



ZAMBIA

NATIONAL

GUIDELINES

FOR

HIV COUNSELLING

&

TESTING

March 2006

FOREWORD

The burden of HIV and AIDS continues to pose a major challenge to Zambia's health care system. Strong government interventions over the past 10 years and the enactment of the National HIV/AIDS/STI/TB Council through an act of parliament in 2002, has given rise to high levels of awareness on HIV and AIDS and effective interventions at different levels.

In 1999, only 21 sites country wide in the public health sector offered counselling and testing services. In 2006, there are over 450 sites providing counselling and testing services country wide. This scale-up entails a big challenge for the government to ensure that all sites adhere to quality standards.

The Ministry of Health recognizes the need for comprehensive and standardized HIV counselling and testing operations in Zambia. A multidisciplinary team representing public health workers, Non-Governmental Organisations, physicians, social workers, counsellors and laboratory experts have developed these guidelines. This team solicited inputs from a wide range of experts such as support groups, people living with HIV/AIDS (PLWHA), donors, the private sector, people with disabilities and many others with varied expertise. It is hoped that these guidelines will serve as a 'blueprint' for the scaling up of HIV counselling and testing services and will help health workers and counsellors establish and maintain high quality HIV counselling and testing services in Zambia.

We expect that all service providers in both public and private, Zambia Defence Force Medical Services and mission hospitals and facilities will use these guidelines.

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Permanent Secretary
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ACKNOWLEDGEMENTS

The Ministry of Health wishes to express its gratitude to all stakeholders on HIV Counselling and Testing for their valuable input towards the development and finalisation of the National HIV Counselling and Testing Guidelines. Special tribute goes to the Japan International Cooperation Agency (JICA) who facilitated the engagement of the consultant and the printing of these guidelines.

The Ministry also commends the National AIDS Council VCT/CHBC Technical Working Group, in particular the sub-committee and the consultant, Ms. Eleonora Tasco who compiled the guidelines.

PREFACE

Numerous research projects in Africa, have demonstrated that Counselling and Testing (C&T) and knowledge of one's serostatus encourages clients to reduce risky behaviour, and thus C&T is important in any HIV prevention, treatment and care effort.

Research has also found that C&T is a cost-effective method of prevention and has a vital role to play within a comprehensive range of measures for HIV/AIDS prevention and the provision of care and support. Furthermore it is the entry point for the continuum of care and support. The potential benefits of counselling and testing for individuals include improved health conditions through good nutritional advice, early/prompt access to ART, treatment of opportunistic infections, preventive therapy for tuberculosis and other sexually transmitted infections; psychosocial support and ability to cope with the consequences of HIV/AIDS. It also provides individuals with opportunities of awareness on safer options for reproduction, reducing mother-to-child transmission, and infant feeding; motivation to initiate or maintain safer sexual and drug related behaviours among others. Furthermore, C&T provides an opportunity to reduce the spread, burden and the stigma of HIV/AIDS.

C&T services can serve as the entry point for long-term supportive services for clients who learn they are HIV infected, and it can assist HIV positive clients adopt behaviour that does not transmit HIV to others. HIV positive clients can also be assisted to begin the process of informing their sexual partners, families and children about their HIV status and can be referred for services to help them make appropriate plans for the future.

It is important to remember that most people requesting the services will learn that they are not HIV infected. This information, and the counselling that accompanies it, can be a powerful catalyst for behaviour change so that the client can remain uninfected.

This Guideline document is based on the current best international practice and has been adapted to suit the Zambian context. Any comments and suggestions for improvement of future editions will be highly appreciated.

Dr. Ben U. Chirwa
Director General
National HIV/AIDS/STI/TB Council

LIST OF ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
ARV	Antiretroviral
ART	Antiretroviral Therapy
CDC	Centre for Disease Control and Prevention
CHBC	Community Home Based Care
C&T	Counselling and Testing
CTC	Counselling Testing and Care
DHMT	District Health Management Team
HCP	Health Care Providers
HIV	Human immunodeficiency virus
IEC	Information Education and Communication
IGA	Income Generation Activity
JICA	Japan International Cooperation Agency
MCZ	Medical Council of Zambia
M&E	Monitoring and Evaluation
MOH	Ministry of Health
MTCT	Mother To Child Transmission
NAC	National AIDS Council
NGO	Non Governmental Organization
OI	Opportunistic Infection
PEP	Post-exposure Prophylaxis
PLWHA	People living with HIV/AIDS
PMTCT	Prevention of Mother To Child Transmission
QA	Quality assurance
STI	Sexually Transmitted Infection
TB	Tuberculosis
UNAIDS	United Nation Joint Action Against AIDS
UTH	University Teaching Hospital
UTHVL	University Teaching Hospital Virology Laboratory
VCT	Voluntary Counselling and Testing
WHO	World Health Organization
ZCC	Zambia Counselling Council
ZVCTS Services	Zambia Voluntary Counselling and Testing Services

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NATIONAL OVERVIEW OF C&T SERVICES IN ZAMBIA

Voluntary Counselling and Testing Services were established on a larger scale in Zambia in 1999 with the aim of providing quality and friendly counselling and testing services on the same day. It was initiated with the establishment of 21 pilot sites evenly distributed in each of the nine provinces of Zambia and the major funding in this pilot phase was provided by the Norwegian Government through NORAD. The Government of the Republic of Zambia provided the required human resource through the establishment of the Zambia Voluntary Counselling and Testing Service which is housed in the Virology Laboratory at the University Teaching Hospital.

It was against this backdrop that a consolidation and expansion phase was then undertaken with lessons and experiences learnt from the pilot. Counselling and testing services have become an important entry point for prevention, care and support. By January 2006, 485 C&T centres were established in all the 72 districts of Zambia

Zambia has a generalized heterosexual HIV-1 epidemic with a stabilizing seroprevalence trend. The national HIV seroprevalence among adults between 15-49 years is 16%. (ZDHS 2001/2002) It is estimated that slightly over 1,000,000 Zambians are infected with HIV; 200,000 of whom are in need of Antiretroviral Therapy (ART). The government of the Republic of Zambia has committed itself to provide ART to 100,000 Zambians by the end of 2006 in the context of the WHO the "3 by 5" initiative. This entails that C&T and CTC services have to be scaled up.

As antiretroviral treatment programs and palliative care services are being scaled up in Zambia, the demand for counselling and testing is growing exponentially. As both the public and private sector are scaling up their C&T activities, now is a critical time to ensure that C&T guidelines policies and procedures foster this growth and help to ensure universal access to HIV counselling and testing. This can be achieved through the use of various C&T models, which include involving both health workers and non- health workers in different settings.

There is need to promote routine counselling and testing for HIV at all health facilities and community outreach settings. HIV counselling and testing should be offered routinely as part of the strategy to effectively manage clients and patients and those presenting themselves for various medical and social reasons. Testing for HIV infection and AIDS-related illnesses should not be forced onto clients but rather offered under mutual agreement, based on informed consent and perceived need.

Counselling and Testing Goal

The goal of counselling and testing (CT) is twofold. Firstly, CT facilitates behaviour change and hence **preventing** acquisition and transmission of HIV.

Secondly, CT serves as an entry point to HIV/AIDS **Care, Treatment and Support** services.

Purpose of the Guidelines

In July 2004, UNAIDS/WHO related guidelines on HIV counselling and testing based on global consensus that the range of entry points for HIV testing must be expanded. Additionally counselling and testing must be promoted as a more routine practice, particularly in the clinical setting, so more people can learn about their status and benefit from HIV prevention, care and treatment services.

In line with the changes in service delivery of the “traditional HIV VCT”, it has become necessary to develop guidelines that encompass the different models of HIV counselling and testing.

