation
MCH	Maternal and Child Health
MTCT	Mother to Child Transmission
NGO	Non-Governmental Organisation
OI	Opportunistic Infection
PLWHA	Person Living with HIV/AIDS
PMTCT	Prevention of Mother To Child Transmission
QA	Quality Assurance
S/R	Simple/Rapid [HIV test]
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

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DEFINITIONS

Community mobilisation: A community is said to be mobilised when community members become aware of a problem, share the concern, and decide to take action toward a common solution. In this guide, the term refers to education and outreach work in diverse community settings using community structures, leadership, partnership and participation to create awareness and change.

High/low HIV prevalence areas: WHO distinguishes between three different epidemic stages based on prevalence rates in subpopulations and the general population. Low prevalence areas are those where HIV prevalence is below 1% in the general population and below 5% in vulnerable groups. High prevalence areas are those where HIV prevalence is greater than 1% in the general population.

A ‘concentrated’ prevalence is described as one in which the epidemic is not well established in the general population (less than 1%), but has spread rapidly in specific subpopulations (over 5% in at least one vulnerable group).

Re-infection: Re-infection refers to a person with HIV or a STI becoming infected again with HIV (either the same strain, a different strain, or a resistant strain) or another STI.

Safer sex: Safer sex is defined as any of the following sexual activities: using a condom (either a male or female condom) during sexual intercourse, having a monogamous relationship with an HIV-negative partner who has no other sexual partners, or having non-penetrative sex. Delaying sexual activity of young people (until they become sexually active) and abstaining from sex are also strategies to avoid infection from HIV and other STIs.

Window period: The window period is described as the time it takes for a person who has been infected with HIV to ‘seroconvert’ (test positive) for HIV antibodies. A person who tests during the window period may receive a negative test result even though they may be HIV positive. It is important to determine risks and possible exposure to HIV in the window period before testing. If the person has potentially been exposed to HIV in the window period, they are encouraged to be retested at the end of the window period, usually after three months.



Photo: IPPF/Chloe Hall/India

Section 1

INTRODUCTION

1.1 WHY INTEGRATE SEXUAL AND REPRODUCTIVE HEALTH SERVICES?

Participants at the 1994 International Conference on Population and Development made a commitment to increase the availability of comprehensive sexual and reproductive health (SRH) services for women, men and young people globally. While recognising that there is no standard, universal package of SRH services, emphasis has been placed on the integration of services such as family planning (FP), maternal and child health (MCH), antenatal care (ANC) and prevention and management of sexually transmitted infections (STIs) and HIV in order to provide clients with a more holistic approach to their reproductive health needs.

Integration means incorporating aspects of two or more types of services as a single, coordinated and combined service. Integration is shaped by the mission of the organisation, the local context, needs of clients and the community, partnerships for referral locally, and the organisation's own capacity. An organisation that does not meet all of its clients' SRH needs with its own services can meet those needs by developing and actively participating in a referral network of other services in the local community.

In December 2003, UNAIDS and WHO estimated that 40 million people were infected with HIV. Organisations offering SRH services have a responsibility to support clients to develop the knowledge and skills to protect themselves from HIV infection, and to support those clients already infected with HIV to get the care and support they need. Integrating and expanding voluntary HIV counselling and testing services in SRH settings provide opportunities for organisations to respond to this responsibility and for clients to benefit from knowing their HIV status.

1.2 WHAT IS VOLUNTARY COUNSELLING AND TESTING?

Voluntary counselling and testing (VCT) is the process by which an individual undergoes confidential counselling to enable the individual to make an informed choice about learning his or her HIV status and to take appropriate action. If the individual decides to take the HIV test, VCT enables confidential HIV testing. The voluntary nature of VCT is one of its underlying principles. Counselling for VCT consists of pre-test, post-test and follow-up counselling. During pre-test counselling the counsellor gives an individual (or a couple or

group) the opportunity to explore and analyse their situation and consider being tested for HIV. Each individual makes an informed decision of whether or not to take the HIV test after they have been given information and supported to reach an understanding of what is involved.

The client-centred nature of counselling enables trust between the counsellor and the client so that there is an opportunity for in-depth discussion of HIV/AIDS, including how to prevent it. Counselling helps people identify the implications of a negative or positive result, and helps them think through practical strategies for coping with the test result. Post-test counselling supports people in understanding their test result and its implications, whether the result is positive or negative. Counselling also helps clients explore whom they might share the test result with, and how to approach sharing their test result. Follow-up counselling supports clients in coping with issues raised as a result of learning HIV status, and is relevant for both clients that test positive or negative.

1.3 WHAT ARE THE BENEFITS AND BARRIERS TO VCT?

VCT is an effective strategy for facilitating behaviour change for both clients that test negative and positive. Different studies have shown the effects of VCT including a decrease in unprotected sexual intercourse, a reduction in multiple partners, an increase in condom use, and more clients choosing abstinence. Although VCT is a relatively costly activity, it is seen to be a cost-effective intervention for behavioural change.

In addition, VCT is an important entry point to other HIV/AIDS services, including prevention of mother to child transmission (PMTCT), prevention and management of HIV related illnesses, and social support. From a human rights perspective, VCT can play a role in addressing stigma and discrimination. Making VCT more accessible to enable people to know their status can help break the cycle of silence and the myths and misconceptions that fuel the epidemic and may assist in the normalisation of having an HIV test. Table 1 summarises the benefits of VCT to clients that test negative, those that test positive, and to society.

Table 1. Expected benefits of VCT for clients and society

HIV NEGATIVE CLIENTS	HIV POSITIVE CLIENTS	SOCIETY
Can be a strong motivating factor to remain negative, and supports and enables changes in sexual behaviour to avoid infection	Promotes early uptake of care and support services	Promotes awareness and knowledge of HIV/AIDS, potentially leading to reduced transmission in the wider community
Enables informed decisions about sexual relationships, informing partners of HIV status, contraceptive methods, safer sex, pregnancy and breastfeeding	Promotes changes in behaviour to prevent infecting others with HIV and prevent becoming re-infected with HIV or other STIs	Contributes to a more supportive environment for safer sexual behaviour
Improves uptake of SRH services through referral	Supports women/couples to prevent mother to child transmission	Encourages openness and reduces fear and stigma surrounding HIV
Provides opportunities and support to inform partners of the benefits of being tested	Enables informed decisions about sexual relationships, informing partners of HIV status, contraceptive methods, safer sex, pregnancy and breastfeeding	Stimulates a community response in support of people with HIV, including the development of care and support for people living with HIV/AIDS
Supports women/couples to prevent mother to child transmission	Improves planning for the future	Supports human rights
	Supports adherence to anti-retroviral therapy (where available)	

In addition to these benefits of VCT, there are also barriers to VCT. Sites aiming to set up an integrated VCT service will need to acknowledge and explore these barriers, and develop strategies to overcome them.

Box 1. Common barriers to VCT

STIGMA

"My family would reject me if they found out that I was HIV positive."

"If I found out that I was positive I would feel like I had been given the death sentence. At the moment I live my life unsure, but it is better than knowing I am definitely going to die."

HIV is stigmatised in all countries, resulting in those with the virus experiencing discrimination or rejection. Fear of rejection or stigma is a common reason for not wanting to know HIV status. Linking testing with ongoing care and support services may contribute to wider acceptance of VCT. Ongoing community education to develop a better understanding of HIV will also help reduce stigma. VCT itself can be seen as an important strategy in reducing stigma because, as more people become aware of their HIV status, HIV will become more normalised.

LACK OF PERCEIVED BENEFIT

"As there is no cure or treatment available, what is the point in being tested?"

For people living in areas with few resources, there may be a perception that little support will be available to them if they learn they are infected with HIV. Linking VCT with care and support services will help reduce this barrier to testing. For example, clients that test positive can be referred for treatment of opportunistic infections (OIs). Offering interventions to prevent mother to child transmission (PMTCT) once a woman is known to have HIV is a benefit that many people may not be aware of until VCT is established. Clients and the community should also be supported in understanding that people infected with HIV may remain healthy for many years even without anti-retroviral therapy by looking after their health (e.g. nutritious food, rest, etc.).

GENDER INEQUALITIES

"My husband died of illnesses related to HIV seven months ago and his family forced me to leave the house. The stress this has caused is even greater than knowing there is no cure."

In many countries, women are particularly vulnerable and may risk rejection, violence, abandonment, or loss of home and children if their HIV status becomes known. The need for protection and support of vulnerable women must be considered when developing VCT services. Couple counselling in VCT, when conducted in a skilled manner, may play a role in reducing gender-based violence, discrimination, isolation, or abandonment experienced by some women who test HIV positive.

LACK OF UNDERSTANDING OF RISK

"The test is not necessary for me because I have only had a few partners and they looked healthy."

"I have had a number of partners and I am certain that I have HIV so there is no need to have a test that will tell me what I already know."

Many people, particularly in low prevalence areas where knowledge levels about HIV/AIDS may be low may not perceive that they are at risk. In high prevalence areas, people may believe that they are already infected. VCT services can help people understand their personal level of risk, encourage safer sex practices, and support people to access care early if they are infected.

1.4 WHY INTEGRATE VCT IN SRH SETTINGS?

In addition to the barriers to integrating VCT there are also opportunities:

Helps meet the demand for knowing HIV status

VCT services are currently not available to many people who want to know their HIV status. Integrating VCT in SRH settings is one way to increase the availability of these services because SRH settings serve large numbers of people.

VCT and SRH services have similar aims

Integrated SRH services recognise the relationship between FP, STI and HIV. In particular, FP services and VCT have similar aims of reaching sexually active people, preventing unwanted pregnancy, HIV and STIs, and promoting safe and healthy sexuality.

Integration makes it easier for some clients to use VCT services

Many people wanting to learn their HIV status do not want others to know that they are seeking HIV testing. Many people are not comfortable attending freestanding sites because of the stigma and discrimination associated with HIV testing. VCT services that are truly integrated in SRH settings are not physically segregated from other services, so clients attending the site for VCT could appear to be attending for any of the services provided.

Opportunities to reach young people, men, and couples

Providing VCT in SRH settings can promote SRH services to those that might not otherwise access them (e.g. young people and men), promote condom use in these groups, and increase their involvement in FP and HIV prevention. Couples VCT is a promising variation, and SRH settings are ideally placed for supporting couples to learn their HIV status.

Costs of establishing integrated VCT is lower because of similarities between VCT and SRH services

Start up costs for integrated VCT services are lower than those for freestanding sites, making integration an important option for scaling up VCT. In particular:

- The infrastructure needed to provide confidential and private VCT services is similar to that provided in SRH settings. Integrating VCT may require only minimal changes to the existing infrastructure.
- Service providers in SRH settings typically have basic counselling skills. These can be further developed to deliver high quality VCT.
- The logistics management system for SRH services can be used to manage VCT commodities. For example, SRH services ensure the constant supply of commodities and services, such as HIV test kits, male and female condoms.
- SRH service providers are familiar with providing referrals for additional services.
- Existing SRH outreach activities could be developed to include HIV/AIDS prevention. The role of community based distributors (CBDs) and outreach workers could be expanded to inform communities about the benefits and challenges of knowing HIV status, and to promote VCT.

Experience from integrating other services tells us that there are also potential challenges

associated with integrating VCT in SRH settings. By being aware of these challenges, programme managers can take these into account during the planning stages.

Extra financial and human resources needed for integration must be considered

Funding VCT may result in reduced resources for other services. It is important to identify the extra resources needed to integrate VCT so that the overall quality of other services is maintained.

In environments where resources for SRH are declining, it may be difficult for planners to consider expansion of services to include VCT. However, there are many ways to integrate services; integration may require different ways of working rather than large amounts of financial resources. In addition, the integration of VCT may attract more funding.

Depending on the demand for VCT services, the workload of staff may be increased to a point that affects the quality of the service provided. Managers should monitor the situation to ensure that enough resources are available for the integration.

Integrating VCT in SRH settings may not be seen to be cost effective. In areas where HIV prevalence is low, SRH service users may not be at disproportionate risk of HIV, and the cost of integrating VCT services may be seen as too high if the number of HIV positive tests is low. However, planners should recognise the value of prevention – through opportunities for individual risk assessment, prevention counselling, and condom promotion – when calculating the cost of integrated services. In addition, vulnerable groups may be attracted to SRH services by the VCT services.

VCT services require specialist skills and SRH sites may need to develop this capacity

HIV counselling requires a non-judgemental approach that focuses on both reproductive health and HIV. Some providers, particularly those providing FP services, focus on contraceptive methods rather than on sexuality and reproductive health, and discussing sexual behaviour may be difficult for some providers. This can be overcome through training, support and supervision of those providing counselling, and through challenging staff to examine their role in broader reproductive health issues such as preventing STIs including HIV.

VCT recognises the contribution that non-health care workers (such as people living with HIV/AIDS (PLWHAs), social workers, community workers, and volunteers) make in HIV prevention and care. If providers have rules disallowing these workers to play a part in VCT services, these rules will need to be amended.

Sites must be prepared to challenge perceptions

Providers may need to challenge their clients' perception that service quality has been reduced as a result of VCT services. Providers should help clients to see that more comprehensive SRH services are being provided as a result of the integration.

Clients may abandon clinics because of the stigma of HIV. It is important that clients and the community are given information and opportunities to discuss HIV/AIDS and to break down the stigma attached to HIV and taking an HIV test.

It can be argued that groups vulnerable to HIV, for example, young people, sex workers, and men would not attend VCT services in a SRH setting. However, experience shows that comprehensive promotion of the benefits of VCT may encourage these populations to access VCT services regardless of the setting, with the further benefit of reaching these groups with other SRH services.

1.5 PRINCIPLES OF VCT

A summary of the key principles of a VCT service is listed in Table 2 below:

Table 2. Principles of VCT

Voluntary	Knowledge of HIV status is voluntary. The decision to have a test must be made by the client.
Confidential	Information shared during counselling must not be shared with others. The HIV test result must only be reported to the client unless the client states the desire to share the test result with a family member, partner or close friend.
Counselling	Pre-test counselling provides an opportunity for clients to explore their risk of HIV and how to reduce it, and helps clients decide whether or not to take the HIV test. Counselling must be offered to any client considering taking a test. Clients are informed of their HIV test result during post-test counselling. Counselling services must be of high quality. Counselling is further described in sections 3.5 and 4.2.
Testing	The presence of antibodies against HIV in the blood, saliva or urine confirms a diagnosis of HIV. Positive test results are confirmed using additional tests. A system for HIV testing on-site or through referral must be developed. Testing is further described in sections 3.6 and 4.3.
Informed consent	The client agrees to HIV testing through giving their informed consent.
Privacy	The physical environment must allow private discussions between client and counsellor. The service provider must keep clients' personal details private.
Referral	Clients must have access to prevention, care and support services as available. Referral services should be made with respect for the client's confidentiality. Care and support are discussed further in sections 3.7 and 4.4.
Counsellors	Characteristics of counsellors include being non-judgemental, empathetic, respectful, and supportive. Staff with counselling duties must be trained in HIV counselling techniques.
Equality	HIV positive people should not be discriminated against.
Adherence	The service should adhere to local and national protocol, laws and regulations governing the provision of HIV services.
Monitoring and evaluation	Counselling and testing services should be monitored and evaluated, both quantitatively and qualitatively, to ensure the services are of high quality.

1.6 COMPONENTS OF AN INTEGRATED MODEL OF VCT SERVICE DELIVERY

There are several models of VCT service delivery, each with benefits and challenges. These include freestanding services, integrated models (within primary health care services, hospitals, clinics, etc.), social marketing models, private sector models, mobile/outreach models, and home testing. This guide focuses on an integrated model of VCT service delivery, where VCT is incorporated into all aspects of ongoing SRH services. For example, contraceptive counselling would not only address the advantages and disadvantages of certain methods, but would also consider the client's STI and HIV risk, promote contraceptive methods that offer protection from STI and HIV (condoms), and if appropriate, give the option of learning HIV status through VCT. VCT services that are offered at the same time as other SRH services promote linkages between services. Integration also takes into consideration the idea that it is not necessary for every site to provide all components of VCT services.

VCT is part of a continuum between HIV prevention and care. Within this continuum, there are a number of components of VCT. The 'classic' model of VCT offers individual pre-test counselling, testing, and individual post-test counselling. Within this model, there are several variations regarding counselling that may be appropriate in different settings. For example, some sites offer group information followed by shortened individual pre-test counselling as an alternative to individual pre-test counselling, which can extend the reach of VCT services and can reduce costs. Some services offer couples pre and post-test counselling, which can be even more beneficial than individual counselling, because sharing one's HIV status with one's sexual partner is important for changing sexual behaviour for HIV prevention, and for preventing re-infection. Family counselling can help support children and other family members to understand the result and cope with the implications of the result.

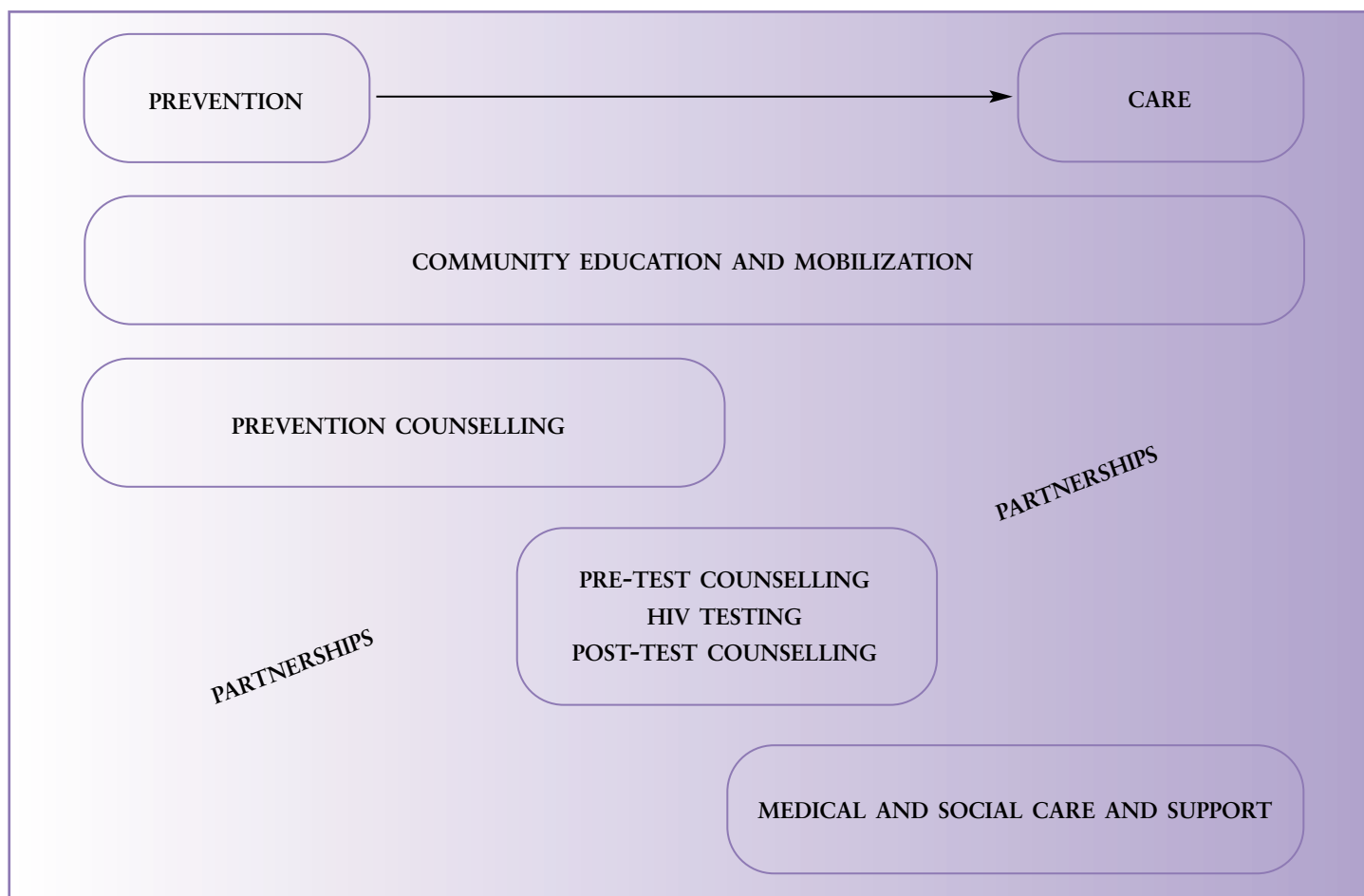


Photo: IPPF/Liba Taylor/The Gambia

Other components are essential for successful VCT. Community education and mobilisation are important because they help prepare communities for VCT by increasing awareness of the benefits of VCT, as well as contributing to reducing stigma towards PLWHAs. The success of VCT will rely on understanding and challenging myths and barriers to testing, and gaining the support of the community during the development of the integrated VCT service. HIV prevention counselling involves individual counselling for risk reduction and can help identify clients that might benefit from VCT. Support and care to those using VCT services must be offered. Support and care services include activities such as follow-up counselling, post-test clubs, management of opportunistic infections, interventions to prevent mother-to-child transmission of HIV, social and material support, and anti-retroviral (ARV) therapy where available. If the range of VCT components is not offered directly, then mechanisms for referral to partner organisations or other providers must be well developed.