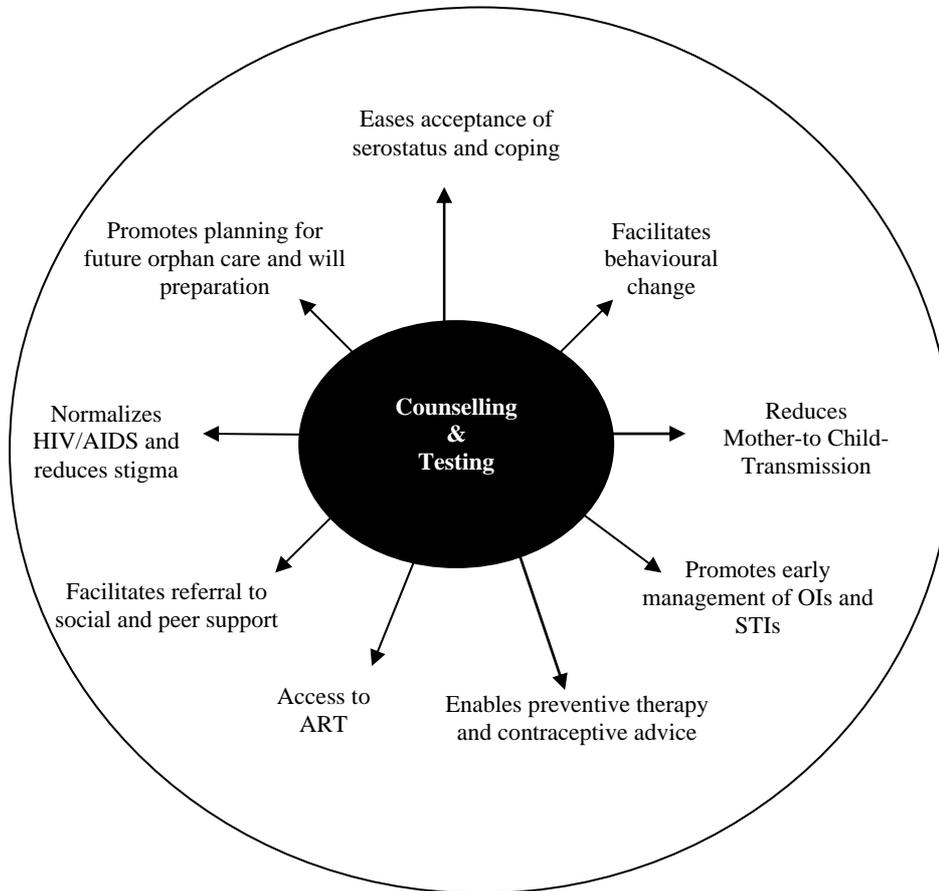
Aims of the Guidelines

- Standardising capacity requirements for implementation of C&T services.
 - Provision of guidance on programme operations.
 - Regulation of HIV testing approaches and technologies for HIV sero-diagnosis.
 - To strengthen and support the expansion and extension of HIV C&T services in the public and private sectors.
 - To make quality HIV testing services more accessible and available to HIV infected people, people at increased risk of infection and the population as a whole.
 - To emphasize the need to provide information regarding the result of the HIV test to all clients.
 - Protection of human rights by ensuring that HIV testing is informed, confidential and written or verbal consent is obtained.
 - To ensure the use of a prevention counselling approach aimed at personal risk reduction for HIV infected people, people at increased risk of infections and the population as a whole.
 - To help in assessing appropriate care, treatment and services such as sexually transmitted infections, prevention of mother to child transmission, ART and OI treatment such as TB.
-

We expect that decision makers planning new services, care and support service providers, and counselling staff will use these guidelines:

- As an ongoing resource to deliver high quality C&T and referral services to the people;
 - To apply their newly acquired skills in their workplace and in communities;
 - To continue to build the capacity of other service providers in order to prevent further transmission of HIV;
 - To provide care and support to people living with HIV/AIDS.
-

Counselling and Testing as an Entry Point For HIV Prevention and Care



Adapted from: UNAIDS, "Report on the Global HIV/AIDS Epidemic –July 2002"
(www.unaids.org/barcelona/, accessed July 8, 2002).

OPERATIONAL PROCEDURES FOR C&T SERVICES

A. General guidelines for provision of C&T services

Informed Consent:

- All clients should be helped to understand the importance of HIV testing so that can make an informed decision
- Even if recommended by the health worker, clients may decline an HIV test (opt-out).
- Consent can be given verbally or in writing.

Confidentiality and anonymity:

- It is essential that confidentiality be maintained when conducting HIV testing of any type.
- All providers involved in C& T should maintain the highest standards of confidentiality.
- HIV results must be kept confidential and shared with only those who need to know to provide appropriate care with the knowledge and consent of the client.

Confidential record keeping:

- Clients' records must be stored securely.
- Only personnel with a direct responsibility for clients' medical condition should have access to the records.
- All personnel with access to medical records on which HIV test results are recorded should be trained in procedures to maintain confidentiality of HIV test results.

Disclosure of results:

- In general, HIV test results should be disclosed only to the client. Shared confidentiality should be encouraged.

(See additional discussion on disclosure of test results in Appendix 1)

Written results:

- C&T sites should not provide written results.
- Clients requesting testing for official reasons such as employment or to obtain a visa should be referred to the in-charge of the facility who may authorise release of the written results to the requesting organisation.

Minimum age:

- Those 16 years of age and above requesting C&T should be considered able to give full, informed consent.
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Testing of children:

- When children are brought to a C&T site for testing, the counsellor should meet with the parents or guardians to determine the reasons for testing.
- The welfare of the child should be the primary concern when considering testing a child.
- Counselling should be provided to the parent or guardian, and to the child, if possible, taking into account his/her age and level of understanding.
- Referral for the child should be made to medical or child welfare services, if considered appropriate.
- Young people under 16 who are married, pregnant, parents, heads of households, engaged in behaviour that puts them at risk or are child sex workers should be considered 'mature minors' who can give consent for C&T.
- Additional training should be provided to counsellors providing C&T services to children.

People of unsound mind:

- To provide informed consent one must have full mental capacity. Where a person is thought to lack such capacity, a guardian should provide that decision based on the best interest of the individual for who the decision is being made.
- People who request C&T services but are found to be under the influence of alcohol or illegal drugs cannot give true informed consent for testing. They may be given counselling, and if appropriate, asked to return for C&T when they are no longer mentally impaired.

Partner notification:

- All C&T clients, both HIV positive and HIV negative, should be strongly encouraged to inform their sexual partners of their test results..
- The counsellor should encourage all clients to bring in their partner(s) for couple counselling and testing.

Confidential referrals:

- Counsellors in C&T sites should be familiar with additional follow-up services available in their communities and should be able to make specific referrals, based on the client's needs.
- Clients may decline a referral if they do not wish their name and status to be disclosed. Regardless of whether a code number or the actual name is used.
- The same standards of confidentiality must be maintained. (See Appendix 1).

Family planning services:

- Basic family planning information should be incorporated into C&T.
 - When possible, family-planning services should be provided at the C&T site.
 - If family-planning services are not available, clients should be referred.
-

Networks of referral agencies and support services:

- C&T providers should actively work to ensure that they become part of existing networks of relevant services.
- A two-way referral system should be established between the C&T site and other agencies providing services in the C&T site catchment area.

Community participation and outreach:

Some of the main objectives of these linkages with the community are to:

- Promote awareness among target populations of the availability of high-quality C&T services;
- Encourage the target population to use C&T services
- Promote understanding of C&T and its benefits;
- Encourage sustained behaviour change;
- Reduce stigma and discrimination.
- Involvement community counsellor is encouraged

Human rights:

- C&T providers should ensure human right are protected.
- HIV/AIDS often affects certain populations more than others –for example, drug users, prisoners, sex workers, men who have sex with men, refugees and displaced people and migrant workers and women in general.

(See Appendix 2 for more details on human rights)

B. Models of service delivery

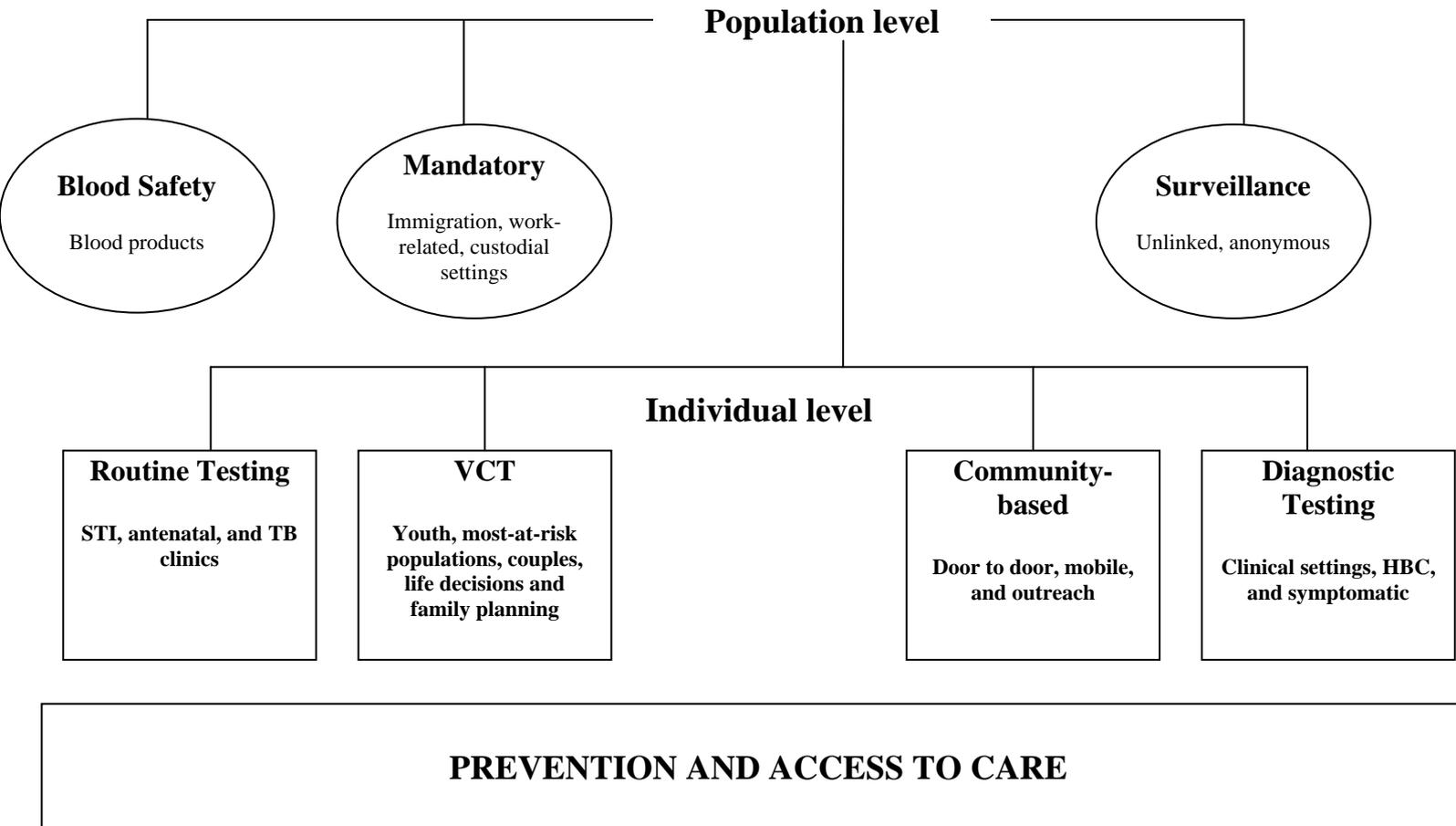
There are several approaches to Counselling and Testing service delivery. The choice depends on the target population, cost effectiveness, sustainability, affordability and convenience of the clients. The models that have been used to date are: stand-alone, integrated and mobile/outreach. Each of these models has strengths and weaknesses and should therefore be implemented appropriately to suit the different populations and regions of the country and to minimise potential weaknesses. There is no best approach or best model for counselling and testing. Different models work well in different settings. In some cases, a combination of elements of different models may be most appropriate.

Model of Counselling and Testing Service Delivery

Model	Benefits	Constraints
<p>Stand alone (free standing)</p> <p>For reasons of cost and cost-benefit, located in high population density areas and where HIV infection rates are high.</p>	<ul style="list-style-type: none"> • Attracts populations who otherwise would not attend health facility-based services. • More flexibility with staffing and hours of operation. • Easier to link with post-test clubs and support groups for people living with HIV/AIDS. 	<ul style="list-style-type: none"> • Often not linked with other medical/social services. • High set-up and operating costs. • Limited geographic accessibility. • Can be stigmatising, as facilities are associated with HIV.
<p>Integrated</p> <p>C&T services integrated into existing services, usually public sector, such as hospitals, STI clinics, TB clinics, ANC clinics, or out patient clinics.</p>	<ul style="list-style-type: none"> • C&T as part of routine of health services thus normalizing HIV/AIDS. • HCP can work in HIV prevention. • Direct referral to relevant HIV-related care. • High volume of potential clients at public sector facilities. • Staff can provide services other than C&T. • Huge potential for scale-up. 	<ul style="list-style-type: none"> • Dilution of other services and potentially lower quality C&T services. • Possible regulations disallowing the use of non-HCP to provide counselling services. • Low motivation in public sector personnel. • Quality assurance more difficult to implement. • Limited management capability to run complex services. • Long waiting times. • Possible client perception of poor quality of care.
<p>Mobile/Outreach</p> <p>There is limited experience with these models – current models offer temporary, rotating services for hard to reach groups.</p>	<ul style="list-style-type: none"> • Improved access for populations not using stand-alone services or rural populations. 	<ul style="list-style-type: none"> • Expensive. • Difficult to ensure confidential services and follow-up after post-test counselling. • Limited capacity.

C : Approaches To HIV Counselling & Testing

Different models are deemed to be appropriate for different needs in different settings



Adapted from: Family Health International, Arlington, VA

1. Voluntary counselling and testing

Client-initiated HIV testing to learn HIV status provided through voluntary counselling and testing remains critical to the effectiveness of HIV prevention. UNAIDS/WHO promote the effective promotion of knowledge of HIV status among any population that may have been exposed to HIV through any mode of transmission. Pre-testing counselling may be provided either on an individual basis or in-group settings with individual follow-up. UNAIDS/WHO encourage the use of rapid tests so that results are provided in a timely fashion and can be followed up immediately with a first post-test counselling session for both HIV negative and HIV positive individuals.

2. Routine offer of HIV testing by health care providers

Should be made to all patients being:

- Assessed in a sexually transmitted infection (STI) clinic or elsewhere for a sexually transmitted infection to facilitate tailored counselling based on knowledge of HIV status;
- Seen in the context of pregnancy to facilitate an offer of antiretroviral prevention of mother-to-child transmission;
- Seen in clinical and community based health service settings where HIV is prevalent and antiretroviral treatment is available (injecting drug use treatment services, hospital emergencies, internal medicine hospital wards, consultations, etc.) but who are asymptomatic.

Explicit mechanisms are necessary in provider initiated HIV testing to promote referral to post-test counselling services emphasizing prevention, for all those being tested, and to medical and psychosocial support, for those testing positive.

The basic conditions of confidentiality, consent and counselling apply but the standard pre-test counselling used in C&T services is adapted to simply ensure informed consent, without a full education and counselling session. The minimum amount of information that patients require in order to be able to provide informed consent is the following:

- The clinical benefit and the prevention benefits of testing;
- The right to refuse;
- The follow-up services that will be offered and;
- In the event of a positive test result, the importance of anticipating the need to inform anyone at ongoing risk who would otherwise not suspect they were being exposed to HIV infection.

For provider initiated testing, whether for purposes of diagnosis, offer of antiretroviral prevention of mother-to-child transmission or encouragement to learn HIV status, patients retain the right to refuse testing, i.e., to 'opt out' of a systematic offer of testing.

3. Diagnostic Counselling and Testing

Counselling and testing in a clinical setting

- HIV counselling and testing in clinical settings is called HIV Diagnostic Counselling and Testing (DCT).
- The primary focus is on diagnosing HIV for appropriate TB and HIV management, particularly by referral for HIV care.
- Diagnostic counselling and testing should be requested by health workers as part of the diagnostic work-up for patients who present with symptoms or signs that could be attributed to HIV.
- Failure to provide such people with counselling and testing has resulted in sub-standard care for HIV infected patients.
- Health care providers can provide the pre-test information, obtain informed consent and do the HIV test on site in the clinic (after a short training). This is more efficient and more likely to be successful than referring patients elsewhere for HIV counselling and testing.
- Group education lessons can also be used for the pre-test information and counselling in many settings.

Consent for HIV testing

- DCT uses an **“opt-out”** approach. Presentation with symptoms of disease to a health care facility implies a desire for diagnosis, therapy and care. This therefore, implies consent for diagnostic testing including for HIV.
- All patients must be informed that the test is being done and have the right to decline HIV testing.
- In cases where after the initial encounter the patient is still unsure/uncomfortable with proceeding with the HIV test or has additional questions he/she would be referred to the facility based counsellor for a full pre-test counselling session.
- In the case of children, consent from the guardian or parent will be required. Post test counselling should include advice to the parents to learn their HIV status.

HIV testing

- Conducting such testing within out-patients and in-patients wards may improve uptake and better integrate HIV testing as part of clinical diagnosis and patient management.

Communication of HIV test results

- HIV infected persons should be advised about long term clinical care and follow-up, including home based care, as well as prevention of HIV transmission.