An organisation seeking to integrate VCT should consider which of these components to provide, given its own resources and capacity, the needs of the community, and existing services available within the community. Figure 1 on the following page represents different components of VCT integration.

Figure 1. Components of an integrated model of VCT service delivery



It is important to remember that VCT is not an end in itself. Integrated VCT services will be most effective within a supportive community environment and alongside a range of both medical and social care and support services. It is not expected that every SRH provider will be able to provide all of these components. Through developing partnerships and networks with other service providers, the SRH provider can develop integrated VCT linked to both HIV prevention and care.

There is no ideal model of VCT integration. The components that sites choose to integrate and develop will depend on factors such as the needs of the community, the groups the site intends to reach with the service, HIV prevalence, political and community commitment to HIV/AIDS, financial and other resources available, and the setting in which VCT is offered. The challenge for sites is to develop an integrated service that increases uptake of VCT and provides high quality services that ultimately contribute to the prevention of HIV and improved support for those that test positive.

1.7 SUMMARY

When considering integration of VCT each site will need to think through the benefits, the challenges, the potential barriers, and how these barriers can be overcome. It is important for planners to determine how to appropriately integrate VCT based on their own context. In the next two sections, the guide discusses how to make an assessment to help determine an appropriate level of service integration, and how to plan services based on the findings from the assessment.

Case Study 1. Family Planning Association of India, Lucknow Branch

Staff at a Family Planning Association of India (FPAI) clinic in Lucknow (population 260,000) weighed up the benefits and challenges of integrating VCT services into its work. The clinic, located in the capital of Uttar Pradesh, a largely rural state, provides a range of family planning services and serves approximately 9,000 people each year. The HIV seroprevalence in the state is low. The 2002 National AIDS Control Programme's HIV sentinel surveillance study at the Uttar Pradesh sentinel sites found that 1.37% of STI clients tested HIV positive, and 0.37% of ANC clients tested HIV positive.

At first, staff were reluctant about the intention to integrate VCT services. They felt that if they were to integrate services, the new VCT service should not change the profile of service users, and that the client perception of the clinic should not change. Staff expressed concern that HIV services might 'take over' the clinic. Also, they felt that clients should not feel forced to have HIV counselling and testing. Staff expressed concerns about the increased workload to identify clients at risk to recommend for VCT. In addition, staff expressed concerns about their own occupational exposure to HIV.

The clinic addressed the concerns about occupational exposure first. Procedures for universal precautions and sterilisation of equipment were reviewed and revised, resulting in staff feeling more at ease about their risk of occupational exposure. The discussions also provided an opportunity for people to explore their own personal risks. Nurses started to explore how to determine if clients were at increased risk of HIV or STIs, and began implementing a low-key risk assessment procedure to enable them to refer clients to VCT services. Counsellors sensitively started developing and using IEC materials on HIV prevention and care. One counsellor was employed for outreach education in the communities in and around Lucknow. All of the staff were involved in performing dramas in and near the clinic to promote the benefits of knowing HIV status through VCT. Several months after the start of the new service, all staff at the clinic – from the programme leader to nurses, reception staff and cleaning staff – saw that they had a role in the new service, and in maintaining the low rates of HIV seroprevalence in Uttar Pradesh.

Through their outreach work, staff learned that the community's understanding of HIV/AIDS issues was low, characterised by fear and denial. Staff decided to embark on an extensive community education campaign focused on normalising attitudes of the community to HIV/AIDS, breaking down the culture of denial, stigma, and discrimination, reducing anxiety, and developing people's confidence to seek information and take the test. This received a positive response, opening up discussions about HIV/AIDS, sexuality, and reproductive health in new ways.

From initial reluctance, the FPAI Lucknow clinic has understood the benefits of integrating VCT services in their FP work. Even though HIV prevalence is low, the VCT service – including the new community education work on HIV/AIDS – provides an opportunity for people to explore and understand their risk. The clinic has also expanded their STI services as a result of their work in building greater understanding of HIV/AIDS.

Section 2

ASSESSMENT

Taking time to assess community needs, analyse strategic, operational, and management issues related to integration, and understand the policy context is important in planning appropriate services that will be accepted and used. By the end of the assessment, those responsible for the integration should have a good understanding of which VCT components (as shown in Figure 1) to offer and some understanding of how the services will be implemented. The case study at the end of this section illustrates some of the principles of assessment.

2.1 THE ASSESSMENT PROCESS

The assessment should be participatory and inclusive and should use a variety of sources of information and methods (both quantitative and qualitative) to gain a picture of the situation regarding the needs of the community, the capacity of the organisation considering integration, and the context. It may be useful to identify one person to coordinate the assessment process, and a small team to help collect data to inform the assessment. Methods could include: a review of secondary data on characteristics of the local population and socio-demographic indicators; clients' knowledge, attitude, and practices regarding sexual and reproductive health; in-depth interviews and/or focus group discussions with key informants, staff, clients, other organisations providing HIV/AIDS prevention and care services, and members of the community; and workshops/planning meetings with relevant stakeholders.

The time an organisation allows for assessment will depend on the resources available, the size of the community, the complexity of factors affecting HIV rates, the number of other services available, etc. A relatively brief assessment of two to six weeks can yield useful information.

2.2 ANALYSING COMMUNITY NEED FOR INTEGRATED VCT SERVICES

In order to understand the need for integrated VCT services and the appropriate level of integration, it is important to look at the situation regarding HIV/AIDS in the community. In addition to helping understand the need for VCT services, this analysis (baseline information) is also used during evaluation to determine change. Table 3 opposite outlines these issues, explains the rationale for understanding the answers to them, and considers possible sources of information.

Table 3. Analysing community need

<p>What is the scale of HIV/AIDS and STI in both the client population and the community?</p>	<p>The first step in analysing need is to learn more about the epidemiology of HIV/AIDS and STIs in the community and in the client population. The epidemiology will help assess whether to focus services on only those groups most vulnerable to acquiring and transmitting HIV, or the general population. Knowing the prevalence of HIV in the community will also help determine which components to integrate to best allocate resources. For example, in low HIV prevalence areas more resources might be directed towards education activities, while in high HIV prevalence areas, more resources might be allocated to establishing and maintaining partnerships for referral, or developing care and support services such as HIV positive support groups. Data on HIV and STI prevalence is likely to be available from the Ministry of Health, National AIDS Programme, hospitals, other national or international organisations, or non-governmental organisations (NGOs) working in HIV/AIDS/STI prevention and care.</p>
<p>What are the views of clients and the community on HIV/AIDS and VCT? What is the level of knowledge and understanding of HIV, STI, and MTCT? Is there interest in knowing HIV status? Will the community accept integrated VCT services?</p>	<p>Learning about the community's knowledge, understanding and beliefs about HIV/AIDS will help determine the focus of VCT activities. For example, if effective HIV/AIDS campaigns have already sensitised people to the benefits of knowing HIV status, then the focus of work might be on promoting the new service and providing quality counselling, testing and care. If little education work has been done or there are still misconceptions and stigma attached to HIV, then the site may need to include an education component. Organisations working in HIV/AIDS prevention may already have conducted research to learn about knowledge, attitudes, and practices related to HIV/AIDS at the community level or with specific groups. Listening surveys, observation of participatory education sessions, or focus group discussions can help planners get an understanding of what community members know and think about HIV/AIDS, MTCT, STI and VCT. If no data are available, the site may have to collect its own. A sample tool for collecting qualitative information is included in Appendix A.</p>
<p>To what extent are clients/potential clients vulnerable to HIV? What are the social, economic, cultural, political or other factors influencing the rates of HIV?</p>	<p>In order to understand the rates of HIV and STIs, planners should try to obtain information on the factors that contribute to vulnerabilities. This could include information on power relations between men and women affecting negotiation of sexual relations, economic pressure resulting in people selling sex for money or other goods, relations between young women and older men, cultural practices that contribute to high rates of HIV, etc. This information, along with data on levels of HIV and STIs, will help determine whether to target specific groups or the general population. If risk factors are high in the general population, it may be appropriate to introduce routine risk assessment in all SRH services with referral to on-site VCT. If risks are higher in certain populations or groups (for example sex workers, migrant workers, or truck drivers), specialised outreach services may be appropriate. Behavioural research describing the risks of HIV in the local area may be available from NGOs, the national AIDS programme, universities, or other organisations working in HIV/AIDS prevention and care.</p>
<p>What other HIV/AIDS and STI services are available? Who uses them? Will new services duplicate existing services? Do other providers support the idea of integration?</p>	<p>It is important to know what other related or similar VCT services are currently provided, whether services are well used or not, and why. This will help plan VCT services that build on existing services and fill gaps, rather than duplicate what already exists. Mapping existing services related to HIV/AIDS and STIs is an important part of the assessment process, and should include interviews and visits to other local organisations. Discussing your plans with other service providers can help determine whether integrating VCT within the site will be welcomed. Mapping can also be the first step in compiling a directory of care and support services for referral purposes.</p>
<p>Who uses the services now? What change in clientele, if any, will integrating VCT mean?</p>	<p>It is important to reflect on what services are currently offered, the profile of users of the SRH services, and the profile of people who do not use services. This will help when considering how to target integrated services. The site can determine the level of service use and profile of users through examining monitoring information. Discussions with staff and service users about integrated services will give planners an idea of how integrated services might affect existing services in the site.</p>

2.3 ANALYSING ORGANISATIONAL CAPACITY TO INTEGRATE SERVICES

In addition to looking at community needs, it is important to assess the organisation as a whole: its capacity to integrate services, its readiness, and the extent to which the organisation already includes HIV-related services. Questions to consider are found in Table 4:

Table 4. Assessing organisational capacity

AREA OF ANALYSIS	QUESTIONS TO CONSIDER
Mission and strategic plan	To what extent does the organisation's mission and strategic plan allow for integrating VCT into its services? What impact would the new services have on the organisation's mission, strategic plan and image? Does integration fit with the organisation's goals?
Decisions on service provision	How does the organisation make decisions on what services to offer (e.g. expressed community need, epidemiological data, opinions of staff, analysis of resources, cost-benefit analysis, funding/income generation, etc.)?
Staff readiness and training needs	To what extent are staff prepared for integration? What is their level of knowledge, understanding, training, and skill to promote and deliver VCT? What are their attitudes about people with HIV/AIDS and/or STIs? What are their attitudes about integrating services and their beliefs about how integration will affect their workload and the clientele of the clinic?
Infrastructure and resources	What resources and infrastructure does the site already have for VCT (private space for counselling; laboratory capacity and infrastructure; logistical systems for supply and storage of test kits and other commodities; educational material on HIV/AIDS; systems for keeping confidential data; established referral networks)?
Monitoring and evaluation systems	To what extent can monitoring and evaluation of an integrated VCT service be included in sites' existing monitoring and evaluation systems?
National laws or policies related to HIV and VCT	Is integration aligned with national guidelines? What, if any, laws or policies exist regarding VCT or HIV testing? How will laws/regulations affect the integration of VCT within the SRH setting?

Source: IPPF/WHO (2002). *Have you integrated STI/HIV into your sexual and reproductive health services?*

2.4 OPERATIONAL ASSESSMENT OF INTEGRATED SERVICES

Having conducted an assessment of community needs and of the organisation, planners can begin to think about the services that it may be appropriate to offer. It is important to involve staff, clients, community members, and other organisations in this part of the assessment to help identify how VCT could be integrated. Table 5 outlines issues to consider when assessing the operational aspects of integrated VCT services.

Table 5. Operational assessment

What are the similarities and differences between existing services and VCT?

If existing services are similar to VCT activities, then fewer changes may be needed to develop and manage services. Key items to compare are staff and infrastructure. The better the match between existing services and VCT, the smaller the financial investment and the easier it will be to integrate. If the services are very different, the integration will be more complex and more costly, and there may be greater risk of compromising quality of current services.

Planners should consider the personnel currently providing services, in particular their training in and attitudes about complex behavioural issues and sexuality, and their experience in working with both the clinic population and with specific groups (such as sex workers, young people, etc.). Both SRH and VCT services require staff to have knowledge related to reproductive health and communication skills related to sexual behaviour. Since provider skills are similar, training may only be required to introduce specialised tasks such as HIV pre and post-test counselling. If the site already has laboratory staff, these existing staff could be trained in conducting HIV tests.

The infrastructure required for VCT services needs environments that provide privacy and permit confidentiality. Many SRH service providers already have existing laboratory infrastructure. Existing educational materials may be easily adapted to include information on HIV, how people can protect themselves from becoming infected, and the benefits of VCT. Commodities management systems may be adapted to manage necessary VCT materials, and strong information collection systems may enable easily integrated systems for monitoring and evaluating VCT.

In what settings does the site offer services? Which components of VCT could be delivered in these settings?

As described in section 1.6, there are a number of different components of VCT services, as well as a number of settings (e.g. community outreach, clinic based, etc.) appropriate for providing different aspects of VCT. The setting can either constrain or offer opportunities for counselling, testing, education, care and support. For example, some settings allow privacy, while others may not.

Who should the VCT services target?

As part of the assessment, planners should review the profile of clients using existing services, to help determine whether the VCT service should target specific groups, existing clients, or the general population. For example, although it would be beneficial to offer VCT to all those who use FP services to support behaviour change, in resource constrained areas it may be more appropriate to target VCT to the most vulnerable clients. In areas where HIV prevalence is high, it may be most effective to offer prevention counselling to all those who use FP services, and then pre-test counselling to those most vulnerable to HIV or who are interested in VCT. In low prevalence areas, it may be most appropriate to target VCT to those who are most vulnerable to HIV after carrying out an individual risk assessment. In all areas it is important to offer (or refer clients to) VCT to those who show signs and symptoms of HIV/AIDS and to those concerned about their HIV status.

Which VCT services are appropriate to integrate into existing services?

The next step is to identify opportunities for integrating VCT within the setting. Using the information collected during the assessment, planners should now determine whether the site aims to provide on-site counselling and testing, the extent to which it will be involved in educating its clients and the community about VCT services, and the extent to which it will provide follow up counselling, care and support, given the setting(s), staff and other resources, and situation regarding HIV/AIDS. While it is acknowledged that many sites will be unable to provide a full spectrum of prevention, care and support services for HIV, the site must consider the full range of needs for those using VCT services. Partnerships for referral to other providers must be established to enable people testing HIV positive to access the care and support they need.

What additional resources are needed to integrate VCT?

The final step is to consider additional resources that will be needed to realise the model of VCT provision planned. Section 3 on Planning considers the resource requirements for VCT in more detail.

Source: Management Sciences for Health (2001). *Integrating STD/HIV services in reproductive health settings.*

2.5 SUMMARY

Taking time to assess and analyse the situation in which sites plan to integrate VCT services will help ensure that the integrated services are accepted by the community, used by clients, supported by staff within the FP setting, and meet the needs of those using the services. An assessment process that uses a variety of different sources of information and includes staff, service users, and others will help the site determine how best to meet the needs of clients and the community within the organisation's capacity to integrate VCT services.

Photo: IPPF SARO/Annette Britton/India



Case Study 2. Needs assessment for integrated VCT services

The Family Guidance Association of Ethiopia (FGAE) model SRH clinic in Nazareth opened in 1993. The clinic serves about 110 clients each day, and provides a range of integrated SRH and maternal and child health services. In addition to its clinic-based services, the FGAE Central Branch undertakes work in the community to reach young people, sex workers, and factory workers using a range of different approaches. The clinic's VCT services started in March 2002.

Prior to initiating VCT services, FGAE Central Branch undertook a needs assessment. They reviewed available data on HIV/AIDS in the area. The estimated local HIV prevalence rate is 18.7%. The reasons for this high prevalence rate were discussed and analysed. For example, Nazareth is on a busy trucking route on the main road between Addis Ababa and Djibouti, and is known as an 'inland port'. Sex work is a common source of income for women. In addition, Nazareth is a popular tourist destination. Social and cultural factors make women in particular vulnerable to HIV.

The Branch was already well aware of the HIV/AIDS related services in the community, because of its participation in existing networks. After reviewing the existing HIV/AIDS services, programme planners then collected further information. Their additional research was primarily qualitative and included focus group discussions, a survey of clients at the clinic, a household survey in the area near the clinic, and discussions with staff. In addition, planners visited the two other VCT sites in the area and took advice from them, discussing the advantages and disadvantages of the existing VCT services. Planners learned that there was indeed a need and a demand for VCT services, and that integrated services at the clinic offered advantages over other available VCT services. For example, some clients and community members said they would not attend VCT services at the existing, freestanding VCT centres because of the stigma associated with the sites, but would use VCT services if they were offered at the FGAE clinic. Planners decided to develop pre and post-test counselling, testing, and ongoing counselling, alongside community education work on HIV prevention, and treatment for the most commonly seen opportunistic infections. Clients would be referred to other providers for further medical and social care and support using the clinic's and Branch's well-developed partnerships.

During the assessment, planners identified training needs of staff. Training and information sessions were held on HIV/AIDS for all the staff – including managers, clinic staff, guards and cleaners. Clinic staff selected for counselling duties were trained in pre and post test counselling, the lab technician was trained in carrying out rapid HIV tests and ELISA tests, and other clinic staff were trained in HIV and STI risk assessment. Nurses were also trained in diagnosing and treating opportunistic infections. The site linked its existing outreach work to a new community-based condom promotion and distribution service, and trained outreach workers to promote condoms. Processes for ensuring confidentiality for clients using VCT services were developed and tested before the service started. A referral system for medical, social, and economic support for clients using VCT services was established among local institutions and organisations prior to the start of the VCT service. Monitoring and evaluation systems were discussed and developed.

Because of resource limitations, VCT is offered two days/week but operates at capacity. Over half of the service's clients are men, and 43% are young people. Approximately 20% of the HIV tests are positive, slightly higher than the HIV sentinel surveillance estimates for the region but similar to the prevalence rates of the other VCT providers in the area.

FGAE attributes some of its success to the comprehensive assessment they carried out. Learning from other providers was important in planning their services, and gathering information from clients, staff and the community helped confirm the need for and commitment to integrated VCT services.

Section 3

PLANNING

After undertaking an assessment and deciding which components of VCT services to offer, this section gives those seeking to integrate VCT further information to help plan the services. Depending on the VCT components integrated, it will be helpful to involve a range of people in planning the integrated services. For example, if the service includes education and mobilisation work, education and outreach staff should be involved in planning. Service users should be consulted during planning. Involving PLWHAs can help ensure that the service is sensitive to the needs of people with HIV. Whatever VCT services are integrated, the aim should be to develop high quality services that are appropriate, acceptable, accessible, convenient, and affordable to all clients that need and use the services.

Planners should be aware of any existing national guidelines on HIV counselling and testing services and consult experts locally for further support if required. This guide should be used to supplement existing national guidelines.

Although monitoring and evaluation are an integral part of planning, monitoring and evaluation tools and methods are described in Section 5.