Recording HIV results

- The results of the HIV test should be recorded into the record that the clinicians use in caring for the patient

Medical referrals

- All HIV positive patients should be referred to the ART clinic for HIV care

Difference between 'opt-in' and 'opt-out'

Opt-in: HIV test is routinely recommended and **offered** to each patient and the patient explicitly consents to receive the HIV test. (The service provider may say something like this: "As you may know, it is fairly common for people with TB to have HIV. In order to ensure you receive the appropriate and essential care treatment services you need, it is important to know whether or not you have HIV. *As part of your clinic visit today, I recommend that we perform the HIV test. May I have your consent for this test?* What questions can I answer for you about this?)

Opt-out: HIV test is routinely recommended and **provided** to each patient and the patient is informed of his/her right to refuse the test. (The service provider may say something like this: "As you may know, it is fairly common for people with TB to have HIV. In order to ensure you receive the appropriate and essential care treatment services you need, it is important to know whether or not you have HIV. *Unless you object, as part of your clinic visit today you will receive an HIV test. What questions can I answer for you about this?*)

4. Mandatory HIV screening

UNAIDS/WHO support mandatory screening for HIV and other blood borne viruses of all blood that is destined for transfusion or for manufacture of blood products.

Mandatory screening of donors is required prior to all procedures involving transfer of bodily fluids or body parts, such as artificial insemination, corneal grafts and organ transplant.

UNAIDS/WHO do not support mandatory testing of individuals on public health grounds. Voluntary testing is more likely to result in behaviour change to avoid transmitting HIV to other individuals. Recognising that many countries require HIV testing for immigration purposes on a mandatory basis and that some countries conduct mandatory testing for pre-recruitment and periodic medical assessment of military personnel for the purposes of establishing fitness, UNAIDS/WHO recommend that such testing be conducted only when accompanied by counselling for both HIV positive and HIV negative individuals and referral to medical and psychosocial services for those who receive a positive test result.

Approaches to HIV Counselling and Testing

	Voluntary Counselling and Testing (VCT)	Routine Counselling and Testing	Diagnostic Counselling and Testing (DCT)	Mandatory
Clients/Patients	Come to clinic/centre specifically for HIV test Expect to get tested More likely to be asymptomatic	Come to the clinic for Antenatal Care Services or STI treatment	Come to clinic because they have TB/suspected of having TB/other opportunistic infection Not necessarily expecting HIV test.	Attend a private clinic for HIV testing in order to fulfill Visa requirements, insurance purposes etc
Providers	Usually trained counsellors, not necessarily trained as healthcare providers.	Health care workers	Healthcare workers trained to provide counselling/education	Health Care providers
Setting	Clinics, Hospitals, can be offered as a mobile service and in the community	Clinics and Hospitals	Clinics and Hospitals	Clinics and Hospitals, often private providers
Purpose of HIV Counselling and Testing	Primary focus is on preventing HIV transmission through risk assessment, risk reduction, and testing.		Primary focus is on diagnosing HIV for appropriate TB and HIV management, particularly by referral for HIV management and care.	Often non medical reasons

D. Minimum requirements: Staff, space, equipment and supplies for a CT site

	Large facility	Small health centre
Staff	<ul style="list-style-type: none"> - Minimum of 3 counsellors - Minimum one counsellor supervisor - Laboratory staff for QA for all HIV testing in the facility - CT coordinator 	<ul style="list-style-type: none"> -Minimum of two counsellors including community counsellor -Arrangement for supervision can be made with a supervisor from another facility
Space	Dedicated CT rooms with good ventilation and privacy	Any room with auditory and visual privacy and good ventilation
Equipment	Each CT room to have : <ul style="list-style-type: none"> -3 chairs, -one desk, -one lockable cabinet for documents, -one lockable cabinet for storage of HIV test kits and supplies, -testing table with sharps disposal bin, -hand washing facility -bench in waiting area 	<ul style="list-style-type: none"> -3 chairs, -one desk, -one lockable cabinet for documents, -one lockable cabinet for storage of HIV test kits and supplies, -testing table with sharps disposal bin, -hand washing facility
Supplies	<ul style="list-style-type: none"> -HIV test kits -Gloves and other supplies -Disinfectant -Counselling registers and monthly summation forms, other required stationary 	<ul style="list-style-type: none"> -HIV test kits -Gloves and other supplies -Disinfectant -Counselling registers and monthly summation forms, other required stationary

E. Technical requirements: Human Resources

The emphasis in all C&T sites should be on building a strong, multidisciplinary, multi-sectoral team for C&T services. The team should include the site manager, counsellors, laboratory staff, receptionists, volunteers, and ideally, people living with HIV/AIDS. Representatives of local organizations that provide related HIV/AIDS services in the community and other community organizations and leaders should also be included.

Selection and training of counsellors

- C&T counsellors do not necessarily require training as health workers. They may be recruited from the public, private or non-government sectors. It is encouraged the selection of lay counsellors to scale up C&T. Moreover, counsellors should be recognized as an independent cadre.
- Selection criteria should include personal attributes conducive to HIV counselling including: capacity to be non-judgmental, understanding; patient, empathic, warm, mature and genuine.
- They should be comfortable speaking explicitly about “taboo topics” including sexual practices and sex work; they should be comfortable demonstrating and discussing condom use.
- It is encouraged that those selected as C&T providers be willing to get tested themselves, voluntarily, both for their own personal risk-reduction planning and to understand C&T as a consumer. However being tested should not be mandatory for selection as a counsellor.
- In selecting counsellors, those who are HIV positive should not be discriminated against because of their serostatus. Conversely their personal experience as PLWHA may be highly beneficial for the counselling process.
- All staff selected to serve as counsellors shall undergo the required training and possess the requisite certification. The training shall take place in institutions recognized by the ZCC and counsellors should be registered with the ZCC.
- Community counsellors should be able to read and write in English and be accepted by their community.

In Zambia there are nine recognized institutions that have counsellor-training programmes:

- | |
|---|
| <ul style="list-style-type: none">• University of Zambia;• Chainama College;• Kara Counselling and Training Trust;• Luanshya Technical and Vocational Teachers’ Training College;• Chikankata Mission Hospital;• College for Management and Development Studies;• UTH in service training centre;• MOH counselling service unit;• Chalimbana College. |
|---|

These institutions each offer different kinds of courses over varying periods of time and each institution has its own curriculum. It is recommended that curriculum and operational procedures for training counsellors are standardized.

HIV/AIDS and counselling are very dynamic fields with changes occurring every day. Plans should be in place for ongoing training to improve counsellors' knowledge and skills.

Provisions should be made to continuously update knowledge and skills for the trainers of counsellors.

Selection and training of personnel to conduct testing

- All laboratory staff are expected to be trained in HIV testing and Quality Assurance
- For sites that are using the finger-prick testing methodology, non-health workers can perform the whole process of testing, thus all counsellors should be properly trained in HIV testing.
- Laboratory staff may also be trained in counselling. This will give them more understanding of the whole process of counselling and testing and the importance of privacy and confidentiality.
- The facility should ensure that all clients receive their results as quickly as possible. Staff should be trained in conducting the test to ensure that this goal is achieved.

Test performance

Testing demands a very high degree of accuracy, thus only those who have been properly trained in the art of HIV testing may be involved in testing. Individuals carrying out such tests must be conversant with the test format, its correct usage and application. The person is expected to understand the principle of the test, its interpretation and the objectives of the quality control measure involved.

Zambian law provides that for tests that require a venous blood draw, only medical staff/laboratory technicians perform the testing (draw the blood). This law causes constraints to the C&T facilities, particularly to the stand alone sites, due to the lack of such personnel. The introduction of the finger-prick methodology has enabled counsellors and other non-health workers, with adequate training and supervision, to perform the test. (See Appendix).

Training of ancillary staff

Ideally all staff and volunteers involved with the C&T site, including the receptionist, drivers, administrative staff, should receive basic introductory training in the role and purpose of counselling and testing, how services are delivered, basic communication skills and the need to observe strict standards of confidentiality.

Summary: To offer high-quality standards C&T services at any site, C&T program planners need to address the following key issues:

- National policy issues and plans regarding C&T services;
 - Establishment of design, management and partnerships at all levels;
 - Site selection, development, support and maintenance processes;
 - Counselling and testing protocols;
 - Training needs;
 - Community support and linkages with other services, including formation of post-test clubs/support groups;
 - Promotion and advocacy, including the need for communication materials;
 - Monitoring and evaluation, including quality assurance measures;
 - Care for counsellors. (Stress management and Burn out)
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GUIDELINES FOR HIV COUNSELLING

A. General guidelines

Counselling and Testing (C&T) is an important component of HIV prevention and care. Moreover counselling should be viewed as a means to initiate prevention and ensure access to continuing care.

Counselling about HIV should be incorporated into existing health and social services and testing for HIV should always be offered. The decision to be tested should always be made by the client himself/herself and consent must always be obtained and documented before HIV testing occurs.

The purpose of counselling is to ensure that people:

- Receive high-quality HIV prevention counselling to reduce their risk of transmitting or acquiring HIV, and have access to appropriate medical, preventive and psychosocial support services;
- Promote early knowledge of HIV status through HIV testing and ensure that all people receive information regarding transmission, prevention, and the meaning of HIV test results;
- Are helped to cope with the emotions and challenges they face when they:
 - Are worried about being infected with HIV;
 - Have found out that they are infected with HIV;
 - Are affected by AIDS in their family or among their friends;
 - Are living with HIV and can make choices and decisions that will prolong their lives and improve their quality of life.

Counselling should always be adapted to the needs of the client.

Taking an HIV test is an important decision. Results have implications for those infected and affected. It is essential that confidentiality be maintained throughout the whole process of counselling and testing.

Counselling consists of pre-test, post-test and follow-up counselling/support; and approaches to counselling may include:

- Face to face individual counselling sessions;
- Couple counselling;

Group information sessions can be held as long as they are followed by an abbreviated pre-test counselling session in which counsellor and client can discuss personal and risk issues.

B. Pre-test counselling guidelines

In the pre-test session, counselling should be centred on four main topics:

- The client's personal history and risk of being or having been exposed to HIV.
- The client's understanding of HIV/AIDS and previous experience in dealing with crisis situations.
- The client is asked to describe previous risk reduction steps attempted.
- Understanding of what the HIV test is and deciding if the client wants to take it.
- The clerk/counsellor should be trained to explain procedures to the clients and how long they may wait.
- The counsellor should not engage in any counselling but refer the clients to the counsellor.
- Educational materials about C&T and HIV, such as posters, brochures or video shows should be available while the client waits to see a counsellor.
- All C&T sites should endeavour to provide same-day or even same-hour results to clients.

More than one pre-test counselling session may be required for clients who refuse testing or are unprepared for testing.

Registration and client flow

- The Clerk/Counsellor should be able to explain procedures to the clients and how long they may wait.
- Educational materials about C&T and HIV, such as posters, brochures or video shows should be available while the client waits to see a counsellor.

Waiting period

- All C&T sites should endeavour to provide same-day or even same-hour results to clients.

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

Reasons why the client is requesting C&T;

- HIV testing procedures at the site, including whether or not written results will be given;
 - Basic facts about HIV infection and AIDS including modes of transmission and prevention;
 - Meaning of an HIV test, including the window period and possible results;
 - Personal risk assessment (if undertaken in a group, details should not be shared openly);
 - Client's readiness to learn status;
 - Client's intentions after learning test results;
 - Exploration of what the client might do if the test is positive, and the possible ways of coping with an HIV positive result including notification of significant others;
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- Exploration of what the client might do if the test is negative and possible ways of staying uninfected;
 - Disclosure of the results; shared confidentiality;
 - Exploration of behaviour change, including condom use and demonstration;
 - Development of risk -reduction plan where necessary;
 - Client's reproductive intentions and the role of family planning;
 - Exploration of potential support from family and friends;
 - Knowledge on treatment and ARVs;
 - Any special needs discussed by the client;
 - Informing the client about the HIV test and asking if they give consent.
-

If demand at a C&T site is very high, group information can be given if the following conditions are followed:

- All clients consent to having pre-test counselling as a group;
- Measures for privacy are adequate;
- Ideally six people should constitute the group;
- When possible, efforts should be made to compose groups of clients with similar ages and of the same sex.

C. Post-test counselling guidelines

This session should not be offered in a group and should consist of the following:

Giving test results

- If possible the results should be available same day
- Calmly and in a private setting
- Allow supportive person at the client's request

Window period

- Clients who test negative should be encouraged to return for additional testing within three months to make sure that they are truly uninfected.

Positive living

All clients whether HIV positive or HIV negative should be counselled about living positively which includes:

- Maintaining a positive attitude
- Avoiding additional exposure to the virus and other STIs
- Providing early referrals for medical services
- Good diet and avoiding stress

Risk-reduction planning

- Every post-test counselling session should include the development of a risk-reduction plan specific to the client's test results and personal life situation.
- If use of condoms is part of client's risk-reduction plan, explain and demonstrate proper condom use

Disclosure of status

- The client is helped to deal with the issues of disclosure

Family Planning counselling and education

- Information on family planning, its role for both HIV positive and HIV negative clients, and how to have access to services should be included in counselling sessions.
 - Importance of dual methods of family planning
 - If possible provide FP methods on site
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D. Referrals

- In consultation with the client, make appropriate referrals to additional services as needed.
- These may include medical, social, legal, economical, spiritual and psychological support.
- For clients who are HIV positive, post-test support services should include referral to ART, PMTCT, treatment services for TB, STI and other OIs.

E. Special circumstances for C&T services

Premarital and Marital C&T Services

- Premarital and marital C&T services should always be encouraged but should remain voluntary and confidentiality maintained.
- It is preferred and recommended that couples receive their results together. If the clients are reluctant to reveal the results to each other, individual C&T should be encouraged as a first step, with the hope that the couple will later request couple C&T or that the couple will reveal results to each other before they marry.
- Efforts should be made to protect the rights of individuals and couples who are HIV positive, and to prevent negative outcomes for HIV positive individuals and discordant couples (couples where one partner is positive and the other one negative).
- Additional counselling services are recommended, both individual and couple sessions, for those who test HIV positive.
- Written HIV test results are not encouraged and religious leaders and the community shall be educated about this fact.
- Referral: Couples, both HIV positive and HIV negative, should be referred for medical, social, legal, spiritual and psychological support if the counsellor determines that these services would be helpful.

Discordant couples

- The counsellor should maintain confidentiality and encourage the couple to disclose their HIV status to each other. The counsellor should not take sides and should be respectful and understanding if conflicts or arguments arise between the couple during the session. There is need to discuss the window period and need for retesting, especially of the HIV negative partner. Relevant and accurate information about HIV/AIDS should be given and the couple should be helped to make informed decisions regarding their health, family planning, child bearing and safer sex;
 - Disclosure: There is need to be patient and understanding with the partner who is HIV positive and is reluctant to disclose to the other partner. Most people if
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supported and helped to explore the costs and the benefits of disclosure to their partner usually disclose in the end;

- Prevention of further transmission: The counselling session should include discussion of the role of consistent condom use in preventing HIV transmission to the uninfected member of the couple;
- Referral: The counsellor should make referrals for medical, psychological, social and spiritual support for all discordant couples. If available, marital and family counselling may also be of benefit.

Counselling children

Please refer to Section 1, Testing Children.

In addition, it is of major importance that the counsellor counselling children had received special training in “Child Counselling Skills”.

Adolescents and C&T

- Adolescents should be encouraged to delay their sexual relationships and practise abstinence.
- Those already engaged in sexual relationships should be encouraged to discontinue sexual activity, engage in less risky practices or use condoms.
- Both the staff and the site should be “adolescent friendly”. The staff should be understanding, non-judgemental and accept adolescent language, needs, dressing and behaviour. The counsellor should be respectful of the feelings and emotional turmoil that adolescents commonly experience;
- Links with other agencies: C&T sites should make contacts with schools, community centres and so forth. Outreach to sites where youth are present should be made to explain the role and benefits of C&T;
- Referral to youth network: C&T sites should compile a register of the local youth network so that adolescents may be referred for other activities. C&T providers should work to ensure that adequate youth-friendly services are available and accessible;
- Age of consent: Please refer to Section 1, Minimum age;
- Condoms: for adolescents that are sexually active, male and female condom education and demonstration should be provided during counselling sessions. Condoms should be offered to the sexually active.

Prevention of Mother to Child Transmission of HIV

- HIV testing should be routinely recommended and provided to each pregnant mother, although she has the right to refuse it, “opt-out”.
 - C&T counsellors in a PMTCT or ANC setting should follow the PMTCT guidelines.
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F. Other special circumstances

Request for testing only

- When clients request testing but decline counselling, the counsellor will explain that C&T services are provided as a package including both counselling and testing.
- The benefits of counselling should be explained, and the client should be encouraged to return when he/she has more time and is ready to undergo counselling and testing together. Tests should not be undertaken without a client having first been counselled.