3.1 TARGETING

During the assessment phase, the team considered what different VCT components to offer, which groups are most in need of services, and the organisation's capacity to integrate the different components. It is important to finalise the decision about which groups the site intends to reach early in the planning phase, as it will have implications for the resources required. For example, will the services target all clients attending the site? Will the site target only clients that are particularly vulnerable? Or will the site target community members that currently do not use the site's services but might benefit from integrated VCT services (such as men, young people, or sex workers)?



Photo: IPPF/Heidi Marriott/Mali

Box 2. Service component and targeting checklist

- Are we going to be involved in community education and mobilisation related to VCT? If so, who are we trying to reach with these services?
- Are we offering prevention counselling? Which clients or community members will benefit most from prevention counselling services?
- Are we offering pre-test counselling, testing and post-test counselling? Who are we trying to reach?
- What care and support services will we offer? What services exist in the community? In particular, what services exist for the groups we hope to reach with counselling and testing?

3.2 ORIENTING STAFF TO INTEGRATED SERVICES

It is important to plan an orientation programme for staff about the planned service and the benefits of VCT. The orientation programme should include all staff and volunteers working at the site. Many of the staff may not know what VCT involves. They may not understand the benefits of testing or may have personal fears about knowing their own HIV status. They may have concerns about how the service will affect their workload. By providing opportunities through orientation and training sessions, staff are enabled to learn more about VCT and HIV, ask questions, and raise concerns about the proposed services. Their knowledge of the clients and community can inform the plan.



Photo: IPPF SARO/India

From experience 1. Communicating the service to staff

"When a client comes to our clinic, the first person they see is not a nurse, or even the receptionist. It is the guard that stands at the gate of our drive. When we started planning, we realised that this guard is important. He needs to understand what happens in the clinic. If he has stigmatising attitudes towards people with HIV, he could affect the use of our VCT services."

Manager, FGAE Central Branch, Nazareth, Ethiopia

3.3 ORIENTING OTHER SERVICE PROVIDERS AND STAKEHOLDERS

During the assessment phase, the team learned about VCT and related HIV services provided by others in the community. During the planning phase, the team should have further discussions with other SRH and HIV/AIDS service providers and stakeholders to gain their support for the proposed service. Some service providers may feel initially threatened by the plans. Staff communicating with other service providers should emphasise how the integrated VCT services will be different from and/or complement existing activities within the community. Other providers and stakeholders should be invited to visit the site, and to participate in planning meetings if appropriate. The relationships built with other service providers during planning will help establish strong referral networks for clients using VCT.

3.4 COMMUNITY EDUCATION AND MOBILIZATION

Without adequate understanding, acceptance of VCT is likely to be low. Within this component of VCT, planners need to consider the messages the organisation aims to communicate to clients and the community, and the methods and strategies the organisation will use to communicate them.

The education messages must be planned according to the context and needs of the clients and community. Using information on local knowledge, attitudes, and practices related to HIV/AIDS collected during the needs assessment, appropriate approaches and messages can be designed. If knowledge about HIV/AIDS is low, it may be necessary to educate people about the basic facts and how HIV may affect their lives. All community education and mobilisation work should focus on normalising attitudes to HIV/AIDS to reduce fear, denial, stigma, and discrimination. Once the basic messages are understood, promotion of VCT services should focus on its positive aspects such as its confidentiality and the benefits of knowing HIV status in relation to prevention and access to early care and support. Networking and partnering with other organisations involved in HIV/AIDS education will be beneficial.

Box 3. Checklist on messages for community education and mobilisation related to VCT

- Basic facts about HIV/AIDS.
(If extensive work has already been done to educate clients and the community, then work should focus on the other points in this checklist)
- Normalise attitudes to HIV/AIDS.
Messages should reduce stigma and discrimination and address fear and denial
- Promote the benefits of knowing HIV status
- Promote counselling and testing services available

Some of the most effective communication strategies are ones that engage people in discussion about HIV/AIDS – through the use of small groups, role-plays, informal conversation, and real life stories or drama. Other strategies such as mass media (billboards, posters, radio campaigns) and written information such as leaflets can be useful, but are more effective when used in combination with more interactive methods that promote two-way communication.

Outreach services help promote counselling and testing services for those that need them but may not normally attend a clinic setting. Many SRH organisations have outreach services involving peer educators and CBDs, and their role could be expanded to mobilise the community in relation to VCT. PLWHAs also play an important role in communicating the benefits of knowing HIV status, and in challenging stigma and discrimination. Promoting VCT to current clients is also important. One advantage of education in SRH clinic settings is that clients are already in a health service environment and may be open to receiving information about HIV/AIDS and VCT. Incorporating VCT into existing education materials and strategies will help to normalise HIV counselling and testing.

From experience 2. Educating communities about HIV/AIDS

In low HIV prevalence areas, community education and outreach is probably as important as offering counselling and testing from a clinic site. The FPAI clinic in Lucknow noted the importance of sensitive community education in breaking down denial, stigma and discrimination. The programme manager noted: *"In India, some of the messages still being used have inadvertently promoted a culture of fear, denial, and blame. The purpose of communication messages should be focused on normalising attitudes to HIV/AIDS. The messages used for educating the community and promoting VCT should be moulded by the values that form the basis of the principles of counselling, such as care, support, openness, and practical actions to address people's situations."* The clinic found that networking with other agencies in carrying out community education is particularly important in low HIV prevalence areas such as Lucknow.

3.5 COUNSELLING

HIV counselling, whether for prevention or before and after the HIV test, involves confidential dialogue between a person and a care provider aimed at enabling the person to evaluate personal risk of HIV transmission and make decisions related to HIV/AIDS. Counselling is a resource intensive strategy, but can be particularly effective in promoting behavioural change. This section outlines key considerations related to counselling.

3.5.1 Selecting staff for HIV counselling

Counselling staff are perhaps the most important assets of a VCT service. If the organisation offers counselling on-site, then it will be essential for the site to select people with the necessary training, knowledge, skills, and attributes (or be prepared to develop these) to provide high quality counselling services. People providing HIV counselling do not need to be academically qualified, but need to be motivated to provide HIV counselling and have the ability to show clients that they respect and care about them. Existing clinic staff, peer educators, volunteers, and PLWHAs can be effective counsellors if they are provided with

training and support. Gender and age of those providing counselling may be important considerations in some settings. Those selected for counselling should have the essential training, knowledge, skills, and personal attributes for the role, as outlined in Box 4 opposite. Note that many (though not all) of the characteristics listed in Box 4 can be developed with comprehensive training and support.

Although there may be challenges in using existing staff to provide HIV counselling, developing the skills of existing staff can result in better integrated services. For example, a FP provider trained in HIV counselling may be more aware of assessing clients' vulnerabilities and advocate condoms for dual protection. If selecting counsellors from existing staff, HIV counselling should not be made a mandatory staff task. Only staff interested in HIV should undertake HIV counselling duties.

The number of trained HIV counsellors needed will depend on the types of counselling offered (e.g. prevention counselling, pre and post-test counselling, and/or ongoing counselling), the target groups for such services, and other factors.

From experience 3. FP providers need to develop skills to provide integrated SRH services, including VCT counselling

"Traditional FP service providers deal with sexual health in a clinical manner. For example, they examine a client's symptoms and provide treatment. There is little discussion on sexual behaviour and practices. Our culture does not encourage open discussion on sex, and service providers are embedded in this same cultural milieu. They too carry the same inhibitions. Skills need to be developed to remove these inhibitions. FP providers need to be supported to examine their own beliefs and attitudes to sexual behaviour and practices, in order to better meet the sexual health needs of their clients."

Programme Manager of integrated VCT services, FPAI clinic, Lucknow, India

3.5.2 Training staff for HIV counselling

All staff involved in HIV/AIDS work will benefit from a training programme that enables them to examine their knowledge, attitudes, and beliefs related to HIV and encourages them to develop their understanding. Those involved in counselling duties need to develop their counselling skills, and must be trained in using the counselling protocols developed. Most national AIDS programmes will either conduct or recommend training courses specifically for VCT counselling. Initial training courses for HIV counselling usually last from one to three weeks, and should focus on using client-centred techniques that allow clients to discuss issues important to them. Courses may be intensive sessions, or regular seminars on a part-time basis. Experience has shown that role-plays, active participation in discussion, feedback, and case studies are essential in helping trainee counsellors identify and develop strategies to address key issues that arise in HIV counselling.



Photo: IPPF SARO/Annette Britton/India

Remember to plan for monitoring and evaluating counselling services. See section 5.4 for guidance

Box 4. Essential training, knowledge, skills and personal attributes for counsellors

Qualifications/Training

- Must have completed (or be willing to undertake) a training course in HIV counselling with a focus on client-centred or other behaviour change models of HIV prevention
- Must be interested and willing to update training as needs emerge

Knowledge

- Must have up to date knowledge of HIV including: the distinction between HIV and AIDS, modes of transmission and prevention, details of HIV testing and its limitations (e.g. testing within the window period), treatment available and how clients can access it
- Must have up to date information about a range of services available for those that test HIV positive to refer clients
- Must have an understanding of the importance of continual and periodic monitoring, evaluation and quality assurance techniques

Skills

- Must be able to use active listening skills (verbal and non-verbal)
- Must be skilled in using open-ended questions to negotiate rather than persuade
- Must be able to create an environment of trust in a short period of time
- Must be able to sustain focus on HIV prevention and safer practices
- Must be able to engage clients in conversation
- Must be able to talk about sensitive issues plainly and in a manner appropriate to the culture, educational level and beliefs (spiritual and traditional) of clients
- Must be able to prioritise issues to make best use of limited time
- Must be able to appropriately manage a range of client reactions that emerge in counselling (e.g. anger, distress, fear, etc.)

Personal attributes

- Must be able to discuss HIV/AIDS and sexuality comfortably
- Must be approachable and easy to talk to
- Must be able to establish a rapport with clients regardless of their gender, age, culture, education level, socio-economic status, beliefs, and behaviour
- Must be aware of her/his own biases and moral judgements and treat clients in a non-judgemental manner
- Must have a belief in the counselling process
- Must view clients as individuals, and treat all with respect and empathy
- Must be sensitive to nervous or embarrassed clients

From experience 4. Training VCT counsellors in Kenya

All people providing VCT counselling must enrol in a three week residential VCT counselling course. There is a national VCT training curriculum that all training providers must use. Family Planning Association of Kenya's senior programme officer for service delivery commented, "*The VCT counsellor training programme in Kenya is of high quality and helps ensure the quality of counselling. Enrolling on a course does not mean that you automatically become a VCT counsellor. Only those who pass the exams at the end of the training course are certified and can be employed to provide VCT services.*"

3.5.3 Establishing counselling protocols

While flexibility within counselling sessions is important to enable counselling to meet the needs of clients, planners should develop a general protocol to ensure a high quality service. Two models of counselling that most SRH service providers will be familiar, GATHER and REDA, can be adapted for VCT services (Box 5). This section give planners a general description of the content of counselling sessions, while the accompanying Appendices B, C, and D contain detailed checklists to enable planners to develop counselling protocols. A further description of counselling is provided in Section 4.2.1.

Box 5. General protocol for counselling in VCT

The GATHER model

- G Greet the client
- A Ask the client questions about their situation and why they have come
- T Tell the client how you can help
- H Help the client to come to her/his own decision about the test
- E Explain issues surrounding HIV/AIDS and the test
- R Return visits are arranged for the test, post-test counselling, FP or other services

The REDA model

- R Rapport is developed
- E Explore the present and past situation, problems and ideas for change
- D Decide on the best option
- A Act on the decision

Prevention counselling

Clients visiting an SRH clinic may not consider themselves vulnerable to HIV or other STIs. All SRH providers should be trained to introduce the topic of HIV and STIs, and give opportunities for clients to discuss their concerns. Prevention counselling provides an opportunity

to help clients assess their personal risk, make a plan to reduce their risk of HIV or other STIs, and develop practical skills to implement their plan. After prevention counselling, some clients may want to learn their HIV status through VCT. The detailed content of a prevention counselling session is found in Appendix B. Planners and service providers who will be involved in prevention counselling should review and modify this checklist as appropriate for their setting and develop a protocol.

Pre-test counselling

Pre-test counselling must be of high quality to ensure that individuals make an informed decision about being tested, understand that the procedure is entirely voluntary, and give their informed consent to taking an HIV test. During pre-test counselling, the counsellor should assess the client's knowledge of HIV/AIDS, and correct any misinformation, assist the client in establishing her/his level of risk, and discuss the implications of a positive or negative HIV test result.

Although individual counselling has the added benefit of exploring the individual's risk and appropriate ways to reduce this risk, other models of pre-test counselling are sometimes used. For example, basic information about HIV/AIDS is sometimes provided in groups. This is followed by a shortened pre-test counselling session for those clients interested in learning their HIV status after the group information session, during which the counsellor helps clients assess their individual risk and determines if clients consent to taking the HIV test.

Group information sessions may help extend the reach of VCT services and can help reduce costs, but should not entirely substitute for individual pre-test counselling.

The detailed content of a pre-test counselling session is summarised in Appendix C. Planners and those who will be involved in pre-test counselling should develop this content into a protocol for service providers.

Post-test counselling

Post-test counselling allows clients to learn their test result and to discuss the implications of the test result. The length and content of counselling required will depend on the client and her/his HIV status. If the client's HIV test results show that s/he is HIV negative, the counselling session should reiterate the HIV preventative information discussed during pre-test counselling, in particular the risk reduction plan, so that the client remains HIV negative. If the client has had unprotected sex in the three months before testing, it may be necessary to repeat the HIV test. The counsellor should discuss the HIV status of the client's partner(s) and the benefits of sharing the test result with a partner, and explore how the client can share the result.

Counsellors play an important role in providing immediate psychological support to people whose test result is HIV positive. Once the client is clear about the meaning of the test result, they may be ready to discuss what they will do next. The counsellor should help the client review the plan discussed during pre-test counselling. The session should help the client explore how to share their test result with their partner or family and think about how others might respond to learning the test result. It should also include discussion about how to prevent the spread of the HIV virus. People who learn that they are HIV positive are likely to require further counselling and referral services, so a follow-up counselling session should be offered.

A detailed checklist outlining the content of a post-test counselling session is found in Appendix D. This should be further developed into a counselling protocol for the provision of post-test counselling.

Follow-up counselling

Many clients who use VCT services, both those that test negative as well as those that test positive, require follow-up counselling sessions to discuss issues raised during the process. The counsellor should listen to the client, help the client prioritise their concerns, and enable the client to take up relevant referrals to access the most appropriate care and support services available for their needs, if these needs cannot be met by the service provider directly.

Case Study 3. Stress related to HIV counselling

"A woman was referred to VCT services because her 8-month old child had been suffering from fever and because she herself was also feeling weak. During pre-test counselling, she revealed that another of her children had died of TB at the age of three. She decided to take the HIV test and returned for her result, which was HIV positive. When I told her the result, she wept and cursed her fate for being infected. During the post test-counselling session, she started breastfeeding her child, and on seeing this, I told her not to breastfeed the infant because she could pass the virus to the baby. Because the woman stopped, I felt I had taken away the basic right of the infant to be breastfed, and that the woman would be worried that she had already infected the child. I later shared my concerns with my supervisor and colleagues. We discussed how the situation could have been handled. I have not seen woman again. This case still bothers me, even though it happened seven months ago..."
Counsellor

3.5.4 Supervision and support of counsellors

Counselling is a difficult task. For the same reasons that make counselling effective in supporting people to make changes (inter-personal communication in a safe environment that enables people to discuss very personal issues), many counsellors feel responsible for their clients long after they provide counselling services. Case study 3 illustrates how one statement can affect a counsellor and client.

HIV counselling can be emotionally draining, so it is important to ensure that counselling staff have an acceptable workload, and get the supervision and support they need. Planners will need to consider how to support staff with counselling duties to prevent 'burnout'. Table 6 outlines strategies to support counsellors.

Table 6. Strategies for supporting HIV counselling staff

Supervision	Those responsible for managing HIV counsellors should provide regular supervision to learn how counsellors find their role, particularly during the initial stages of an integrated VCT service.
Training	Identification of follow-up training courses or seminars will enable counsellors to learn new skills to better address the issues that arise during counselling sessions.
Peer support	Providing opportunities for counsellors to support each other can provide a strong team environment, where counsellors are encouraged to share skills and experiences.
Case conferences	The use of case conferences held between supervisors and counsellors can help counsellors address specific difficult situations. Case conferences can also give new information or teach new skills.
Mentors	Mentors are professionals carrying out similar work who provide support to staff. Regular support from a mentor can help in professional and skill development.
Breaks in counselling	Some counsellors may function more effectively if they alternate their counselling work with other activities.
Setting limits on numbers of counselling sessions	During supervision, managers of counselling staff should discuss the counsellor's workload. If counsellors feel that the sessions are too emotionally draining or that the workload is too heavy, the manager might consider limiting the number of clients a counsellor can see in a day or a week. The limits may vary for different counsellors.

3.5.5 Other resources needed for counselling

Programme planners will need to consider the physical environment for counselling. Counselling requires privacy to enable the client and counsellor to discuss confidential information. There is no ideal size for a counselling room, but it should be large enough to accommodate three people (counsellor and client or couple). The room should be well ventilated, have natural light to increase comfort, and have a door to ensure privacy. Clients should not be stigmatised for entering the counselling room. In some settings, family counselling may be appropriate or requested, and the site should be prepared for the possibility of needing a larger room on occasion. The service should be sensitive to the languages clients may speak and be prepared to overcome any potential problems. Other needs may include a table and a filing cabinet that locks for confidential client information.

From experience 5. Structured supervision for VCT counsellors in Kenya

Structured ongoing supervision sessions for VCT counsellors are provided every two to four weeks for FPAK's VCT counsellors. This is recommended in Kenya's national guidelines on VCT, and includes both group sessions and one-to-one support. VCT counsellors interviewed cited these 'counselling sessions for counsellors' as an essential aspect of high quality service provision. It provides counsellors with an opportunity to feel supported and valued, share information, discuss and get help with difficult cases, and get feedback from client exit questionnaires in order to improve their work.

From experience 6. Supporting counsellors at Chhatrapati Shivaji Maharaj Hospital, Kalwa, India

Early in the development of the service, the project manager arranged orientation programmes for all of the hospital staff about the new VCT services. This not only informed staff of the new services but also enabled VCT staff to be recognised and understood for their difficult role. In addition to regular supervision sessions, counselling staff have instituted their own peer support system, meeting in the afternoons to complete their paperwork and discuss any difficulties they had during the day. The counsellors benefit from having a large number of colleagues – both those involved in clinical care, as well as social workers in the hospital's medical social work department. On several occasions, they have sought help for particularly difficult cases from lecturers on the VCT counselling training course. Counselling staff are also involved in community outreach activities through the links it has developed with a UNFPA programme, and with local NGOs and community based organisations. Visits to community services providers on Saturdays, when there are generally fewer VCT clients, enable counsellors to develop a better understanding of and greater confidence in the services to which they refer clients. This work not only strengthens the VCT services but also gives counsellors a break from counselling duties.

3.6 TESTING

The key objective of testing within VCT is the client's request for diagnosis. When a medical practitioner wants to confirm a client's HIV status in order to provide appropriate medical care, testing should occur through the regular channels for clinical and laboratory based investigation and diagnosis (including informed consent), not through VCT.

The decision to offer testing within the site should be based on specific issues that were identified during the assessment, such as the availability of resources to purchase test kits, and the feasibility of providing tests within the site. Programme planners need to be aware of any national guidelines or policies on HIV testing and ensure that the proposed VCT service complies with all existing policies. If the site does not provide testing services directly, then planners must consider how to enable testing services for its clients who have made the decision to have the HIV test. This might include having samples drawn at the SRH site or providing written referrals to testing institutions. Arrangements must be made so that test results are returned to the site.

Box 6. Potential misuse of VCT testing services

Programme planners need to be aware of the potential misuse of VCT. In some countries, health and other providers sometimes pressure clients to use VCT testing services to confirm a medical diagnosis, to screen clients prior to surgery, for marriage certificates, or for other certificates to provide evidence of economic need for poverty programmes. This is a misuse of VCT.