Request for counselling only

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

Repeat testing

- Clients should be encouraged to disclose if they have been to other centres for HIV testing.
- The reasons for seeking repeat testing should be explored with clients who have been tested elsewhere.

Clients who seek repeated testing should be counselled about the reasons they continue to seek testing, and unnecessary repeat testing should be discouraged.

GUIDELINES FOR HIV TESTING

HIV screening is one of the most important activities associated with C&T.

It has been established that early detection of HIV infection can result in public health benefit by decreasing risk behaviours that could transmit HIV to uninfected people. On the other hand uninfected people may benefit from HIV testing, if knowing their HIV status assists them in reducing their risk taking behaviour. In addition, knowledge of one's own HIV status and that of the partner may be an important influencing factor for preventing acquisition of HIV.

The recently demonstrated medical benefits of antiretroviral therapy have underscored the influence of expanding voluntary HIV testing services to facilitate early diagnosis and treatment of HIV infected people.

A. Types of HIV tests

There are two main types of HIV tests: antibody/antigen tests and virologic tests.

Antibody/antigen tests look for antigens or antibodies against HIV; they do not detect the virus itself. When HIV enters the body, it infects white blood cells known as T4 lymphocytes, or CD4 cells. The infected person's immune system responds by producing antibodies to fight the new HIV infection. Presence of the antibodies is used to determine presence of HIV infection.

Virologic tests determine HIV infection by detecting the virus itself. Virologic tests are rarely used to diagnose HIV since they require sophisticated laboratories and their cost is much higher than the antibody tests.

In C&T settings antibody tests are utilized.

B. Selection of HIV testing strategies

Selection of testing strategies takes into account the scientific validity (accuracy) of the test. The two measures used are sensitivity and specificity.

Sensitivity: is the probability that a test will be positive when infection is present. For example, if a test is 99 percent sensitive, 99 of 100 HIV positive people will correctly test positive, and one person will falsely test negative.

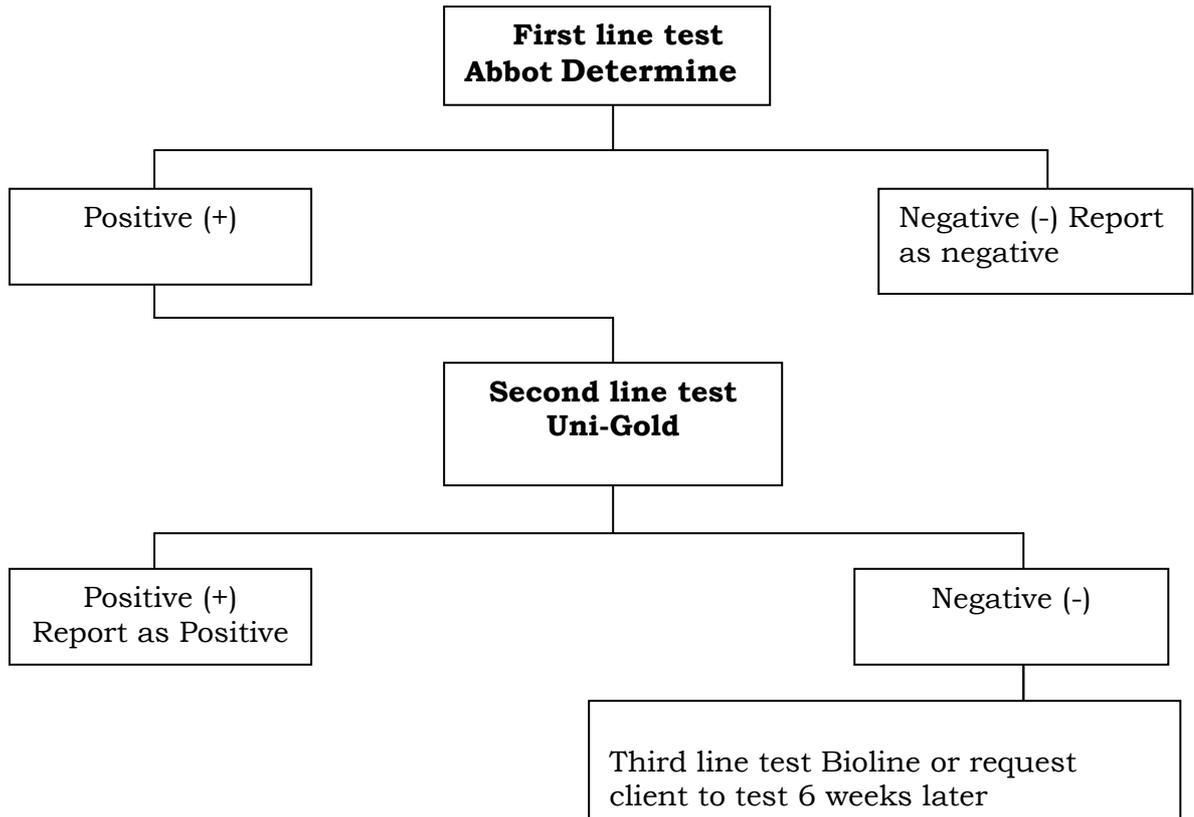
Specificity: is the probability that a test will be negative when infection is not present. In other words, if a test is 99 percent specific, 99 of 100 people who are not infected will correctly test negative, and one person will falsely test positive.

An antibody test is rarely 100 percent sensitive and 100 percent specific. Therefore, UNAIDS, WHO and the CDC recommend that all positive tests results be confirmed by retesting, preferably by a different testing method.

C. The National Testing Algorithm

Testing algorithm of Ministry of health recommends the following testing kits:

- Abbot Determine HIV 1/2 Test
- Genie II HIV 1/2 Test
- Uni-Gold HIV Test
- Bionor HIV 1/2 Test



These tests are based on different principles, thus when used together provide an approved testing algorithm.

D. Testing procedures

- All samples are tested for HIV antibodies using Abbot Determine HIV 1/2 test as a first line test (screening test).
- All non- reactive (negative) samples are reported as negative.
- A reactive sample (positive) will undergo a second HIV test, second line test, usually Genie II. If the result indicates a reactive sample, it is reported as positive.
- If the result of the second line test is negative, the sample is sent to a reference laboratory where it will undergo the third line test, Bionor HIV 1/2 test or the client is asked to come back for testing after six weeks. The third line test acts as a tiebreaker and its result is the one that will be issued to the client.

E. Test Results

Negative Results	HIV antibodies were not detected in the person's sample, either because the person is not infected or because the person is still in the window period.
Positive Results	Antibodies to HIV were detected in the person's blood. It means the person is infected with HIV and he or she can transmit the virus to others if he or she engages in risky behaviours. It does not necessarily mean that the person has AIDS.
Indeterminate Results	The presence or absence of HIV antibodies could not be confirmed. This could be because the person is in the process of sero-converting; the person may have a prior medical condition that is affecting the test. In this case, the person is always asked to come back after six weeks for retesting.

F. Confidentiality in HIV Testing

- Confidentiality is a key concern for clients. It is therefore essential that confidentiality be maintained when conducting HIV testing of any type.
 - All information about the individual should be kept strictly confidential.
 - Careful record management is a prerequisite for confidentiality.
-

G. Safety procedure

Laboratory staff works with materials that may contain infectious and potentially pathogenic organisms. Personal protection and prevention of possible cross-contamination are paramount.

The primary danger is parenteral exposures through accidental needle sticks, cuts with contaminated equipment, exposure of mucous membranes to aerosolized droplets, and exposure of broken skins, wounds and scratches to contaminated specimens. Universal safety precautions should be followed.

Practice of Personal Hygiene - Hand Washing with Soap

- A hand basin should be situated near the exit;
- Soap dispensers should be provided exclusively for hand washing;
- Paper towels or hand dryers must be provided.

Personal Protective Equipment - The following should be worn:

- Coats, gloves, mask. Coats should be hung on pegs or hooks in the laboratory near the exit;
- Goggles if eye splashing is a risk;
- Protective clothing in biohazard areas.

Storage

- Laboratory coats should be stored separately from personal items (for example, outer clothing, valuables, bags), preferably in a locker or cupboard in a separate room;
- Laboratory coats must not be worn in a staff canteen or dining room.

Washing Clothing

- Soiled protective clothing should be placed in a laundry bag, not in a locker;
- Coats should be soaked overnight in one percent domestic bleach before washing.