3.6.1 HIV Tests

The most widely used HIV blood test kit is the Enzyme Linked Immunosorbent Assay (ELISA), which detects the antibody generated by HIV infection. ELISA tests were originally developed for blood screening and are used for batch testing (testing multiple specimens, accommodating 40-90 samples per run). ELISA tests require laboratory equipment, electricity, and cool storage facilities (2-8°C), as well as skilled laboratory technicians to prepare reagents for the test and operate the equipment.

A number of rapid HIV antibody tests are now used as alternatives to the ELISA test. Most come in a kit form, require no reagents to be prepared, and allow for a single test (as opposed to batch testing). Results are returned in 5 to 60 minutes. Compared to ELISA, rapid tests are simple to use and interpret, and staff can learn to perform these tests with minimal training. Their diagnostic performance is similar to ELISA. Rapid HIV tests have enabled the expansion of VCT services.

Although the cost of simple/rapid (S/R) tests is higher than ELISA, S/R HIV test kits have a number of advantages over ELISA. Some kits can use whole blood obtained from a finger prick method, which eliminates the need for a skilled technician/phlebotomist, and laboratory facilities. There are also saliva and urine based HIV test kits, which reduce the risk of health care workers being exposed to blood.

Because of the short waiting period between taking the HIV test and learning the result, VCT sites using the S/R tests have reported an increase in demand for VCT and return rate, with satisfaction for both clients and counsellors. However, some view the wait for test results as a time for reflection, which can enhance the issues covered in pre-test counselling, in particular reflection on risk behaviours and how to reduce these.

When selecting HIV tests, sites should consult the country's national AIDS programme to get advice regarding appropriate tests and to ensure adherence to national policy and regulation. Other local or national VCT sites may offer valuable advice about the various test kits available. National AIDS programmes' test kit recommendations will be selected from the list of WHO recommended assays. WHO evaluates the operational characteristics of test kits (such as sensitivity, specificity, ease of performance, storage conditions, etc.), and publishes reports on findings annually (www.who.int/bct/Main_areas_of_work/BTS/HIV_Diagnostics/HIV_Diagnostics.htm). The test kits selected should be checked by a reputable national research laboratory to determine performance under local conditions and on local serum samples.

Remember to plan for monitoring and evaluating testing services. See section 5.5 for guidance

From experience 7. Same hour same provider - VCT in Kenya

FPAK's VCT services offer pre-test counselling, testing, and post-test counselling within one visit and within one hour. FPAK sites use parallel testing (two different simple, rapid whole blood tests administered at the same time) for same hour test results. No separate laboratory facilities are used. Counsellors have been trained to do the rapid tests, with external quality control provided by the government's district AIDS control office. Advantages include improved confidentiality (the client only sees one provider, who does both counselling and testing), and high client satisfaction because only one visit is made. A disadvantage is the higher cost of parallel testing, since confirmation tests are only needed if the first test is reactive. According to the counsellors interviewed, people who come for testing generally have a high level of knowledge about HIV/AIDS and have reflected about the implications of the result. They are ready to know their status and want to learn it on the same day. Clients are given the option of returning for results and post-test counselling on another day but this is rarely taken up.

3.6.2 Strategies for testing

WHO has established recommendations for HIV testing strategies to maximise accuracy while minimising cost. These testing strategies take into account contextual factors such as the rate of infection in the population, and whether the clients presenting are symptomatic or asymptomatic. The recommended strategies for each of these situations for HIV diagnosis (including VCT) is summarised in Appendix E.

It is important to note that for VCT, seropositive tests from one test must be confirmed by an additional test that uses a different test principle. Further guidance on an appropriate test strategy for the site should be available from the national AIDS programme in the country, a national reference laboratory, or national research institution.

3.6.3 Protocol for testing

Sites providing testing need protocols to ensure that all staff are following the same procedures for testing, know how to carry out the testing procedure, and how to read and report results. Protocols will differ depending on the testing strategy and test kits selected. Planners should consult existing national guidelines that govern HIV testing, and take advice from others when developing a comprehensive protocol that provides clarity for staff using the protocol. The protocol should be verified before offering the service to clients. Appendix F gives a sample protocol for HIV testing.

3.6.4 Staff training for HIV testing

Staff carrying out the tests must be trained to safely carry out the tests, dispose of waste, manage the supply of test kits, and interpret and report results. It is important that staff carrying out the tests understand what effect the environment (e.g. high temperatures) has on test performance. The manufacturer's instructions must be followed closely so that test results are as accurate as possible.

Although many countries allow non-laboratory trained staff to carry out HIV tests as long as they are trained in administering HIV tests, some countries have regulations governing the technical qualifications of staff carrying out HIV tests. Planners should consult the national guidelines in their country to determine the requirements for staff training.

3.6.5 Other testing needs

If on-site testing is provided, planners will need to consider space for conducting the tests, storage space for test kits and other commodities, and equipment (such as refrigerator units). If the site needs to be renovated or refurbished to provide testing services, a higher level of financial resources will be required. In addition, planners should consider that refurbishment might cause disruption to existing SRH services.

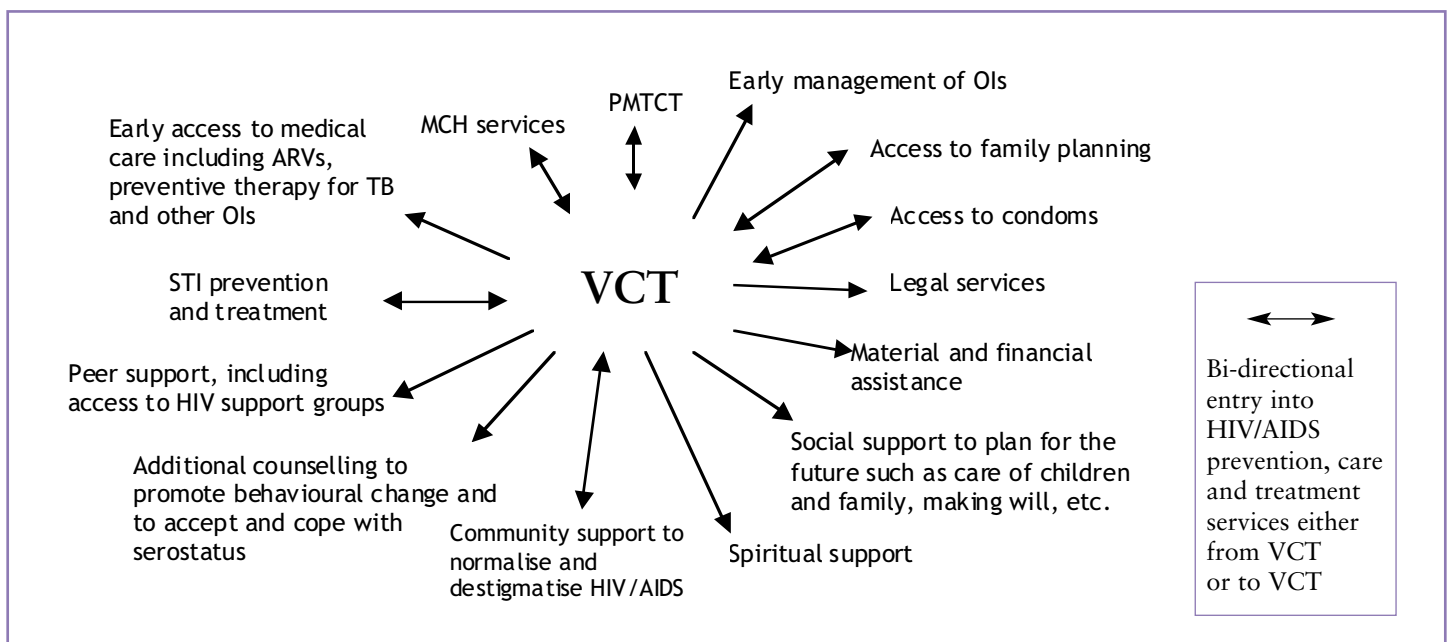
From experience 8. Non-laboratory staff can be trained to perform rapid HIV tests

FPAK's VCT services offer same-hour HIV counselling and testing. Most of the staff providing this service are not medically qualified, but have been trained to carry out rapid HIV tests. The tests used only require a small sample of blood obtained from the finger prick method. Training in conducting the rapid tests is part of the VCT counselling curriculum. Tests are monitored through a quality assurance provided by the national AIDS programme.

3.7 CARE AND SUPPORT

The development of VCT services must consider how the site will provide care and support to clients that use counselling and testing services, whether the client's HIV test result is negative or positive. The range of services that planners should consider is included in Figure 2 below. It is not expected that SRH sites will provide all of these services, but planners should be aware that counselling and testing is likely to raise further support needs for clients, so linkages to a range of other services must be established.

Figure 2. VCT and its links to prevention, care and support services



Adapted from UNAIDS (2002), *HIV Voluntary Counselling and Testing: Gateway to Prevention*

3.7.1 Care and support services provided within the provider's own setting

Planners should consider which care and support services it can provide within its own setting. Many providers of VCT offer additional counselling sessions, post-test clubs, or support groups for people testing HIV positive. Some SRH organisations link their VCT services with services to treat STIs, while others offer treatment for opportunistic infections alongside VCT.

From experience 9. Setting up a PLWHA support group

VCT Counsellors at Chhatrapati Shivaji Maharaj Hospital in Kalwa, India, organised a workshop for spouses and family members of people who had tested positive. Families of eight PLWHAs attended. The workshop allowed family members to express their worries and concerns about how HIV is and is not spread. The counsellors discussed the importance of using condoms to avoid sexual transmission. At the end of the workshop, counsellors asked if the people living with HIV would like to continue meeting on a regular basis. The group now meets on the third Wednesday of every month, providing an opportunity for people living with HIV to express their emotions, viewpoints, and concerns. Others that test HIV positive are welcome to join the group.

3.7.2 Referring clients to other care and support providers

Planners should learn about the providers of other services shown in Figure 2 in order to develop referral networks for their clients who need such services after using VCT. During the assessment phase, planners made a map of available services. During planning, relationships with these other service providers should be formalised. Formalised referral systems will help counsellors confidently make referrals, which will subsequently help clients access care and support services. Clients using VCT services in a health care setting such as a SRH clinic may assume that they will be able to get other health related support from the same provider. At a minimum, planners should ensure the development of referral systems for locally available clinical services for those that test positive – e.g. medical care and access to ARV, maternity services to reduce MTCT for pregnant clients, management of OIs and STIs, therapy for TB, and access to FP advice and condoms.

From experience 10. Referrals within a hospital setting

The Chhatrapati Shivaji Maharaj Hospital in Kalwa, India has several care and support services within its own setting. The hospital provides a range of health services, including an HIV outpatient department where clients who test positive can get early access to care, including anti-retroviral therapy, preventive therapy for TB, and treatment for OIs. In addition, the hospital has a PMTCT programme, so pregnant women who test positive can access preventive therapy. Also within the hospital is a legal aid and counselling service for women. For other social and community care and support services, counsellors have developed links with a range of NGO service providers.

Referral to social and community care services is also important. Sites that do not offer ongoing counselling or other social support services (such as post-test clubs or support groups) must develop formalised referrals to providers of such services in the community before beginning counselling and testing services.

From experience 11. Referrals to care and support services

The Association Rwandaise pour le Bien-Etre Familial (ARBEF) SRH clinic in Kigali has integrated VCT with its own services and has developed referral systems with other service providers in Kigali. The site provides antenatal care for pregnant women. All women attending for antenatal care are offered VCT. ARBEF has developed a formal linkage with the local hospital so it is able to refer pregnant women who test HIV positive for preventive therapy to prevent mother to child transmission.

Planners must be aware of the time implications in developing these linkages before the service begins, and in maintaining these partnerships once the service has started.

Remember to plan for monitoring and evaluating referral services to other care and support providers. See section 5.6 for guidance

3.8 MONITORING AND EVALUATION

During the planning stages, planners should consider the overall aims for the integrated service, so progress can be measured. Questions to consider during the development of the service might include:

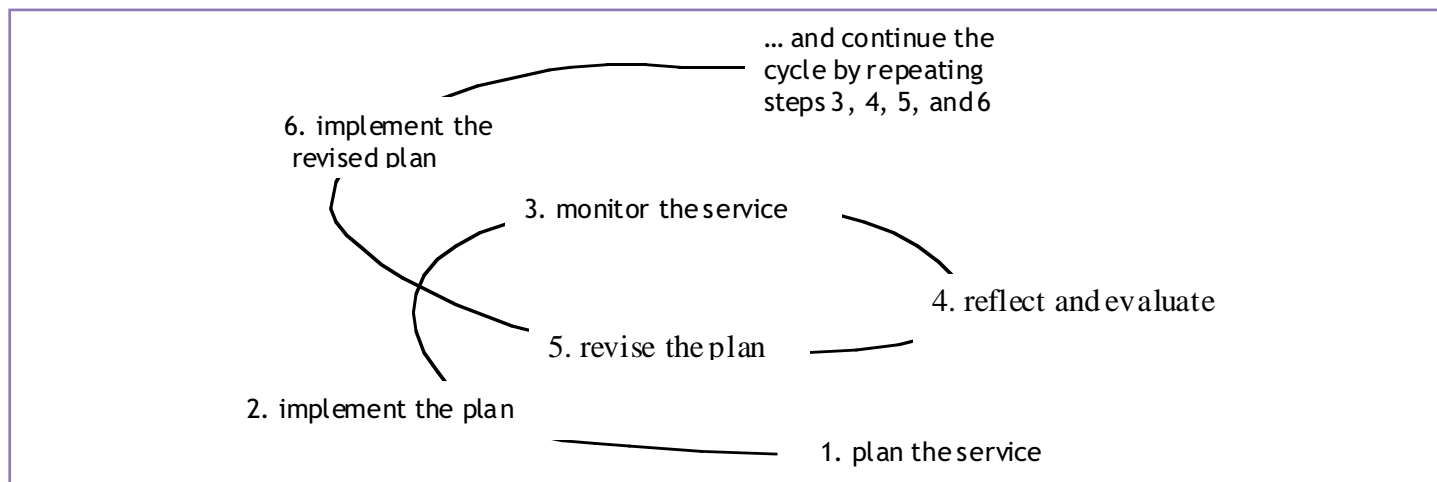
- What do we hope to achieve by integrating VCT in our service provision?
- What positive things will happen as a result of this new integrated service?
- How will we know if integrating VCT is successful?
- How will we know if integrating VCT is worth the effort, time and cost?

The answers to these questions will help those involved in the project choose measures and indicators to determine progress.

During planning, it can be useful to view the development of the service as a spiral, where learning and reflection are integrated into improving the service, as shown in Figure 3 opposite. This continuous process of monitoring and self-evaluation will enable those involved in planning, implementing, and managing the service to reflect on what is going well, and identify and implement changes and improvements to the service as it progresses.

Each of the components of VCT described in this section – community education and mobilisation, counselling, testing, and care and support – requires the development of systems and tools to monitor the service. This will enable those involved in implementing and managing the service to evaluate the integration of VCT in order to ensure that the service meets the needs of those it intends to reach. Planners are referred to Section 5 for further guidance on monitoring and evaluating an integrated VCT service.

Figure 3. Planning and evaluation cycle



3.9 RESOURCE REQUIREMENTS AND DEVELOPING A WORKPLAN

The checklist in Box 7 lists considerations when determining the resources required for integrating VCT services, which will depend on which VCT components the site integrates.

Box 7. Checklist for determining resources for integrating VCT

Infrastructure	<ul style="list-style-type: none"> • Space for counselling • Space for group information or education activities • Space for testing and storage of testing commodities
Materials	<ul style="list-style-type: none"> • Materials for community education and mobilisation • HIV and STI test kits and other testing commodities • Condoms
Staff	<ul style="list-style-type: none"> • Staff with appropriate skills and motivation for integrating the VCT activities identified (e.g. community education and mobilisation, counselling, testing, and/or care and support) • Supervisory staff time to support staff implementing the service, in particular those providing counselling
Training	<ul style="list-style-type: none"> • Enrolment on training courses as needed by staff involved in integrated VCT
Partnerships	<ul style="list-style-type: none"> • Time needed to develop networks and partnerships for both prevention and care and support activities, visit community services, attend meetings, and network with other service providers • Budget for transport to maintain partnerships
Monitoring and evaluation	<ul style="list-style-type: none"> • Staff time to develop monitoring tools and systems • Staff time to collect monitoring information and compile data • Evaluation support, depending on level of evaluation carried out

After considering the resources needed to realise the plan, the next step is to develop an implementation work plan setting out the objectives and activities for the service over the next one to three years.

3.10 SUMMARY

This section has outlined key information about various components of VCT that programme planners need to consider when developing integrated VCT services. The case study below illustrates some of the key points in planning integrated services.

Case Study 4. Planning VCT services - Association Ivoirienne pour le Bien-Etre Familial (AIBEF)

AIBEF, established in 1979, has been a leader in FP and SRH services in the Ivory Coast. It operates three integrated VCT sites, two supported by UNFPA and one supported by Family Health International. Based on their experiences in integrating VCT services, a team involved in the work identified the following key steps in planning:

Identify the sites best placed for VCT integration.

The sites selected (Yopougon and Abobo) are located in Abidjan. The reasons these sites were selected were because access to these sites is good, and the sites were already involved in STI prevention activities. In addition, because of the high HIV prevalence rate in the Ivory Coast, planners felt that comprehensive referral services for care and support would be required. Initially, an AIBEF clinic in Bouake (Ivory Coast's second largest city) was selected to implement integrated services, but because of the social and political crisis in Bouake, Abobo was substituted.

Select components to integrate.

AIBEF decided to develop counselling and testing services, outreach services for community education, and some of its own care and support services and linkages to available care and support in the community.

Select the target group for services.

AIBEF planned to target its regular FP clients, with the aim of supporting clients to reduce their risk of HIV through behaviour change. The site serves approximately 14,000 clients each year primarily from the urban area, of which 91% are women. The majority of clients are not married.

Renovate the sites.

Both clinics selected required modification so that counselling sessions could be private. VCT services started in Yopougon in August 2003 and in Abobo in December 2003.

Identify and train providers in counselling, HIV/AIDS, and STIs.

Ten providers were trained in counselling for HIV, and in using protocols developed for pre and post-test counselling.

Set up a structure for referrals to medical and social care and support services.

Early in the development of the services, AIBEF found that provision of counselling and testing services in isolation - without established links to care and support services - would fail, and would compromise AIBEF's reputation. Therefore both sites identified existing care and support service in the community and conducted meetings with senior officers in the Ministry of Public Health were held to advocate for care and support services.

Set up care and support services.

AIBEF also develop its own support services for those testing positive. Clients using VCT services are offered home visits by a counsellor.

Set up testing services.

This includes obtaining equipment and test kits. AIBEF identified and trained unemployed but qualified laboratory technicians to carry out the tests. They are employed on a part-time basis, thus reducing the costs of testing. Protocols for testing and quality control were developed, and staff trained in using the protocols by RETROCI, a national research and training project on HIV/AIDS.

Identify a structure for supervision for all staff and volunteers involved in VCT services.

AIBEF found that supervision is essential to ensure the quality of VCT services. AIBEF's clinical service manager is a national supervisor for those providers undertaking counselling. She has been trained in counselling and has developed a supervision plan to build the capacity and skills of providers to provide high quality services.

Train staff and volunteers in sensitising the community.

Twenty-six CBDs and young people have been trained in communication on HIV/AIDS. Two counsellors are available to support volunteers and their work in the community. The volunteers are involved in home visits and give support to PLWHAs.

Develop mobilisation activities.

Based on the knowledge, customs, and sexual behaviour of the community, involve community leaders, and identify key areas in the community for mobilisation activities. The 26 CBDs started conducting sensitisation activities in communities.

Decide the focus of the evaluation.

AIBEF decided to measure the number of FP clients using the service, and the proportion of clients deciding to test after pre-test counselling. In addition, AIBEF decided to evaluate of the quality of counselling and the skill of service providers, and to monitor all service activities. A coordinator for monitoring and evaluation was appointed.

Develop tools for monitoring and evaluation.

AIBEF developed tools to collect data that can help in evaluation, with technical support from Family Health International.

Develop tools for management of information related to the integrated service.

In each VCT centre, there is one computer to enter and analyse data for timely reporting.

Identify extra funding required and search for the funding needed to fully realise the integration.

AIBEF held a launch ceremony and site visits which were attended by the Minister of HIV/AIDS and by AIBEF's partners.

Sustainability.

AIBEF adopted payment for VCT services. This policy will be reinforced by advocacy and partnership.

Section 4

IMPLEMENTATION

This section will be useful for those responsible for implementing the service as well as those managing the service. It focuses on issues that arise during implementation related to each of the VCT components and outlines service providers' role in monitoring and evaluating the integrated service.

4.1 COMMUNITY EDUCATION AND MOBILISATION

Community education activities for raising awareness of HIV and VCT should be based on local knowledge, attitudes, and practices related to HIV/AIDS collected during the needs assessment. Those involved in education and mobilisation activities must be aware of how knowledge and attitudes change over time in order to continue to build messages that are relevant for different groups. For example, once people have an understanding of VCT, educators should listen to what people identify as barriers to learning their HIV status, or factors that motivate people to be tested, so that activities can continue to address people's beliefs about testing. All education and mobilisation work should contribute to normalising HIV/AIDS, reducing stigma and discrimination of PLWHAs, and promoting messages of care and support in the community. Developing and maintaining partnerships with other organisations involved in HIV/AIDS education and mobilisation can strengthen these prevention and care messages.

4.2 COUNSELLING

High quality counselling is essential for successful VCT. For staff with counselling duties, three areas of implementing quality counselling sessions are clarity about the goal and content of the counselling session (supported by a counselling protocol), preparation for special situations that arise during counselling in SRH settings, and adequate support and feedback in counselling.

This section summarises key elements of implementing counselling for prevention, pre and post-test counselling, and follow-up counselling. Readers are strongly encouraged to use IPPF's programme guidance in HIV/STI counselling as a reference when implementing the counselling service.

From experience 12. Implementing high quality counselling at AIBEF

Each client is considered as an individual with her/his own concerns and needs. The process of counselling depends on the characteristics of the client. All clients are greeted when they arrive and received according to the local traditions that show the counsellor's respect for the client. After inviting the client to sit, the counsellor explains her/his role, assures the client that her/his confidentiality will be respected, and asks the client why s/he has come. The counsellor then follows the protocol developed by AIBEF covering all of the key areas for pre-test counselling. The pre-test counselling session lasts 40-45 minutes. The counsellor completes a file and a ticket with the file number is given to the client requesting a blood test at the laboratory. When the test is complete, the laboratory technician gives the test result to the counsellor. The counsellor calls the client back to the counselling room for the post-test session.

When giving the test result, counsellors carefully observe the client's reactions, to ensure that these are managed in a way that is supportive to the client. The counsellor follows the protocols developed depending on if the result is positive, negative, or indeterminate. Post-test counselling takes on average 30 minutes.

By ensuring that counsellors have developed competencies in understanding the detailed protocols and by selecting counsellors that have the skills and abilities to relate to clients as individuals, AIBEF have been able to provide high quality counselling to clients that wish to learn their HIV status.

4.2.1 Content of counselling sessions

Counsellors should use written protocols that identify specific issues to cover during prevention, pre-test and post-test counselling, and follow-up counselling for people who have taken an HIV test. Many national HIV/AIDS programmes have standardised training programmes for VCT counselling which provide participants with sample protocols and support materials for counselling. The material in this section and in the accompanying checklists in Appendices B, C and D can be used to supplement existing protocols while maintaining adherence to national guidelines.

Some providers post shortened checklists on the wall, or keep a copy of the relevant checklist on the desk to remind them what to cover during a counselling session. If using a checklist during counselling, the counsellor should explain to the client that the list will help ensure s/he covers all the important topics during the session.

Where a section of IPPF's UNFPA-supported publication, Programme Guidance on Counselling for STI/HIV Prevention in Sexual and Reproductive Health Settings is relevant, the section and page number are given.

Counselling for HIV and STI prevention

The main goals of counselling for HIV and STI prevention are to help clients determine if they are at risk of HIV or other STIs, to help them explore how they can reduce this risk, and to enable them to put their risk reduction plan into action. Depending on whom the site intends to target with counselling for prevention, the implementation of counselling will vary. For example, if prevention counselling is to be incorporated into every visit to the site, then all providers need to be trained to introduce the topic of HIV and STI. Many clients visiting an SRH clinic will not consider themselves vulnerable to HIV or other STI, so the topic needs

to be raised sensitively within the context of the client's visit. Providers can learn how to do this by participating in training sessions that use role-plays or case studies to enable them to come up with and share their own strategies.

Helping clients put their risk reduction plan into action might include giving clients the opportunity to practice putting a condom on a penis model, or role-playing their partner's reaction to a discussion of using condoms. After prevention counselling, some clients may want to learn their HIV status through VCT. The provider should refer the client for (or provide) pre-test counselling, which can help the client make an informed choice about whether or not to take the HIV test.

A detailed checklist outlining the content of a prevention counselling session is found in Appendix B. Service providers implementing prevention counselling should review and modify this checklist with their manager to ensure that it is appropriate for their setting.

Further information on counselling for HIV/STI prevention is detailed in Programme Guidance on Counselling for STI/HIV Prevention in Sexual and Reproductive Health Settings, section 4, p.21-33.

Pre-test counselling

There is a wealth of information that clients need to know before deciding whether or not to take the HIV test. Pre-test counselling gives people information about HIV and the test, and time to reflect on their personal risk and possible exposure to HIV as well as the advantages and disadvantages of knowing their HIV status. It also helps begin to prepare clients for their test result. During pre-test counselling, clients make an informed decision of whether or not to be tested for HIV.

The quality of pre-test counselling is essential in ensuring that clients have the information they need to make this decision. Whether the client consents to be tested or not, pre-test counselling provides an excellent opportunity to discuss risk and how clients can reduce their risk, and plays an important role in HIV prevention.

Further information on pre-test counselling is detailed in Programme Guidance on Counselling for STI/HIV Prevention in Sexual and Reproductive Health Settings, section 5, p.34-37.

A detailed checklist outlining the content of a pre-test counselling session is found in Appendix C. Service providers should review and modify this checklist with their manager to ensure that it is appropriate for their setting.

Post-test counselling

Post-test counselling enables clients to learn and understand the result of their HIV test, make a plan of action to remain negative or get the care and support they need if their test result is positive. Post-test counselling helps clients develop practical actions to reduce their risk of HIV and to take action to prevent infection or infecting others. It also enables discussion about a range of other issues that may result from the process of taking the HIV test.

When the test result is HIV negative, counsellors should remind clients that the test did not detect antibodies, but that they could be infected if they have had any possible exposure to HIV during the three months before testing. In order to determine whether re-testing is necessary it will be important to further explore the individual's risk assessment discussed during pre-test counselling. The session should emphasise the importance of remaining HIV negative, the risk reduction plan discussed during pre-test counselling, and the benefits of disclosing the test result to their partner(s). Pregnant clients who are HIV

For further information on post-test counselling, readers are referred to Programme Guidance on Counselling for STI/HIV Prevention in Sexual and Reproductive Health Settings, section 6, p.38-44.

negative should be informed about the importance of remaining uninfected during both pregnancy and breastfeeding to prevent transmission to the baby.

Giving clients their test result can be difficult particularly when that result is positive. It is important to use clear language, and check what the client has understood by the result. During post-test counselling, counsellors should be aware of and be prepared to respond to the possible responses of clients in learning their HIV status (anger, fear, denial, distress, etc.). The counsellor should explain that the client may have a long period of relatively healthy life ahead of them. It is important to work at the client's pace, particularly if the test result is positive, as the client may not be able to take in all the information in one session. The counsellor should help the client develop a plan for the short term, discuss the risk of transmission and how to reduce this, and identify referral needs for support and care. Before ending the session, the counsellor should explore the client's immediate plans and the availability of support.

A detailed checklist outlining the content of a post-test counselling session is found in Appendix C. Service providers implementing post-test counselling should review and modify this checklist with their manager to ensure that it is appropriate for their setting.

Follow-up counselling

The purpose of follow-up counselling after post-test counselling for HIV is to support the client in addressing issues that have been raised as a result of taking the HIV test. The counselling session can also be used to review what was discussed during post-test counselling. During the session, the counsellor should help the client identify the client's concerns at this stage and support the client in addressing these concerns.

For those that test HIV negative, the client may have further issues to discuss. For example, some clients may want support in thinking about how to approach their partner to take the HIV test, or how to introduce condoms into a relationship. For those that test positive, it can be difficult to take in all the information covered at a post-test counselling session. Additional counselling sessions may be needed to work through some of the issues such as how to disclose the result to the partner and the possible implications of disclosure (such as rejection or violence), to identify referral needs, and to ensure that the client has the information s/he needs. Counselling after the post-test session enables further reinforcement of prevention messages – both how to prevent becoming infected or how to prevent infection to others.

4.2.2 Counselling in special situations

Some clients may have specific needs or issues that require special counselling strategies. This section outlines counselling strategies for situations that may emerge in SRH settings.

Pregnant women and their partners

For pregnant women who are HIV negative, counsellors should discuss the risk of transmission of HIV to the infant if the woman is exposed to the virus during pregnancy and/or lactation. Pregnant women and their partners should be encouraged to use condoms or practise other forms of safer sex during both pregnancy and lactation.

For pregnant women who test positive for HIV, it is important to discuss the risk that the baby may contract the virus during pregnancy, childbirth, or breastfeeding. Most children born to women with HIV are not infected with HIV themselves. Of those children that are (approximately 30% of

For further information on counselling pregnant women and their partners see section 8 of Programme Guidance on Counselling for STI/HIV Prevention in Sexual and Reproductive Health Settings, p.50-55.

babies born to HIV positive women), about half are infected during pregnancy or at birth and half during breastfeeding. Women with HIV should be informed of the interventions thought to be effective in reducing MTCT, including a short course of antiretroviral therapy (where available) and infant feeding options to reduce transmission of HIV (see ‘Breastfeeding and safer infant feeding’ below). Delivery by Caesarean section has been shown to reduce transmission of HIV and may be available to some women, but the decision to deliver by Caesarean section should be balanced against the risks of the procedure to the mother. Delivery procedures that increase exposure of the baby to the mother’s blood should not be performed unnecessarily, as this can increase the risk of MTCT. Re-infection with HIV during pregnancy (which can increase the amount of HIV in the blood) can result in increased risk of transmission to the baby. Pregnant women who are HIV positive and their partners should be encouraged to take action to prevent re-infection by using condoms or practising other forms of safer sex.

Breastfeeding and safer infant feeding

It is estimated that 5-20% of infants born to HIV positive women acquire the infection through breastfeeding. Breast milk is normally the best food for an infant. However, HIV positive women who breastfeed or plan to breastfeed need information about the potential advantages and disadvantages of different infant feeding options regarding the risk to the baby, cost and the potential stigmatising effects of not breastfeeding. Current recommendations for HIV positive women state that when replacement feeding is acceptable, feasible, affordable, sustainable, and safe, avoidance of all breastfeeding is recommended, to reduce the risk of HIV transmission. Otherwise, exclusive breastfeeding (with no other food or liquids including water) is recommended during the first months of life. Breastfeeding should be stopped as soon as replacement feeding is acceptable, feasible, affordable, sustainable, and safe. Mixed feeding (formula feeding and breastfeeding) is not recommended.

For HIV negative women, infection with HIV during lactation can result in the transmission of HIV to the baby. Women who are HIV positive can be re-infected during lactation, further increasing the risk of transmission to the baby. All women who breastfeed or plan to breastfeed should be encouraged to use condoms or other forms of safer sex during lactation.

Counsellors are encouraged to find out as much as possible on what feeding options are available locally and how safe they are likely to be. Counselling both parents might make it easier for the mother to choose the best option.

HIV negative women vulnerable to HIV

Many people using VCT services test HIV negative, but are still vulnerable to HIV. It is important to emphasise to clients that a negative test result does not mean that they will remain HIV negative, unless they take action to protect themselves from infection. The most important strategy for this group is using male or female condoms to protect themselves from HIV and other STIs. In the context of FP some women may not understand that other contraceptive options will not protect them from HIV/STI. Dual protection – using condoms for prevention of unwanted pregnancy and HIV/STI or using condoms as well as another method of contraception – should be promoted.

It is not always easy for people to accept using condoms. The counsellor should ensure that the client knows how to correctly use condoms. Even if the client wants to use condoms, it can be difficult for a woman to persuade her

For further information on counselling women to reduce their risk, see section 4.4 of Programme Guidance on Counselling for STI/HIV Prevention in Sexual and Reproductive Health Settings, p.24-32

New guidance on HIV and infant feeding was developed collaboratively in 2003 by a number of agencies: HIV and Infant Feeding: Framework for priority action (WHO, UNICEF, UNAIDS, UNFPA, FAO, UNHCR, WFP, WB, IAEA); HIV and Infant Feeding: Guidelines for decision makers; (WHO, UNICEF, UNAIDS, UNFPA); HIV and Infant Feeding: A guide for health care managers and supervisors (WHO, UNICEF, UNAIDS, UNFPA).

For further information on counselling on breastfeeding, see section 8 of Programme Guidance on Counselling for STI/HIV Prevention in Sexual and Reproductive Health Settings, p.50-55.

partner. Counsellors should be aware that negotiating for condom use may be difficult, and may result in violence. Strategies to support clients, such as role-play or discussion to help the client think through how she can approach her partner may help. Couple counselling may be beneficial if the client feels that she needs support to talk to her partner about using condoms.

Clients considering conception

Some women and men may want to learn their HIV status before deciding whether or not to have a baby. HIV positive clients may want to discuss issues related to having a child before pregnancy. Counselling before conception, whether the client is HIV positive or negative, provides an opportunity to provide information on strategies to reduce MTCT.

For further information on PMTCT including counselling clients considering conception, see section 8 of Programme Guidance on Counselling for STI/HIV Prevention in Sexual and Reproductive Health Settings, p.50-55.

Some women with HIV choose to conceive, and it is their right to decide to have a child. Reasons for wanting to have children can be complex. Those counselling HIV positive women or couples should help clients clarify the positive and negative points of conceiving, and should support the client's decisions, even if the counsellor disagrees with the decision. The counsellor should provide information on the risks of MTCT during pregnancy, delivery and lactation, and the ways in which these risks can be reduced. In addition, the counsellor should help the client think through the implications if the child is HIV positive, and help the client explore the family and social support available for either the client or child, should either the child or client develop AIDS.

Women who do not want to become pregnant

Some women may believe that methods to prevent pregnancy will also prevent HIV and STIs. All women vulnerable to HIV who want to avoid becoming pregnant should use condoms to protect themselves from HIV, STI, and unwanted pregnancy. HIV positive women who do not want to become pregnant should use condoms to prevent pregnancy, infection to a partner or re-infection. Some women may choose to use condoms as well as another contraceptive method. Counsellors should discuss the contraceptive options available.

Women who experience or fear violence or abuse

Many women are in violent or abusive relationships with their partners. Sexual cultures and gender norms vary, and abuse and violence may even be sanctioned in some cultures. For example, in some countries rape in marriage does not exist in law. In some cultures, a man has a right to beat his wife if he believes she has not behaved as she should. Counsellors should be aware of the social, economic and cultural subordination of women and how this can affect a woman's ability to protect herself against HIV. Counsellors should also be aware of policies and laws that protect people in relation to human rights and sexual and reproductive health.

Any client could be in an abusive or violent relationship. Counsellors should ask questions about the client's sexual relationship, for example, about the partner's likely reaction to learning that the client is considering testing, has tested HIV positive, or suggesting using condoms. By understanding the client's relationship, the counsellor will be able to better support the client.

For further information on counselling clients experiencing violence or abuse, see section 7 of Programme Guidance on Counselling for STI/HIV Prevention in Sexual and Reproductive Health Settings, p. 45-49.

Couples

Couple counselling is promoted in some countries to promote safer sexual behaviour and to encourage disclosure to the sexual partner. Counselling for couples should be encouraged where appropriate, but services should be flexible and mindful of the different needs of those attending VCT as a couple. Both partners

must give their informed consent to test. In addition, planners and counsellors should be aware that many people do not want to be tested with their partner (or may not be part of a couple) and may not come forward for testing if they perceive that they will be pressured to attend as a couple.

From experience 13. Couples VCT in Kigali, Rwanda

"There are great benefits when a couple in an ongoing relationship decide to undergo VCT together. If both partners are negative, sharing the test result can help in maintaining their negative status. If both partners are positive, counselling can help the couple come to terms with the implications of their results. If the test results are discordant (where one partner is HIV positive and the other is negative), a counsellor can help partners cope with their immediate emotions and reactions, such as blame or violence."

SRH service provider, ARBEF

Discordant couples

Discordant couples are couples that do not have the same HIV test result. Counselling for discordant couples should include helping the couple cope with emotional reactions such as anger or resentment. The counselling session should also help the couple accept and plan for safer sex practices – in particular the use of condoms – to protect the partner who has tested HIV negative. The counselling session should support the couple to develop strategies to help the HIV positive partner live with the infection. The session should also include a discussion about family planning and the risks of HIV to both the woman and child if she becomes pregnant.

From experience 14. Counselling discordant couples in Kigali, Rwanda

"One of the most difficult situations is counselling discordant couples. When the woman is positive and the man is negative, it is likely that she is thrown out of the house. The man cannot accept the woman's status. If the man is positive and the woman is negative, that is even worse. He doesn't accept using condoms and is putting the woman at risk. And the woman is obliged to stay within this relationship due to the culture and her position in society. Counselling in this situation is very difficult. How can she protect herself? As a counsellor, it can be difficult to know what to do. Sometimes we can appeal to his responsibility to protect the woman from becoming infected. Also we can ask him to protect his woman for the sake of their children, so that the children have support from the mother if he passes away."

SRH service provider, ARBEF

Partners of HIV positive people

Clients who have sex or share needles with HIV positive partners should be encouraged to participate in prevention counselling. Couple counselling may help maintain their HIV negative status, through discussing safer sexual and drug taking practices.

Indeterminate test results

Although indeterminate test results are not common, they produce anxiety for clients. If the test result is indeterminate, the counsellor should ask the client to come back for a repeat test in three months after they last may have been exposed to HIV. Counselling a client with an indeterminate result should be similar to that of someone who has received a positive result. The counsellor should emphasise that the client must protect both themselves and her/his partners against potential infection by using condoms during sex.

Young People

Young people account for over 50% of new infections worldwide making it important that VCT services are appropriate to their specific needs. VCT services for young people should take into account the social context of young people's lives. The counselling should be age-appropriate, using language and examples that are familiar. Service providers' attitudes and their level of comfort in talking to young people about sexual health issues will affect their ability to effectively provide counselling services. Sites targeting young people should train providers in youth-friendly approaches to counselling and communication. Providers must also be aware of referral services that are accessible for young people, for example youth-friendly FP services, access to condoms, support groups for young people, and medical care.

For further information on counselling young people, see section 1.4 of Programme Guidance on Counselling for STI/HIV Prevention in Sexual and Reproductive Health Settings, p.10.

From experience 15. Reaching young people with VCT services in Kenya

Recognising that young people are particularly vulnerable to HIV, and that their service needs are different, FPAK has developed youth-friendly VCT in several of its youth centres. Services have been adapted to make them more attractive to young people. VCT services at the youth centres have longer opening hours than the VCT services in FPAK's more traditional clinics and in other VCT centres, more providers resulting in shorter waiting times, anonymous testing (where names of clients are not recorded or stored by the provider; only codes are used), reduced costs or free services, and counsellors that are young adults and/or are sympathetic to issues that young people face. In addition, the youth centre's peer educators promote the services during their outreach activities in the community.

Sites providing counselling and testing services to young people need to be aware of the policy issues that govern services to young people. For example, in most countries, there are legal requirements for parental or guardian consent before medical procedures can be carried out, and HIV testing may be subject to these laws. Planners and managers should determine the legal context on age of consent if providing services to young people and develop a policy regarding age of consent for testing.

Rape

Clients who are survivors of rape need counselling concerning the rape as well as information about HIV/AIDS. It is important that the client is not made distraught by the information given, while at the same time they should be prepared if the result is positive. Where available the client should be given information on ARVs as a post-exposure prophylaxis. The counsellor may need to refer clients for ongoing counselling carried out by someone who has experience of counselling rape survivors.