Working area

- No eating, drinking, smoking, or chewing gum in the laboratory;
 - No licking of labels or placing pens, pencils in the mouth or hair while in the laboratory;
 - No application of cosmetics;
 - No storage of foodstuffs in laboratory;
 - Cuts, bites, open wounds should be covered with waterproof adhesive dressing.
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H. HIV Post-exposure Prophylaxis (PEP)

PEP should generally be given when the source of exposure is known to be HIV infected or when there is information that they are likely to be HIV infected or if the HIV status is not known. This is especially true for a high prevalence area like Zambia. It is important to note that PEP is only given to HIV negative persons.

Procedure:

Immediately following exposure:

- Wash the areas exposed to potentially infectious fluids with soap and water.
- Flush exposed mucous membranes with water. If saline is available, flush eyes with saline.
- Do not apply caustic agents, including antiseptics or disinfectants, to the exposed areas.

Counselling and Testing

- Offer counselling to the person who has been exposed to HIV infection
 - Counsel on prevention with sexual partners until HIV infection has been ruled out
 - Perform baseline HIV test on the person who has the exposure using a rapid antibody test. Also recommended: full blood count, liver and renal function tests.
 - If the HIV test for the person who has been exposed is HIV positive refer for HAART
 - If the test is negative PEP should be started immediately
 - The source of the exposure should also be counselled and HIV test requested
 - In Zambia, currently all exposures are treated as high risk; therefore only the 3 - drug PEP combinations are recommended.
 - Start ARV medications within 1-2 hours of exposure if possible and up to 72 hours post-exposure. PEP is much less effective if given after 24 – 36 hours.
 - Administer PEP for 28 days.
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I. Records and data collection

Test results must be recorded on a daily basis and aggregated on a monthly basis. Data are to be collected by the coordinator and forwarded to the DHMT at the end of each month for analysis.

J. Recommendations for testing

- Rapid and simple Test devices are recommended for C&T to reduce waiting time of the client;
 - Only HIV test kits evaluated by the virology laboratory and approved by MOH should be used;
 - Finger-prick testing methodology is advocated;
 - Adequate laboratory spaces in stand-alone or integrated facilities are essential for C&T.
 - The laboratory should be equipped to a minimum standard of secondary health facility.
 - Ideally laboratory technicians should be trained in HIV/AIDS counselling;
 - Laboratories operating C&T must adhere to the *Zambian testing protocol*;
 - Laboratories operating C&T must adhere strictly to maintenance of client's confidentiality;
 - Laboratories involved in C&T must set up adequate internal Quality Control and External Quality Assurance scheme as per national standards;
 - Laboratories involved in C&T should operate within the realm of minimum bio safety standard, i.e., they should use universal precaution at all times and treat all specimens as if they were infected;
 - Laboratories involved in C&T should keep adequate records of their daily, weekly and monthly activities and abide by the Quality Control measures set by ZVCTS/MOH;
 - Do not use expired test kits.
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QUALITY ASSURANCE

- Quality assurance is a planned and systematic approach to monitoring, assessing, and improving the quality of services on a continuous basis with existing resources.
- The overall aim of quality assurance is to ensure the provision of high quality counselling and laboratory services.

A. Quality assurance strategies for HIV counselling

- All C&T sites and counselling services must ensure that the counselling provided to clients is of high quality.
- The quality of counselling is the most difficult C&T component to measure. Once counsellor and client are alone together with a “do not disturb” notice on the door, external assessment is virtually impossible.
- A quality counselling session is one that is non-judgmental, genuine, accessible and client centered. It should help the client focus on solution and risk reduction. Only trained counsellors on C&T should conduct counselling.

The following strategies should be applied at all C&T sites to maintain quality counselling:

Staff competency:

- The counsellors should have undergone a high quality counsellor training by recognized institutions.

Follow up training:

- To ensure quality counselling, counsellors should undergo regular refreshment trainings to improve counselling skills and update HIV/AIDS knowledge.

Supervision:

- The importance of counselling support supervision to the individual counsellor is in preventing burnout and maintaining quality of the client-counsellor interaction.
- Counsellors should have access to regular support supervision no less frequently than monthly.
- Supervision by an experienced senior counsellor may be conducted individually or in groups. Groups meeting without a supervisor may be trained in peer supervision.

Monitoring sessions:

With the consent of the client, a counsellor can be observed by an experienced counsellor while in session. The value of observed practice is that it gives the counsellor instant feedback from a supportive senior counsellor or supervisor.

Counsellor reflection form:

- No counsellor can be observed continuously or attend supervision after every client. The ultimate responsibility for quality rests with the individual counsellor and the trust that their clients put in them. Despite tools and measures of quality assurance, no one else can know what goes on behind the close doors of a counselling room.
- After seeing individual clients, counsellors can complete a self-reflection form and find areas where they require additional support as well as monitoring improvements in their performance over time. It is recommended that each counsellor fill out 10 self-reflection forms every month. (See appendix 4).

Client exit survey:

- Facilities should conduct client exit survey on a monthly basis. Exit interviews should be kept short and be relevant. Typical questions include factors such as waiting time, cleanliness, counsellor attitude and overall satisfaction with the service.

Mystery client survey:

- This is when a person presents at a C&T site pretending to be a regular client, but he/she is actually there to evaluate the services.
- A mystery client will assess the counsellor performance. Ideally mystery clients should be trained HIV counsellors. Mystery clients should be prepared to be tested on several occasions. Using mystery clients to assess the quality of service delivery is a well-established method but should be used with caution.

Stress management, exchange visits, and formation of a counsellor support network:

- Adequate stress management prevents counsellors from burnout. Burnout refers to a state of mental, physical, emotional and spiritual exhaustion caused by excessive and prolonged stress.

B. Quality assurance for HIV testing

Quality Assurance is a very important consideration in providing HIV testing services. Any result, whether positive or negative, carries with it major implications in a client's life. False positive and false negative results must be minimized. Therefore all components of QA i.e., pre-analytical, analytical and the post analytical phases must be adhered strictly.

Adherence to laboratory protocol:

- The testing protocol is designed to reach maximum reliability and validity in accordance with local conditions, such as the type of equipment and test kits available.
 - Standard Operating Procedures should be followed. Laboratory staff and other non-laboratory staff should be trained in the standard procedures for, handling specimens, testing, disposal of bio-hazardous materials, and the storage and transportation of samples as well as documenting.
 - Refresher trainings have to be provided.
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Quality control of samples:

- Having highly accurate HIV tests does not necessarily guarantee reliable laboratory results.
- Many processes take place from the time the specimen arrives in the laboratory until the results are recorded, during which time errors can occur. Therefore, the ongoing process of monitoring the laboratory system, both internally and externally, is essential.

Internal quality control:

- It is included in the testing device or as part of the kit.

External quality control:

- Are the known positive and negative specimens that are used to validate the reliability of the test system. These are tested:
 - Once a week, at the beginning of the week;
 - When there is a new shipment of the test kit;
 - At the beginning of a new lot number;
 - When the environmental conditions exceed range needed for the stability of kits.

External Quality Assessment

- Proficiency testing: Panels of specimens are sent to multiple sites by the reference laboratory;
 - On-site evaluation: Conducting periodic site visits for systematic assessment of laboratory practice;
 - Re-testing: Is the process by which, monthly a random selection of 10 % of specimens are collected from the routine workload at the test site and sent to a reference laboratory for validation. The reference laboratory will validate results using a standard ELISA test.
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Quality Control of Testing Kits and supplies

- Testing kits shall be procured only from recognized, reputable sources;
- The use of test kits shall be in accordance with the national algorithm;
- Stocks shall be stored according to manufacturers' recommendations and their shelf life shall not be allowed to expire;
- Storekeeping procedures shall be observed strictly;
- Stock monitoring shall be carried out regularly; important stocks include testing kits, buffers and reagents, equipment, and blood drawing tools, protective gear, and any other supplies.
- Test kits that do not show the expected reaction shall be destroyed according to regulations;

For effective Quality Assurance for the overall quality of the results coming from the laboratory an effective monitoring and evaluation of the laboratory procedures for the pre analytic and post analytic phases should be put in place.

These will include:

- Personnel: specialized training, refreshers training of laboratory staff;
 - Facilities: adequacy of space, water, ventilation, lightning, bio-safety policy;
 - Equipment: purchase, preventive maintenance and repair;
 - Test kits: acquisition and distribution, storage, records of lot and batch numbers, and expiry dates;
 - Methods for collecting, handling, identifying, processing, storing and recording of specimens;
 - Information provided on the request and result forms;
 - Accurate record keeping of all Quality Control measures.
 - Review and revision of Laboratory Policies and procedures to assure the Quality Assurance Programme;
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Record Keeping, Data Management, Monitoring and Evaluation

The handling of C&T records and data requires confidentiality and efficiency. This is to give the client a sense of security as well as provide reliable data for various users. Systems for collection and analysis of all C&T data should be coordinated nationally, conforming to the existing management information system of the Ministry of Health. ZVCTS has produced a system that should be used by all service providers. The ZVCTS system should be linked to the HMIS system so that uniform information is available at all levels.