For further information on counselling survivors of rape, see section 7 of Programme Guidance on Counselling for STI/HIV Prevention in Sexual and Reproductive Health Settings, p. 45-49.

Men

Integrating VCT services in SRH settings may attract more men to the site. Planners and counsellors need to be aware of the implications of the changing profile of service users. For example, in cultures where it is not appropriate for male clients to talk to female providers, the site may need to train male service providers for counselling duties. Attracting men to SRH settings can be beneficial in terms of their participation in family planning.

From experience 16. Men attend VCT services in SRH settings

Men will attend services in traditionally women-dominated settings if they are high quality and welcoming to all. In a six-month period, VCT services offered in FGAE's SRH clinic in Nazareth, Ethiopia were used equally by men (49.3% of clients) and women. In FPAK's six VCT sites (integrated in two youth centres and four SRH clinics), 51.9% of VCT clients were male.

Premarital VCT

Some faith-based organisations and church groups have proposed that couples undergo VCT prior to marriage. Premarital VCT can support the couple to make decisions about having children and in planning for the future. Premarital VCT should be voluntary, with both individuals giving informed consent.

From experience 17. Marriage is a key reason for people using VCT services

Over half of the clients using VCT services at ARBEF's SRH clinic in Kigali cited marriage as their reason for wanting to learn their HIV status. At FGAE's SRH clinic in Nazareth, 23% of clients cited marriage as a reason for using VCT services.

Programme planners should be aware of the ethical issues involved in testing prior to marriage. For example, in Rwanda, some churches request a certificate saying that the couple have undergone HIV testing and are not infected before they will agree to perform the wedding ceremony. Although this is against national policy, VCT providers have felt pressured. A group of NGOs are working with faith-based organisations to promote a better understanding of HIV/AIDS and VCT.

Sex Workers

Women, men, and young people sometimes exchange sex for money, goods, or other help in difficult times. It can be difficult for people to negotiate condom use in these situations because the person buying sex may insist on sex without a condom. Sex workers can be vulnerable to violence if they suggest using condoms. Even when sex workers use condoms with commercial clients, they may still be vulnerable to HIV if they have unprotected sex with regular clients or partners.

As with all counselling, discussions with sex workers requires a non-judgemental attitude. Counselling should include practical risk reduction and should support the client to develop negotiation skills. If the site does not specifically target sex workers, counsellors should be aware of other community programmes and services to support sex workers, for example, through other income generating activities.

Same Sex Relationships

Same sex activity is stigmatised and illegal in many countries, making it difficult for people to develop safe and caring sexual relationships. It is important for counsellors to feel comfortable discussing same sex relationships and to give all people opportunities to discuss their sexual behaviour as it relates to their risk of HIV. Counsellors should be aware of services to meet the needs of individuals in same sex relationships such as support groups or other activities for referral.

Further information on counselling drug users is found in section 1.4 of Programme Guidance on Counselling for STI/HIV Prevention in Sexual and Reproductive Health Settings, p.10-12.

Injecting Drug Users (IDUs)

Injecting drug use is a key mode of HIV transmission in some parts of the world. In addition to risk of transmission through infected needles, drug use may lead to a risk of HIV because people sometimes find it difficult to think about or use condoms when under the influence of drugs. For IDUs, using personalised and interactive models of counselling which set goals for the client can be successful in behaviour change to reduce HIV risk. Those who inject drugs should be referred to services that carry out community preventative strategies such as needle exchange programmes.

Occupational Exposure

Health workers who have been exposed to HIV should not have unprotected sex until a negative test result has been confirmed. The health worker should be given information about the rationale for using ARVs as a post-exposure prophylaxis as well as the need for a second test after the window period to confirm whether or not they have been infected. If the person is pregnant, considering becoming pregnant, or breastfeeding, counselling should include a discussion of the risks of MTCT and how these can be minimised.

Settings where no HIV treatment is available

In places where there are no treatments to manage HIV and related illnesses, counsellors may perceive an ethical dilemma in counselling clients with HIV. Counsellors working in such settings should explore their own feelings about this issue and whether or not the situation is likely to change. Counsellors that feel that VCT is unethical should be released from their counselling duties.

4.2.3 Supervision and support for counsellors

Staff providing HIV counselling need regular supervision and support. Section 3.5.4 describes some of the ways in which counsellors can be supported and gives examples of support provided by several sites. Supervision sessions can be provided individually or in groups, but all counsellors should have access to an individual supervision session if requested to deal with specific issues that may arise from counselling. Both counsellors and their managers can make the most of supervision if they are prepared for the session. A sample framework for a supervision session is included in Appendix G.

4.3 TESTING

This section summarises key elements of implementing HIV testing. For staff responsible for testing, the main areas of implementing quality testing are clarity about the process of testing including quality assurance and safety.

4.3.1 Quality assurance and safety

Reliable HIV testing is an important component of any VCT service. Having accurate test kits does not necessarily mean that the laboratory results are reliable. Depending on the type

of test used and protocol developed, there are many times during which errors can occur between the time a specimen is collected until the time a result is recorded. Appendix H outlines a checklist to help ensure the quality of HIV testing. One person should be responsible for overseeing the quality assurance programme.

WHO and UNAIDS have prepared guidelines for the establishment of national external quality assurance schemes, and many national programmes have requirements for external quality assurance for sites carrying out HIV testing. These schemes assess the quality of test performance on a nationwide basis and provide assurance to both staff and clients that the test results are reliable. Programme managers should adhere to external quality assurance requirements.

Staff responsible for HIV testing that involves needles and blood samples should assume that all samples are potentially infected and adhere to universal precautions to prevent infection. Access to post-exposure prophylaxis should be made available to all health workers at risk of infection through their work.

4.4 CARE AND SUPPORT

Counsellors play a key role in helping clients get the care and support they need. The easiest way to find out a client's care and support needs is to ask directly. The services that are provided directly by the site are more likely to be taken up, since the client is likely to be comfortable in accessing services in the same setting. Referral to care and support by other providers requires knowledge of services available, maintenance of referral networks, and skill in making appropriate referrals.

4.4.1 Knowledge and maintenance of referral networks

VCT service providers must have up to date knowledge about the HIV related services available in the community. The map of services developed during assessment should be updated as new services become available, and as providers learn more about the services. Counsellors should have information about the services available, for example opening hours, target groups served, and costs.

Counsellors should be given the opportunity to visit different facilities to enable them to become familiar with what the providers offer, and ensure that people with HIV who access the services will not be stigmatised and that their confidentiality will be maintained. Although time consuming, the effort put in to developing and maintaining good linkages and partnerships will help counsellors confidently refer clients for the services they need.

4.4.2 Making a referral

Counsellors should explain in as much detail as possible what the client should expect from the referral, and if it helps, give the client a written referral to take to the provider. If more than one site provides the service, the counsellor should ask the client if there are places that s/he would prefer. If appropriate, clients should be given a written list of service providers with addresses, a description of services provided, and opening hours.

It is useful to find out from the client if there is anything that will make it easier for them to take up the referral. Counsellors should ask the client if they intend to follow through, and if not, should try to find out what barriers might prevent them from accessing services. Clients may be reluctant to take up the referral because they are unsure of confidentiality or want to remain anonymous. The counsellor should ask if there is anything that s/he can do to reduce these barriers.

Counsellors should document the services to which the client was referred, and if the site provides follow-up counselling, the services that the client used. If the client has not taken up the referral, the counsellor should try to find out the reasons for this. This may help determine barriers that prevent clients from using specific services and recommendations to help make these services more responsive to the needs of clients.

Case Study 5. Care and support linkages for VCT clients in India

A 32-year old woman attended the family planning outpatient department at Kalwa Hospital in Thane with fever and lower abdominal pain. The doctor treated her for her STI and referred her to the VCT service. She consented to testing and was found to be HIV positive. With the encouragement of the counsellor, the woman decided to share her test result with her husband. The woman returned the following day with her husband, because he wanted to verify the test result. The counsellor provided information on how HIV is transmitted and how it can be prevented. During the session, the woman revealed that she was having a sexual relationship with a neighbour, because her husband was an alcoholic, had abused her physically in the past and also neglected her sexual needs. On hearing her story, the husband also decided to take the test. He was HIV negative. The woman returned to the centre a few weeks later for further counselling because her husband had become violent and had beaten her for being unfaithful and for being HIV positive. She was referred to Aarohi, a legal aid and counselling centre for women victims of violence. Over the next few weeks, counsellors at Aarohi counselled the woman and her husband. Her husband was further referred to a treatment programme for his alcohol problems and the woman was referred to the HIV outpatient department for further medical care.

4.5 MONITORING, EVALUATION & INCORPORATING LESSONS LEARNED

Those involved in overseeing and implementing the service should regularly monitor the services provided so that they can review progress and adjust the service as needed. During the planning phase, the tools for monitoring the service should have been developed. During implementation, those involved in delivering the service must collect monitoring information and compile it so that progress can be reviewed continuously. In this way, lessons learned during implementation can be incorporated to improve the service. Section 5 outlines more information on monitoring and evaluation and sample tools for monitoring and evaluating integrated VCT services.

As part of implementation, programme managers should ensure that staff involved in implementing the service are clear about the importance of collecting monitoring information, and are trained in using the monitoring forms. Involving implementing staff in reviewing the information collected and the service as a whole helps strengthen the work in several ways. It helps in the further refinement of monitoring tools to ensure that only useful data are being collected. It provides feedback to staff about their work and enables them to participate in making decisions about how the service could be improved. Staff that are involved in making decisions about the service are more likely to be committed to its success.



Photo: IPPF/Jenny Matthews/Eritrea

Section 5

MONITORING & EVALUATION

This section focuses on tools and methods that service providers and managers can use to monitor and evaluate an integrated VCT service when the goal is continuous service improvement. This section does not identify specific outcomes of an integrated service to measure or evaluate. This is because each site will have identified their own aims of the integrated service during the planning stages (see section 3.8). However, those involved in the monitoring and evaluation process described in this section will develop documentation on the service and gain an understanding of all aspects of the service and its management, which will contribute to most evaluation goals.

5.1 INTRODUCTION TO MONITORING AND EVALUATION

Monitoring and evaluation are linked but are not the same. Monitoring is a way of systematically collecting information and recording it on an ongoing basis so that people involved in the service can evaluate the service. Evaluation is assessing how the service is progressing and what it is achieving. Evaluation uses monitoring records as well as other methods (for example, observation, interviews, discussions, etc.) to identify the changes the service is making to people, other services, and the facility as a whole, and how the service achieved these changes (sometimes called outcomes). Evaluation involves looking critically at what has been done, and thinking about what was good, what could be improved, and what actions are needed to make these improvements. Three key questions in evaluating any newly integrated service are:

- 1. Is the integration of this service successful? For example,**
 - Are we achieving what we set out to achieve?
 - Are we reaching the people who most need VCT services?
 - How has VCT integration affected what we do?
 - What difference does this service make to those that use it?
- 2. Is it worth it? For example,**
 - Is it worth the time, effort, and/or money?
- 3. What should we do differently? For example,**
 - What have we learned so far from integrating the service?
 - What works well? Why? What doesn't work well? Why not?
 - How could the service be changed for the better?

By asking these kinds of questions during the early stages of service development and implementation, monitoring and evaluation enables those involved to learn from experience and improve services, as shown in the spiral in Figure 3. This is sometimes called ‘process evaluation’ and offers a constructive way to adjust the service based on needs identified by those involved. This section focuses on process evaluation, because process evaluation is most appropriate for sites that are initiating integrated VCT services.

There are other types of evaluation. For example, ‘impact evaluation’ is more complex, and is often used after a programme or service has been operating for a number of years to determine the extent to which an initiative succeeded or failed, or the degree to which observed changes or outcomes could be attributed to a specific service. Over time, sites may want to consider other evaluation goals, such as the impact of VCT services on HIV or STI rates, or on clients’ behaviour.

5.2 WHO SHOULD BE INVOLVED IN MONITORING AND EVALUATION?

Those involved in implementing and managing the service should be involved in monitoring and evaluating it. Planners and managers should ensure that monitoring tools and systems are developed during the planning stage, and that staff understand how to use them. During implementation, this monitoring information should be routinely collected, compiled, and reviewed. Through regular review and evaluation of the progress, those involved can adapt their work to deal with any identified problems.

It is useful to involve other people in the monitoring and evaluation process, such as staff within the SRH setting (including those not directly involved in VCT integration activities), users of SRH services and VCT services, organisations providing care and support services for clients of the VCT services, and planners and decision makers.

5.3 COMMUNITY EDUCATION AND MOBILISATION

5.3.1 Monitoring community education and mobilisation

Monitoring community education and mobilisation efforts should include keeping records of all mobilisation and education activities that relate to the integration of VCT services.

Implementing staff should complete monitoring forms for group or public activities which

include the dates and types of activities, numbers and profile of people attending, key messages, and comments about the session. In the early stages of the implementation of the service, both quantitative and qualitative information should be collected. A sample monitoring form for community education and mobilisation activities is included in Appendix I.

Education staff or supervisors of a team of educators should compile the quantitative monitoring data collected so that it can be reviewed by those involved in implementing activities as well as programme managers. A sample summary monitoring form is found in Appendix J.

Photo: IPPF/Maryse Hodgson/Rwanda



Box 8. A note on adapting sample forms

The sample monitoring forms included in the Appendices are examples and are included to support planners and programme managers to develop appropriate monitoring tools. Each sample tool must be adapted for use according to the needs and plans of the site. For example, in Appendix L, the list of activities should reflect those that the site will be using. The definition of ‘young people’ varies from country to country, so age categories should be changed to ensure that monitoring forms collect data on ages relevant to the site. Religion, education, and occupation may be important variables to add to some of the forms. Response categories of some of the questions may need to be changed to reflect the site’s service. Some of the forms can be shortened (for example, by abbreviating or giving codes to responses).

After monitoring and evaluating the service for several months, those involved may find that the forms need to be modified again, to ensure that only useful information is being collected.

5.3.2 Evaluating community education and mobilisation

Community education and mobilisation activities should be evaluated both quantitatively and qualitatively against the goals and objectives determined during planning. Evaluation should consider, for example, if there are changes in people’s awareness and knowledge of HIV/AIDS, in the level of stigma, discrimination, fear and denial related to HIV/AIDS, in people’s understanding of the benefits of learning HIV status through VCT, or in people’s knowledge of where VCT services are offered in the community. These changes can be assessed by regularly reviewing the monitoring information collected. They can also be assessed through qualitative research (for example, using the focus group discussion tool in Appendix A). Activities can be evaluated quantitatively, for example, by determining if the number and types of activities have been carried out according to the plan.

Regular meetings of those involved in mobilisation activities enable the lessons learned to be incorporated into future education activities. For example, if educators learn through discussions with SRH clients or community members that people are not interested in VCT services because they believe that learning they were HIV positive would be a ‘death sentence’, educational messages could focus on the benefits of knowing HIV status, the support services available locally for those living with HIV, or that many HIV positive people remain healthy for a long time.

5.4 COUNSELLING

5.4.1 Monitoring counselling

Service providers implementing pre and post-test counselling should complete a monitoring form for each client to record information that will provide managers with an understanding of the profile of those that use the VCT services, their reasons for attending, clients’ risk behaviours, whether or not they consented to taking the test, the test result, referral services for care and support services, and duration of the sessions. Instead of writing during sessions, it is less distracting for the client if the counsellor records key words that can then be used to complete the form after the session. Confidential client information (for example, records that include names and records that link names to ID numbers) must be kept in a locked

filing cabinet accessible only to counselling staff. A sample form for collecting information from pre, post-test, and follow-up counselling is provided in Appendix K. If the site has staff with skills to electronically analyse information, this information could be entered into a database for detailed monthly or quarterly analysis. Alternatively, counsellors or their supervisors can complete a summary of counselling sessions provided and test results. A sample summary form is included in Appendix L.

5.4.2 Evaluating counselling

Those involved in implementing and managing the service should review the compiled monitoring information. This will help those involved get a better understanding of the demand for services and whether this is changing, and the types of clients attending. It may help to readjust the overall service strategy. For example, if demand is low, the site may need to do more outreach education work on the benefits of VCT. If monitoring shows that most clients are not vulnerable to HIV and most test results are negative, it may indicate that more targeting is needed.

Evaluating counselling quality

It is not easy to evaluate the quality of counselling. Direct observation of a counselling session is difficult because of the confidential nature of HIV counselling. For this reason, other techniques, such as audio or videotaping counselling sessions (with the client's consent), 'mystery' clients (where a person attends VCT services as a client but is trained to evaluate the service; the counsellor is not aware that s/he is being evaluated), or role-play are used in order to evaluate the quality of counselling provided. Areas for evaluating counselling quality include the counsellor's ability to establish an interpersonal relationship with the client, their skill in gathering and giving information, and their skill in handling special circumstances (such as language difficulties, clients expressing difficult emotions, etc.). The environment in which counselling is provided should also be evaluated. A sample form for evaluating counselling quality through observation of an actual or simulated counselling session is provided in Appendix M.

Another way to evaluate counselling is to ask clients what they thought of the counselling provided. Questionnaires to establish client satisfaction will help to ensure that the needs of clients are being met. A sample questionnaire to evaluate client satisfaction with counselling services is provided in Appendix N.

The information obtained from observation and/or clients should be shared with counsellors, as part of both supervision (see section 3.5.4) and as part of evaluation. In this way, counsellors can directly see both the benefits of their work, and make changes based on client feedback and evaluation.

5.5 TESTING

The monitoring of testing should include a log of tests completed, records of test kits used, and results of the tests conducted. Those implementing and managing the service should compile the monitoring records monthly for review. Sample forms for recording and monitoring testing are included in Appendix O. Results of external quality assurance should be shared with staff involved in conducting HIV tests so that remedial action to improve quality can be taken if necessary.

5.6 CARE AND SUPPORT

5.6.1 Monitoring referrals to care and support services

During pre and post-test counselling, the provider should note any referrals to care and/or support services. To monitor referrals, the site needs to consider how it will know whether clients take up referrals to other HIV related services. If the site provides follow-up counselling and support this will be easier because the provider can ask the client directly, and can record this information on the counselling form (Appendix K). Another way to determine whether referrals are being taken up is to talk to the providers to whom the counsellors refer clients. For example, many providers, particularly NGO providers, will keep information on how clients heard about their services. By maintaining ongoing relationships with the services to which counsellors refer clients, sites will be able to monitor whether or not referrals are being taken up, and report back to other service providers about referrals to VCT and/or SRH services.

5.6.2 Evaluating referrals to care and support services

Another way to determine if referrals are being taken up is to follow-up a sample of clients. This would require the client's consent to be contacted further by the site, and would require additional resources for a member of staff or evaluator to interview clients about whether clients accessed care and/or support services to which they were referred, and what they thought of these services. A sample questionnaire to follow up clients is included in Appendix P.

5.7 MANAGEMENT

An important part of process evaluation is documenting the management of the new service. Keeping an implementation diary can be a systematic way of maintaining key information related to the service. Reviewing this information on a regular basis helps ensure that the service is adjusted to best meet the needs of those involved in it (both clients and staff). Documents in the diary record changes that were made to the service and why. This information will be useful for annual reviews or evaluations. Appendix Q includes sample information to include in the diary.



Photo: IPPF SARO/India

Section 6

CONCLUSION

This guide has aimed to provide programme planners, managers and service providers with the information needed to integrate VCT in SRH settings. During the development of this guide, those involved in integrating VCT services within their SRH provision were asked what advice they would give to others. A checklist of this advice, following the stepwise approach, forms the conclusion to this guide:

Assessment

- Identify the goals of the integration at the outset depending on the context
- Identify the opportunities for integration of VCT in all aspects of the current SRH services
- Identify obstacles to the integration, particularly in terms of the local environment and with respect to political will
- Identify appropriate sites for integration in terms of readiness, staff capacity, infrastructure, and so on
- Establish good baseline data, as this will enable those involved to evaluate and analyse the effect of the services
- Learn from others who have already developed VCT and/or integrated services

Planning

- Become familiar with the national policy on VCT and/or HIV testing
- Invest in building the capacity of existing staff by increasing knowledge, skills and competence, and by challenging attitudes about HIV/AIDS and sexual health
- Plan to deliver the highest quality service. This should include developing protocols and systems that guarantee confidentiality, a short waiting time for clients to get their test results, enough providers to meet the demand for services, imaginative education materials and strategies, and so on, depending on the focus of services
- Build partnerships with others involved in HIV/AIDS prevention and care services in the community
- Determine which care and support services will be offered at the site
- Identify a broad range of available medical and social care and support services in the community for all clients using VCT services, to enable referral to other providers
- Organise meetings of stakeholders, inform them of the planned integrated

- services, and involve them in further development of the service
- Identify the extra resources needed to provide a quality service and raise the funds
- Involve people living with HIV in counselling, support groups, outreach, etc.
- Renovate the site if needed

Implementation

- Promote the services in the community using media and traditional channels of communication
- Provide quality services, through ensuring that staff delivering services are well trained, well supported, and motivated in their work

Monitoring and evaluation

- Determine the goals of the service to ensure that appropriate monitoring information is being collected.
- Develop monitoring and assessment tools at the outset, adapting the examples provided in this guide
- Develop information management systems to enable data routinely collected to be compiled and used to evaluate services
- Share your experiences so that others can learn from them



Photo: IPPF/Ivory Coast

APPENDIX A: SAMPLE GROUP DISCUSSION TOOL

Below is a sample discussion tool to collect qualitative information on client/community knowledge, attitude, and beliefs related to HIV/AIDS and VCT. Discussions using open-ended questions are a good way to understand people's ideas and beliefs about specific topics or issues. During a group discussion, a skilled facilitator or leader encourages the group to express their opinions about the subject in a private, small group setting. Group discussions can give staff a general idea of why a service is or is not used. Group discussions at the beginning of the service's development can help staff understand knowledge, beliefs, and attitudes about HIV/MTCT/VCT. Group discussions held after the service has been running for some time can help staff understand if any of these issues have changed or been addressed by the new service.

Group Discussion Instrument for SRH clients/community members

1. What do you think are the main health concerns of women [people] like you?

[Prompts: What about sexually transmitted infections? What about HIV/AIDS?]

2. Facts about HIV/AIDS

Check to see if everyone in the group is familiar with HIV/AIDS by asking questions such as:

- What is HIV/AIDS?
- How is it transmitted?
- What are the ways it can be prevented?

3. Facts about MTCT

Check facts around MTCT.

- Can a woman pass the AIDS virus to her baby? How? When?
- Is there anything that can be done to prevent a woman with the AIDS virus from passing it to her baby?
- What?

[Make sure that participants have an understanding of the following before moving on:]

- HIV is sexually transmitted.
- Condoms can protect a person from getting HIV but other FP methods cannot.
- Pregnant women can transmit the virus to her child before, during and after birth.
- The risk of MTCT can be reduced if HIV status is known.

4. How do you think people could find out if they are infected with HIV?

[If no one knows that there is a test available, explain that a blood test can determine if someone has the AIDS virus.]

5. Where can people get an HIV test?

6. Has anyone heard of VCT?

[Explain how VCT works if participants are not familiar with VCT.]

7. What do you think would be the advantages of knowing whether or not you are infected with the AIDS virus? What about the disadvantages?

[If no one in the group comes up with the following advantages, make sure they are mentioned:]

- If HIV negative, can make decisions about their behaviour in order to maintain negative HIV status.
- If HIV positive, can get access to care and support at an early stage of infection.
- If HIV positive and pregnant, can take measures to protect unborn baby.
- If HIV positive, can take measures to protect partners.

8. Do you think women [people] like you would go for VCT? Why or why not? What do you think would encourage women to go for VCT? What do you think would discourage them?

[Probe for individual factors (e.g. fear), social factors (e.g. stigma, site related factors (privacy, confidentiality, etc.), characteristics of counsellors, cost, etc.]

9. What about your partners/husbands? Do you think they would go for VCT? Why or why not?

Record general motivating factors and barriers. Probe for information on where they would be comfortable getting a test.

10. There are many advantages for people coming for VCT as a couple. For example, it can help if both people know their HIV status so they can take actions to either remain negative or protect themselves. Sometimes people find it easier if a counsellor helps them think through what the test means for them as a couple.

[Probe to determine why or why not people would come with the partner for VCT. Probe for specific motivating factors and barriers.]

- Do you think men and women would be interested in being tested as a couple? Why or why not?

APPENDIX B: CHECKLIST FOR HIV AND STI PREVENTION COUNSELLING

Counselling goals

- To help clients assess their risk of HIV and STI
- To help clients explore options to reduce risk
- To make a plan to reduce risk and develop skills to put the plan into practice

HIV and STI prevention counselling

- welcome the client
- discuss reason for attending
- if the client has not come specifically for prevention counselling (e.g. if they have attended for discussing FP methods), introduce HIV and STI in the context of wanting to give clients the opportunity to discuss and get help on any aspect of their sexual health (or in any other appropriate way)
- explore client's knowledge about STI and HIV and modes of transmission, and correct any misconceptions
- ask about genital signs or symptoms that concern them
- help client to assess their personal risk
- allow time for client to think through issues, ask questions and get clarification
- discuss personal risk reduction plan including discussion about using condoms
- explore client's skills/abilities to put their plan in action (e.g. how to use condoms, how to negotiate condom use, etc.) and help them develop skills (e.g. putting a condom on a penis model, role-playing how the client might negotiate condom use, etc.)
- provide information about referral services appropriate for the client's needs, including STI treatment, VCT for HIV, etc.
- provide condoms and ensure client knows how to use condoms
- discuss follow up arrangements

*For further information and tips on providing prevention counselling, see section 4 of IPPF's UNFPA-supported publication *Programme Guidance on Counselling for STI/HIV Prevention in Sexual and Reproductive Health Settings*. This publication can be downloaded at www.ippf.org/resource/Counselling*

APPENDIX C: CHECKLIST FOR HIV PRE-TEST COUNSELLING

Counselling goals

- To help the client make an informed choice about whether to take the HIV test based on full and accurate information on the advantages and disadvantages of knowing her/his HIV status
- To explore the client's knowledge on HIV/AIDS and provide correct information
- To assess the client's potential exposure to HIV
- To encourage the client to take appropriate action to reduce their risk of contracting HIV or transmitting it to others
- To explain the process of testing
- To help clients prepare themselves for the test result and the issues that may arise after learning their HIV status

HIV pre-test counselling session

- welcome the client
- discuss reason for attending
- explore client's knowledge about HIV and modes of transmission (sexual, MTCT, and blood), correct any misconceptions, and fill in any gaps in knowledge
- help client to assess personal risk of HIV infection
- help the client make a plan to reduce their risk of HIV (and other STIs), including a discussion about condoms and how to use them. Provide condoms.
- find out what the client knows about the test and give information about the HIV test
- explain that the test is a blood test, and that the test will show whether or not there are HIV antibodies in the blood. If the test result is positive, other tests are done to confirm the result
- explain what is meant by HIV positive, HIV negative, and indeterminate test results, and the implications of each
- explain what is meant by the window period
- explain that the blood sample will be taken today if s/he decides to take the test
- explain when the results will be ready
- explain that the results are given during a post-test counselling session when the results will be discussed with the counsellor
- explain that the procedure is entirely voluntary
- explain that results are confidential and how clients' confidentiality is protected
- inform the client of the cost of the test, and determine whether they are eligible to have the cost reduced or waived.
- allow time for client to think through issues, ask questions and get clarification
- help clients to prepare for a positive or negative test result. Discuss how they might react, how others (partner, family, community) might react, and how they have coped with difficult times in the past.
 - explore risk of depression, suicide, violence, etc.
 - help client come to her/his own decision about taking the test, restating that the process is entirely voluntary
 - give assurance of confidentiality of both counselling and testing
 - obtain informed consent if client decides to take the test
 - if the client decides not to take the test, help them summarise their risk reduction plan, and tell the client that s/he can come back to discuss anything further
 - provide information about referral services appropriate for the client's needs identified during the session (e.g. family planning, STI treatment, domestic violence, support for drug users/families of drug users, support for victims of rape, etc.)
 - provide condoms and ensure client knows how to use condoms
 - discuss follow up arrangements for post-test counselling

For further information and tips on pre-test counselling, see section 5 of IPPF's Programme Guidance on Counselling for STI/HIV Prevention in Sexual and Reproductive Health Settings, www.ippf.org/resource/Counselling

APPENDIX D: CHECKLIST FOR HIV POST-TEST COUNSELLING

Counselling goals

- To help clients understand the meaning of and come to terms with their HIV test result
- To help clients express their feelings about the result
- To help clients make a plan of action for the immediate and short term future
- To help clients decide what to do about disclosing their test result to partners and others
- To help clients reduce their risk of HIV and take action to prevent infection to others
- To help clients access the medical and social care and support they need

HIV post-test counselling

- welcome the client
- ask client how s/he has been feeling since they had the blood drawn for the HIV test
- ask client if s/he has any questions or s/he wants to talk over anything before you give the result
- when the client is ready, give the test result clearly and wait for the client to respond before proceeding
- ensure that the client understands the meaning of the result
- encourage the client to express herself/himself, giving time to do so

For HIV negative clients

- discuss meaning of the result with the client – including repeating the test if client has possibly been exposed to HIV in the 3 months before testing (in the window period)
- discuss personal risk reduction plan (discussed in the pre-test session) and information to prevent future infections. This should include a discussion about condoms, the client's skills in using condoms and in negotiating condom use
- discuss partner's HIV status
- discuss benefits of sharing test results with partner and encouraging partner to test
- check for referral needs, options and resources for support
- discuss follow up plans and referrals
- provide condoms

For HIV positive clients

- discuss meaning of the result with the client
- deal with immediate emotional reactions
- if the client does not have AIDS, remind them of the difference between HIV and AIDS and that people with HIV can remain healthy for a long period of time
- discuss personal, family and social implications, and help the client identify the main concerns at this stage (e.g. anxiety, depression, disclosure of test result to partner and/or family and implications of this disclosure such as discrimination, potential violence or rejection from partner or family, etc.)
- explore how the client can address these concerns
- explore how the client dealt with other difficult situations in the past
- help the client identify sources of support – family members, friends, partner, faith groups, etc. and inform the client of other sources of support locally
- review immediate plans, intentions and actions
- review what will they do when they leave the session
- check availability of immediate support
- discuss plans to share the result with the partner and what support they will need to do that
- discuss the risk of transmitting HIV to others, the risk of re-infection with HIV or other

STIs, the importance of safer sex to reduce these risks, and a plan to reduce risks

- discuss client's responsibility to inform partner(s) if they have been exposed to HIV, and actions that they will take to prevent transmission to others
- if the client feels unable to disclose at this time, discuss using condoms to reduce the risk of infecting the partner(s). Ensure the client knows how to use condoms. Discuss how s/he can negotiate condom use
- if the client requests support to inform partner(s) of HIV status, make a plan to support her/him.
- offer the client a follow-up counselling session
- discuss follow-up care and support (additional counselling, counselling of other family members, social support, legal advice, referral for STI, FP, OI or other medical referral)
- help the client summarise plans for immediate support, preventing infection and re-infection, and referrals
- discuss date of follow-up session

For further information and practical tips on providing post-test counselling, see section 6 (Counselling after the HIV antibody test) of IPPF's UNFPA-supported publication Programme Guidance on Counselling for STI/HIV Prevention in Sexual and Reproductive Health Settings, www.ippf.org/resource/Counselling

APPENDIX E: WHO RECOMMENDED HIV TESTING STRATEGIES

All VCT services should follow testing strategy II or III below:

STRATEGY	CONTEXT	DESCRIPTION
HIV test strategy I	Person presenting is symptomatic; HIV prevalence is greater than 30%	All samples are tested using one ELISA or S/R test. Reactive samples are reported HIV positive and non-reactive samples are reported as HIV negative. This strategy can only be used to confirm a clinical diagnosis, and is not used for VCT.
HIV test strategy II	<p>Person presenting is symptomatic; HIV prevalence is less than 30%</p> <p>Person presenting is asymptomatic; HIV prevalence is greater than 10%</p>	All samples are tested using one ELISA or S/R test. Reactive samples are subjected to a second test based on a different test principle and/or different antigen preparation. If both samples are reactive they are considered HIV positive. Samples that are not reactive on the first test are considered HIV negative. If the first is positive and the second test is negative, results are said to be discordant, and the sample should be tested again with the two different tests. If after re-testing, the results remain discordant, the result is considered indeterminate, and the client is asked to return in 3 months.
HIV test strategy III	Person presenting is asymptomatic; HIV prevalence is less than 10%	All samples are tested using one ELISA or S/R test. Non-reactive samples are considered HIV negative. Reactive samples are re-tested using a second, different test. If these two tests are discordant, they are repeated again. Reactive second tests are subjected to a third, different test. If all three are reactive the person is considered HIV positive. If the result is reactive in the first and second tests, but non-reactive in the third test, the result is indeterminate. If the test is reactive in the first test, but non-reactive in the second and third tests, the result is considered indeterminate for individuals who may have been exposed to HIV in the past 3 months, and negative for those who have not been exposed to any HIV risk.

Source: WHO (1997). WHO *Weekly Epidemiological Record* #12, March 1997.

APPENDIX F: EXAMPLE OF AN HIV TESTING PROTOCOL

This is an example of a testing protocol that uses testing strategy III (see Appendix E) for asymptomatic clients in an area where HIV prevalence is less than 10%. In this example, a laboratory technician collects and tests the blood sample. This example could be adapted as needed, ensuring that the adapted protocol adheres to any existing national guidelines for HIV testing. This testing protocol is not appropriate for sites using testing strategy II.

1. Welcome the client.
2. Record VCT identification number in logbook and on specimen tube.
3. Verify consent.
4. Draw 5cc of blood in plain bulb. Use universal precautions and proper disposal of needles.
5. Thank the client and re-state when the result can be collected from the counsellor.
6. Check and record temperatures on temperature log sheet. Ensure manufacturers' instructions for storage are followed.
7. Check expiry date of kit, and check performance of new test kit lots with controls to verify that the kit works as expected.
8. Test sample with first test kit. Log test results.
 - If it is non-reactive, it is considered HIV negative. Go to steps 13 to 15.
 - If it is reactive, proceed to step 9.
9. Test samples that are reactive on first test with second test kit (based on a different testing principle). Log test results.
 - If it is non-reactive, proceed to step 10.
 - If it is reactive, proceed to step 11.
10. If the sample is non-reactive using the second test (but reactive using the first kit), test the sample again with both the first and second tests. Log test results.
 - If both are negative, sample is considered HIV negative. Go to steps 13 to 15.
 - If one is positive and one negative, the sample is subjected to the third test. Proceed to step 12.
11. If the sample is reactive using both the first and second tests, test the sample using the third HIV test (based on a different testing principle). Log test results
 - If it is reactive, the sample is considered HIV positive. Go to steps 13 to 15.
 - If it is non-reactive, the result is indeterminate. Go to steps 13 to 15.
12. If the results of the first two tests are discordant even after repeating the tests, test the sample using the third test. Log test results.
 - If the sample is reactive with any two of the three tests, it is indeterminate. Go to steps 13-15.
 - If the sample is reactive with any one of the three tests, it is indeterminate if the client has engaged in risk behaviour in the past 3 months. It is considered negative if the client has not engaged in risk behaviour in the past 3 months. Go steps 13 to 15.
13. Preserve serum samples for external quality control.
14. Dispose of contaminated waste.
15. Report full test results on the reporting form.

APPENDIX G: FRAMEWORK FOR A SUPERVISION TEST

Framework for a supervision session

- Review the work since the last session. How many sessions has the counsellor done? What has been the feedback from clients using counselling services?
- Review what has been positive about the counselling work since the last supervision session. Ask the counsellor what s/he feels has been positive, and share your perceptions of what has been positive about the counsellor's work.
- Review what has been difficult. Encourage the counsellor to discuss any specific cases that have been difficult.
- Allow the counsellor time to express any concerns they have about their work.
- Share any concerns you have about the counsellor's work.
- Identify and agree any changes to the counsellor's tasks, targets, workload, or priorities.
- Agree a date for the next supervision session

Preparing for a supervision session

EMPLOYEE/COUNSELLOR	SUPERVISOR
Prepare monthly record of services provided to share with the supervisor.	Compile summary of client satisfaction exit questionnaires to share with the counsellor.
What have I done since the last supervision session that I am pleased about? How has my work improved? What has helped me work better?	What has the worker done since the last session that I am particularly pleased about? How has his/her work improved? What factors might help him/her work even better?
What have I done since the last supervision session that I am unhappy about? What would help me do it differently in the future?	What has the worker done since the last session that I am not happy about? Why did it happen? What could I or others have done to prevent it or make it better? What can we do to prevent this happening again?
Have I done what I set out to do since the last session? If not, why not?	Has the worker done what was agreed at the last session?
What will be the priorities/targets for my work in the next month?	What should the worker be concentrating on in the next month?
Am I happy with the amount and type of work I do and the conditions of work? If I am unhappy, what could improve the situation for me?	Am I satisfied with the quantity and quality of the employee's work? Does the worker seem to be overworking or underworking? Is the worker up to date with routine tasks such as monitoring?
Is there anything or anyone at work creating a problem for me? How could this be dealt with? Are there situations or people in my personal life affecting my work? Do I need support to deal with the effects on my work or with the situations themselves?	Am I aware of any problems for this worker, at work or at home that I should mention?

APPENDIX H: HIV TESTING QUALITY ASSURANCE CHECKLIST

Quality assurance refers to planned, step-by-step activities to ensure that testing is being carried out correctly, results are accurate, and mistakes are identified and corrected. Basic elements of an HIV testing quality assurance programme include:

Establishment of the programme

- Identification of a person to oversee testing quality assurance
- Development of a written protocol made available to all staff involved in testing
- Verification of the testing process before offering service to clients. This includes ensuring staff are trained and able to perform the test, that the test kits work, the logistics for confirmation testing are in place, and that the systems for handling biohazardous waste are in place
- Staff training and assessment (see below)
- Mechanisms for communication
- Development and implementation of mechanisms to ensure the site meets all national requirements for HIV testing

Staff

- **Qualifications:** This will be dependent on the test(s) selected, type of specimen collected, and protocol developed. The staff conducting tests should be able to read instructions and record results, have good organisational skills, be able to recognise and handle problems or seek support to resolve them, and have good communication skills
- **Training:** The training should include how to perform the test(s), how testing is integrated into the overall VCT service, the importance of quality assurance and the site's quality assurance programme, and the use of universal precautions and infection prevention
- **Competency assessment:** Before allowing the staff member to perform the test(s) alone for the first time, the person should demonstrate their ability to carry out the protocol

Process control

- Check storage and room temperatures daily
- Check inventory and test kit lots
- Set up test area and label test kit
- Perform quality control according to manufacturer and site instructions
- Follow biohazard safety precautions
- Collect test specimen
- Perform the test
- Interpret the results
- Clean up and dispose of biohazardous waste
- Report results
- Document results
- Collect, process and transport confirmatory test results
- Participate in external quality assessment as required

Documents and records

- Maintain documentation related to staff training
- Maintain temperature logs of storage area and testing area
- Log results of external controls (e.g. date and time of testing, lot number and expiration date, results, action taken if control results were unacceptable)
- Log test result for each type of test performed (including date and time of testing, ID number, test kit lot number and expiration date, test result, action taken if result was invalid, identification of person performing test, whether confirmation test was required, and results of confirmation test)

APPENDIX I: EDUCATION ACTIVITY MONITORING FORM

This form should be completed by those leading education activities. A separate form should be used for each activity. Quantitative information should be compiled for monitoring purposes (see Appendix J) and quantitative and qualitative information is used for evaluation. The form should be adapted to the site's information needs.

Date of activity: _____

Duration of activity: ____ hours ____ minutes

Place where activity was held: _____

Type of activity

- Group discussion
- Drama
- 1-1 outreach
- Other (describe) _____

Key issues: _____

People reached:

GROUP	NUMBER ATTENDING	Any other information on people reached (e.g. special session for sex workers, out-of-school youth, etc.)?
women (aged 25 and over)		
men (aged 25 and over)		
females (ages 10-24)		
males (ages 10-24)		

Please record comments about the activity – what went well? What did you learn from participants? Should the activity be changed if you were to do it again? If so, how?

Number of condoms distributed: _____

IEC materials distributed (including name of material and quantity): _____

Names of people leading this activity: _____

Name of person completing this form: _____

APPENDIX J: COMMUNITY EDUCATION ACTIVITIES SUMMARY FORM

This form should be completed monthly by the educator (or a supervisor of a team of educators) based on education activity monitoring forms. This information is used to monitor the site's education work. The form should be adapted for the site's information needs.

Month and year _____ Name _____

		DATE OF ACTIVITY, NUMBER OF ACTIVITIES AND ANY OTHER COMMENTS
Activity	Group discussion Drama 1-1 outreach Training session Other (comment)	
Setting	School Youth group Health facility Church Mosque Bar Other (comment)	
People present (numbers)	Adult male Adult female Young people - male Young people - female	
Issues covered (tick all that apply)	General information Stigma/discrimination Benefits of VCT Promotion of VCT services Other (comment)	
Duration	Hours Minutes Condoms distributed Comments	

APPENDIX J

APPENDIX K: VCT CLIENT COUNSELLING FORM

This form should be completed by the counsellor for each client using VCT services. It should be adapted to the site's information needs. Data collected using this form should be compiled and can then be used to monitor the service. This form can also be adapted for HIV prevention counselling.

PRE-TEST COUNSELLING

- 1 Client ID: _____ 2 Counsellor's ID: _____
3 Date of pre-test counselling: _____
4 Start time: _____ 5 End time: _____ 6 Duration _____ minutes

Client information:

7 Age _____ years

- 8 Sex
- Female
 - Male

9 Type of visit

- Individual
- Couple Partner ID _____

10 Marital status:

- Unmarried
- Married or living with long-term partner
- Divorced/separated
- Widow/er
- Other (specify) _____

11 Is the client currently pregnant?

- Yes
- No
- N/A

12 How did the client hear about the VCT service?

- Friend
- Family member
- Partner
- Community activity
- Radio/television
- Poster/leaflet
- Referred (specify who referred) _____
- Other (specify) _____

13 Reason(s) for attending (tick all that apply)

- Opportunistic infection
- STI
- Engaged in risky sexual activity
- Planning for marriage/pregnancy (specify which)
- Other (specify) _____

14 Has the client discussed having the HIV test with anyone?

- Yes (specify relationship, e.g. partner, friend, etc. _____)
- No

15 Client's knowledge of HIV/AIDS (tick all that apply and comment on level of knowledge)

- Client understands modes of transmission

- Client has no incorrect information about HIV transmission
- Client understands methods of preventing transmission

16 Comments on client's level of knowledge of HIV/AIDS:

17 Sexual behaviour

- Age at first sexual experience _____
- Number of sexual partners in the last 12 months _____
- Had sex under the influence of drugs/alcohol in last 3 months • Yes • No
- Have one or more non-regular sex partners in last 12 months • Yes • No
- Used condoms during last sex • Yes • No
- Used condoms during last sex with a non-regular partner • Yes • No
- Have had STI in last 12 months • Yes • No

18 In what ways does the client intend to reduce risk (risk reduction plan)?

19 Did the client decide to have a test today?

- Yes, informed consent obtained
 - No
- What are the main reasons for their decision?

20 Has the client been tested for HIV in the past? • Yes • No

21 How many times has the client been tested for HIV? _____

22 Did the client return for post-test counselling? • Yes • No

23 Result of last test

- Negative
- Positive
- Indeterminate
- Unknown

21 In addition to pre-test counselling, what other services did you provide?

- referral (specify) _____
- condoms
- other FP method (specify) _____
- ANC
- STI diagnosis/treatment
- other _____

22 Record any comments about the counselling session. What went well? What was difficult? Do you have any specific concerns about this client?

POST-TEST COUNSELLING

23 Counsellor's ID: _____

24 Date of post test: _____ 25 Start time: _____ 26 End time: _____ 27 Duration _____ minutes

28 Type of visit

- Individual
- Couple Partner ID _____

29 Test result

- Negative
- Positive
- Indeterminate
- Other (specify) _____

30 Has the client discussed having the HIV test with anyone?

- Yes (specify relationship, e.g. partner, friend, etc. _____)
- No

31 Did the client identify whom they will/might discuss their test result with?

- Yes (specify relationship, e.g. partner, friend, etc. _____)
- No

32 Record support needs and referrals made

33 Please comment about the counselling session. What went well? What was difficult?

34 Follow up counselling scheduled?

- Yes - date of follow-up visit: _____
- No

FOLLOW-UP COUNSELLING

DATE	KEY ISSUES DISCUSSED, REFERRALS AND NOTES	COUNSELLOR CODE

APPENDIX L: VCT SUMMARY FORM

This form should be completed by providers of VCT services by compiling data from the client counselling form (Appendix K). It should be adapted according to the site's information needs.

Clinic _____ Report period _____

Number of people counselled and tested by age and sex

AGE	M F	PRE-TEST COUNSELLED	CONSENTED AND TESTED	POST-TEST COUNSELLED	HIV POSITIVE	INDETER- MINATE	CALCULATE
<15							% male clients
15-19							% female clients
20-24							% not tested
25-29							% testing HIV +ve
30-34							% indeterminate
35-39							% males HIV +ve
40-44							% females HIV +ve
45+							% clients <25 years
Total							% clients referred

Total tested by reason and test result

REASON FOR TESTING	TOTAL TESTED		HIV POSITIVE		REFERRALS	
	Male	Female	Male	Female	Male	Female
Planning for marriage					FP	
Planning for pregnancy					dx/mgmt of OI	
Pregnant					TB therapy	
Suspected exposure - sexual					PMTCT	
Suspected exposure - other					STI dx/treatment	
STI					Other medical care	
OI					Support group	
Just wanted to know					Legal support	
Other					Material/economic support	
Total					Other	
					Total	

Total tested by marital status

MARITAL STATUS	TOTAL TESTED		HIV POSITIVE	
	Male	Female	Male	Female
Unmarried				
Married/living with partner				
Divorced/seperated				
Widow/er				
Other				
Total				

Signature of person completing this form _____ Date _____

APPENDIX M: SAMPLE FORM TO EVALUATE QUALITY OF COUNSELLING

The following observation checklist can be used to evaluate the quality of counselling. Observers can rate the counsellor by scoring each skill (e.g. 0=not adequate, 1=adequate, 2=exceptional). The content of counselling can be evaluated using the checklists in Appendices B, C and D by ticking the areas covered during the session. It should be modified for the site's needs.

AREA	RATING	SKILL
Interpersonal relationship		Greets client Introduces self Engages client in conversation Actively listens (verbally and non-verbally) Displays positive body language Positions chairs properly Is supportive and non-judgemental
Gathering information		Uses appropriate balance of open and closed questions Uses silences well to allow for self-expression Seeks clarification about information given by paraphrasing information from the client to check understanding Avoids premature conclusions Probes appropriately Summarises main issues discussed
Giving information		Gives information in clear and simple terms Gives client time to absorb information and to respond Includes all key information Has up to date knowledge about HIV Repeats and reinforces important information Checks for understanding/misunderstanding Discusses referral needs as appropriate Offers follow-up as needed Summarises main issues
Handling special circumstances		Accommodates language difficulty Talks about sensitive issues plainly and appropriate to culture Prioritises issues to cope with limited time Uses silences well to deal with difficult emotions Is innovative in overcoming constraints Manages client's distress Flexible in involving partner or other person (friend, family member)
Setting		Room is quiet Room is private Session was not interrupted

Source: UNAIDS (2000). *Tools for evaluating HIV voluntary counselling and testing*, 00.09E.

APPENDIX N: CLIENT SATISFACTION FORM

This form should be completed by clients, and will give service providers an understanding of clients' satisfaction of the services. It should be adapted to the site's service and according to the site's information needs.

We are conducting a survey with users of our VCT services to find out what people think about the VCT service. This will help us improve the quality to future clients. Your participation is voluntary, and your answers will be kept confidential.

Date _____

Please place a tick in the box next to response.

Are you ...

- Female
- Male

What have you talked about to the counsellor today?

- HIV and STI prevention
- Having an HIV test
- Receiving test results
- Issues arising from a test taken some time ago
- Another reason _____

If the session was to talk about HIV testing, why did you consider having a test?

How much time did you spend:

Waiting to see your counsellor today? _____ hours _____ minutes
 In the session with the counsellor? _____ minutes

Please indicate 'yes' or 'no' for each question, by putting a tick in the column.

	Yes	No	NA
Did the counsellor explain to you what to expect during the session?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Did the counsellor help you feel free to talk about your concerns and personal issues?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Did you feel the counsellor listened to you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Did you feel the counsellor understood your concerns and personal issues?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Do you feel that the issues you discussed will remain confidential?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Did you discuss sexual risk behaviour?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Did you discuss sharing your test result with your partner?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Did you discuss condom use?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Did the counsellor demonstrate how to use a condom?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Did you feel the counsellor was comfortable talking to you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Was the counsellor respectful towards you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Did you have privacy during the session?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Do you feel you have all the information you needed to know?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Would you recommend this service to others?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Was the time spent with the counsellor ...?

- too long
- about right

- too short

How was the attitude of other staff at the centre?

- Very good
- Fair
- Poor

Overall, what do you think about the quality of the service you received today?

- Very good
- Fair
- Poor

Please write down any other comments you wish to make.

For example:

- What was good about your time in the session?
- What was bad about the time in the session?
- What would have improved your counselling session or the service you received today?

Thank you for your participation and honesty.

Adapted from: UNAIDS (2000). Tools for evaluating HIV voluntary counselling and testing, 00.09E and Family Planning Association of Kenya Client Exit Interview Questionnaire

APPENDIX O: MONITORING INFORMATION FOR HIV

The sample logbook below shows how those recording HIV tests can track test kits and results. It should be modified according to the site's needs.

Sample logbook for recording HIV tests performed

ID No.	TEST 1		CONFIRMATION TEST		COMMENTS
768	Date of test Time of test Test number Expiration date Result	30 July 03 2pm 124589ZX 24 Aug 04 Non-reactive	Date of test Time of test Test number Expiration date Result		
769	Date of test Time of test Test number Expiration date Result	30 July 03 2pm 124589ZX 24 Aug 04 Reactive	Date of test Time of test Test number Expiration date Result	30 July 03 4pm VC876J 04 Jan 05 Reactive	ELISA confirmation arranged with ref lab. Transport sample on 31/07/03. Ref number VCT-769-300703 Results ready 02/08/03
770	Date of test Time of test Test number Expiration date Result	30 July 03 2pm 124589ZX 24 Aug 04 Non-reactive	Date of test Time of test Test number Expiration date Result		

Summary report form: number of clients tested and results

This is an example of a report format for HIV test results. It should be modified according to the information needs of the site.

Report period _____

Test results:

AGE	M F	TOTAL	NUMBER POSITIVE	NUMBER NEGATIVE	NUMBER INDETERMINATE	% POSITIVE
<15						
15-19						
20-24						
25-29						
30-34						
35-39						
40-44						
45+						
Total						

APPENDIX P: INTERVIEW GUIDE AND CLIENT REFERRAL FOLLOW-UP FORM

This form can be used by service providers to collect information from clients who have used counselling and testing services, to learn whether or not referrals were taken up.

Client ID _____

Date of counselling and/or testing _____

We want to find out if people were referred to support services after counselling and/or got support from any of the services we recommended. We want to know what people thought of the services and if they decided not to take up the referral, the reasons why.

The answers you provide will be helpful for us in changing our service to make it better. Your answers will be put together with others who have been asked the same questions, so there will be no way to link your responses to you. Your participation is voluntary.

Do you remember what you discussed with the counsellor about what services might help you? Probe for services referred.

SERVICES	CLIENT	REFERRAL	COMMENTS
List services to which the client was referred – refer to counselling monitoring form	Did client remember the referral? Indicate Yes or No	Referral taken up by client? Indicate Yes or No	If client did not attend probe for reasons why e.g. individual (fear, etc.), social (stigma), site related factors (access issues: time service was offered, time to get an appointment, location, privacy, confidentiality, counsellors), cost, other. If attended, record client's comments on the service.

APPENDIX Q: MANAGEMENT DIARY

The following are examples of the types of information the programme manager could collect. This information can then be used to evaluate the service.

Key documents

Key documents include the proposal, needs assessment, plan, progress reports to funders and so on.

Team meetings

A file with agendas and notes of planning meetings that relate to the VCT integration service should be maintained. These notes should document any key decisions related to the management or implementation of the service, or any major changes to strategy made.

Staff orientation and support

Records of how the staff were oriented to the new service, new procedures, systems and forms. This could include dates of training sessions or meetings when staff were introduced to the new service (as well as training plans and reports) and records of people attending. Any issues raised from staff should be recorded, and any issues raised that could not be immediately addressed should be noted for attention and action by those involved in the service.

Counsellor training and support

Records of training sessions (dates, participants, programme, reports if any), feedback from counsellors about training, and records of supervision and support sessions should be maintained.

Community education and mobilisation

Monitoring information on mobilisation and education work carried out in relation to this service. This could include a file where all monitoring records are kept, as well as copies of educational material produced.

Written protocols

Written, dated protocols of how the service is offered and managed. If protocols are revised, the date of the revision should be added.

Monitoring information and progress reports

Monitoring information (e.g. of education activities, counselling, testing, care and support services, etc.) should be compiled on a monthly basis and reviewed during meetings of staff involved in the service.

Partnerships and links to other service providers

The diary should document links made and joint work carried out with partners providing prevention, care and support work in the community. For example, dates of visits by staff or meetings with other providers, referral protocols, agreements or plans for joint work, etc. should be recorded.

Financial information

The costs of refurbishment, supplies, and service set up, and ongoing costs should be tracked to monitor the budget.

RESOURCE LIST

The following list of resources is not comprehensive, but includes key materials and practical tools available on the internet that may help planners, managers and providers integrate VCT in SRH settings.

Baggaley R., Kayawe I, and Miller D (2001). Counselling, Testing and Psychological Support. In: HIV/AIDS Prevention and Care in Resource-Constrained Settings: A handbook for the design and management of programmes. Lamptey PR and Gayle H (eds.), Family Health International, Arlington, VA. 34 pages of a 789-page resource. www.fhi.org

EngenderHealth (2000). STI/HIV Prevention – Quick Reference Cards for Health Care Providers: What every client should know, New York. 9 pages. www.engenderhealth.org

Family Health International (2002). Behaviour Change Communication (BCC) for HIV/AIDS: A strategic framework, Arlington, VA, USA. 25 pages. www.fhi.org

Family Health International (2001). Voluntary counselling and testing for HIV: A strategic framework, Arlington, VA, USA. 19 pages. www.fhi.org

HORIZONS/Population Council (2003). The PLHA-Friendly Achievement Checklist. 16 pages. www.popcouncil.org/horizons

HORIZONS/Population Council (2002). Integrating HIV prevention and care into maternal and child health settings: lessons learned from HORIZONS studies. 47 pages. www.popcouncil.org/horizons

International HIV/AIDS Alliance (2002). Pathways to Partnerships Toolkit. 60 pages. www.aidsalliance.org

IPPF (2002). Programme Guidance on Counselling for STI/HIV Prevention in Sexual and Reproductive Health Settings. London. 58 pages. www.ippf.org/resource/counselling

IPPF/Western Hemisphere Region (2002). Have you integrated STI/HIV into your sexual and reproductive health services? 6 pages. www.iffpwhr.org

Management Sciences for Health (2001). Integrating STD/HIV Services in Reproductive Health Settings. The Manager – Reforming Health Systems and Programmes. 24 pages. www.msh.org

Southern African AIDS Training Programme (2001). Basic AIDS Counselling Guidelines. Harare. 43 pages. www.satregional.org

Southern African AIDS Training Programme (2000). Counselling Guidelines on Disclosure of HIV Status. Harare. 26 pages. www.satregional.org

UNAIDS (2002). HIV voluntary counselling and testing: a gateway to prevention. 100 pages. www.unaids.org

UNAIDS (2000). Voluntary Counselling and Testing (VCT). Technical Update, UNAIDS Best Practice Collection, Geneva, Switzerland. 12 pages. www.unaids.org

UNAIDS (2000). Tools for evaluating HIV voluntary counselling and testing. Best practice collection, 00.09E, May 2000. 58 pages. www.unaids.org

UNAIDS (1999). Counselling and voluntary HIV testing for pregnant women in high HIV prevalence countries: Elements and issues, UNAIDS Best Practice Collection, 99.44E, Geneva. 22 pages. www.unaids.org

UNAIDS and Penn State (1999). Communications Framework for HIV/AIDS: A New Direction. Geneva. 101 pages. www.unaids.org

UNAIDS and WHO (2000). Opening up the HIV/AIDS epidemic: Guidance on encouraging beneficial disclosure, ethical partner counselling and appropriate use of HIV case reporting, August 2000. 45 pages.

UNFPA (2002). Voluntary Counselling and Testing (VCT) for HIV Prevention. HIV Prevention Now Programme Briefs, number 5. 6 pages. www.unfpa.org

UNFPA/EngenderHealth (2004). Primary Prevention of HIV and other Sexually Transmitted Infections in Pregnancy: Programming and Training Guide for Maternal Health Services, New York. (forthcoming, March 2004).

Voluntary HIV-1 Counselling and Testing Efficacy Study Group (2000). Efficacy of voluntary HIV-1 counselling and testing in individuals and couples in Kenya, Tanzania, and Trinidad: A randomised, controlled trial. *The Lancet*, vol 356:103-112. 8 pages.

WHO (2001). Guidelines for Using HIV Testing Technologies in Surveillance: Selection, Evaluation, and Implementation. Geneva, Switzerland. 38 pages. www.who.int

WHO (1997). WHO Weekly Epidemiological Record, Number 12: 81-87, March 1997. 7 pages. www.who.int

WHO/UNAIDS (2001). WHO/UNAIDS Technical Consultation on Voluntary HIV Counselling and Testing: Models for Implementation and Strategies for Scaling of VCT Services, Harare, Zimbabwe, 3-6 July 2001. 29 pages.

WHO (2003). The Right to Know: New approaches to HIV testing and counselling. 4 pages. www.who.int

WHO, UNICEF, UNAIDS, UNFPA (2003). HIV and Infant Feeding: A guide for health care managers and supervisors www.who.int, www.unicef.org, www.unfpa.org

WHO, UNICEF, UNAIDS, UNFPA, FAO, UNHCR, WFP, WB, IAEA (2003). HIV and Infant Feeding: Framework for priority action, Geneva. 12 pages. www.who.int, www.unicef.org, www.unfpa.org

WHO, UNICEF, UNAIDS, UNFPA (2003). HIV and Infant Feeding: Guidelines for decision makers www.who.int, www.unicef.org, www.unfpa.org



the United Nations Population Fund extends assistance to developing countries, countries with economies in transition and other countries at their request to help address reproductive health and population issues and

raise awareness of these issues. UNFPA's three main areas of work are: to help ensure universal access to reproductive health, including family planning and sexual health; to support population and development strategies that enable capacity building in population programming; and promote awareness of population and development issues and to advocate for the mobilization of the resources and political will necessary to accomplish its areas of work.

UNFPA
220 East 42nd Street
New York, New York
USA 10017
www.unfpa.org



the International Planned Parenthood Federation is the world's largest non-governmental organisation working in the field of sexual and reproductive health. With 148 member associations IPPF champions sexual and reproductive health

and rights through advocacy and the provision of services, especially to the poor and marginalised, by establishing strategic partnerships with key stakeholders and the communities it serves. IPPF is committed to ensuring a woman's right to choose and access safe abortion, to the eradication of HIV/AIDS and to the right of all, including young people, to enjoy their sexual lives free from ill health, unwanted pregnancy, violence and discrimination.

IPPF
Regent's College
Inner Circle, Regent's Park
London NW1 4NS
UK
www.ippf.org