A. Data Collection System

There is need to standardize and regulate procedures for consistent information collection, documentation and reporting at a site, district, provincial and national level.

B. Data collection instrument

A standard data collection instrument should be used at all C&T sites, including government and mission hospitals and health centres, NGOs, PLWHA organizations, and private and commercial sites offering HIV counselling and testing. When using the VCT data form, counsellors should inform the client that the services are anonymous and that no names are recorded on the form to reassure the client of the confidentiality of the information.

C. Data recording

The counsellor should fill out the VCT form before the client leaves the counselling room. The counsellor should ensure that filling out the form does not interfere with establishing rapport with the client, and does not interfere with an effective counselling session. At the end of each day, each counsellor should transfer the relevant information to the register.

Same recording procedure has to be followed by laboratory staff.

D. Coding system

A standardized system of assigning codes or reference numbers to clients for identification purposes should be developed and used within each C&T centre.

E. Record-keeping

A filing system for C&T records should be developed and followed within each C&T centre. All records must be kept confidential and stored in a secure room with lockable cabinets.

F. Data entry

Each C&T centre should submit the ZVCTS data collection forms (daily, monthly and annual report) to the DHMT, where data entry should occur. Submission of C&T data collection forms should be made monthly. All data entry staff will be trained in using the agreed tools for C&T data entry.

G. Data analysis, reporting and feedback

It is intended that C&T data can be used for understanding C&T demand and utilization, service delivery, surveillance, and for improving the management of C&T services. Data collected will be analyzed and findings will contribute to the ongoing review of the national C&T policy. Feedback mechanisms have to be in place to ensure that each level of services and management and staff is informed on the findings.

H. Training of counsellors, medical records officers, and laboratory staff

All people involved in data recording, data entry, data tabulation and analysis should be trained on the relevant software package. Such training is MOH responsibility.

I. Monitoring and evaluation

The C&T database should be used to monitor and evaluate C&T services at each site, in each district and province, and at a national level.

J. Monitoring and Evaluation

Monitoring and evaluation (M&E) is a critical component for successfully implementing HIV C&T services. Well-designed and conducted M&E of HIV C&T helps identify and correct potential problems on an ongoing basis and provides feedback during planning, design, and implementation of the program.

M&E is an integral component of internal and external quality assurance procedures for all facilities where HIV testing is performed. Certain indicators can be used to monitor the performance of the commodity management system and help program managers identify and address problems as part of the overall C&T monitoring programs. These indicators can be useful in evaluating the impact of an intervention designed specifically to address the efficiency of management and coordination of the program and service delivery effectiveness. Part of monitoring and evaluation is having a system in place to record information and track performance over time.

DEFINITION OF KEY TERMS

MONITORING

Monitoring in the context of C&T, comprises day-to-day record keeping, built in system(s) of check and balances, and reporting of daily activities to ensure each staff member is performing his or her job correctly. Monitoring is essentially an ongoing effort to track and report on activities being implemented and ensure that activities are conducted as planned. Monitoring takes place throughout the entire process of setting up and executing C&T services (i.e., through planning, assessment, design, and implementation). Different methods have been used to monitor C&T services, including: reviewing C&T records; reporting regularly on activities; and conducting key informant interviews. These monitoring methods are carried out with “monitoring tools” – logbooks, registers, and client management forms. The goals of monitoring in the context of C&T are to:

- Ensure that activities are being implemented as planned;
- Show how C&T service delivery systems and linkages are working;
- Serving as a preliminary indicator of behaviour change.

EVALUATION

Evaluation refers to structured and periodic assessment of counsellors’ personal skills, a quality assurance system, assessment of clinical settings, program activities (or program components), or training activities (using pre and post test assessments) to determine if expected results (e.g., counsellors’ skills, behaviour change) are being achieved. The purpose of evaluation is to inform action and enhance decision-making.

M&E should address two relevant areas for service providers and policymakers:

- Service delivery: how well C&T is provided;
- Program effectiveness: The intermediate outcomes and long-term impact that HIV C&T may have on the population receiving the service.
(For the M&E indicators refer to Appendix 7)

FEEDBACK

Improved feedback is required to guide C&T program efforts. Program managers and coordinators should appreciate M&E that allows for continuous feedback to staff on the status of services provided and the progress made. Further, they should appreciate that feedback can increase the knowledge of staff involved in the program and guide future improvements. Particular priorities to be noted are where information on uptake of C&T services should be required to guide outreach efforts with specific target groups, and how monitoring data can be used to guide strategies that will increase acceptance of HIV testing.

C&T RESEARCH DEVELOPMENTS

Many feasibility questions are yet unanswered, such as: What is the public perception of rapid tests? Do people prefer using C&T sites far from home? What are the rates for partner notification and how can these rates be improved? These and other operational research questions need investigation to best inform implementation on the C&T scaling-up process, and intervention effectiveness should be undertaken to assess such problematic areas.

APPENDIX I

Ethical Code of Conduct for HIV Counsellors - General Principles

Competence

- Counsellors are responsible for their own competence, effectiveness, conduct, and physical safety, and should avoid any compromise of the counselling profession.
- Counsellors are expected to have received requisite training in counselling skills and techniques.
- Counsellor performance should be monitored regularly through supervision or consultative support, and by seeking the views of clients and other counsellors.
- Counsellors should recognize their boundaries and limitations; they should provide only those services and use only those skills and techniques for which they are qualified through training and practice.
- Counsellors should not claim to have qualifications or expertise they do not have.
- Counsellors should make appropriate referrals to others with expertise they themselves do not have.
- Counsellors should not make exaggerated claims about the effectiveness of HIV prevention and care interventions offered by their facility.

Consent

- Counsellors must obtain their clients' consent to engage in counselling and testing.
 - Unless sanctioned by legal authorities on criminal or mental health grounds, counselling is undertaken voluntarily and deliberately by counsellors and clients, and should take place in a private and confidential setting.
 - Counsellors must explain to clients the nature of the counselling offered and any attendant contractual obligations, such as timing, duration, confidentiality, and cost/fees for services if applicable.
 - Counsellors should ensure that clients understand all issues involved in C&T before giving informed consent for HIV testing.
 - Counsellors must obtain (or be provided with) informed consent before clients are tested for HIV.
 - Counsellors must recognize the rights of individuals whose ability to give valid consent to HIV testing may be diminished because of age, learning disabilities, or mental illness.
 - Counsellors must recognize the right of clients to withdraw their consent at any time, even after their blood has been taken for HIV testing.
-

Confidentiality

- Counsellors must maintain adequate records of their work with clients and take all reasonable steps to preserve the confidentiality of information obtained through client contact. Counsellors also should protect the identity of individuals, groups, or others, unless a client gives express permission to reveal it.
 - No information concerning the client, including HIV test results, should be given without the permission of the client. But “shared confidentiality” is encouraged. This term refers to confidentiality that is shared with a limited number of people (e.g., family members, loved ones, caregivers, and trusted friends). This is provided only on request and consent of the person undergoing testing.
 - Counsellors should be aware that, although HIV test results must be kept confidential, other professionals involved in a given case (e.g., other counsellors and health workers) might need to know a person’s HIV status to provide appropriate care. But even to such personnel, this information should be shared only with the permission of the person tested.
 - Counsellors must take all reasonable steps to communicate clearly the extent of confidentiality they are offering to clients. Normally, this should be made clear in pre-test counselling.
 - Any agreement between counsellor and client about confidentiality may be reviewed and changed by joint negotiation, but the counsellor must work within the guidelines of the current agreement.
 - Counsellors must maintain confidentiality in storing and disposing of client records.
 - Counsellors must not disclose any information about a client to colleagues or third parties without first seeking the client’s consent (except as noted below).
 - Counsellors may break the confidentiality agreement only under the following circumstances:
 - ✓ The counsellor believes a client might cause serious physical harm to himself or herself, or to other people, or be harmed by others;
 - ✓ The counsellor believes a client is no longer able to take responsibility for his or her decision and actions;
 - ✓ A court has ordered disclosure of such information;
 - ✓ The person infected with HIV continues to behave in a way that presents a clear threat to identifiable individual’s lives;
 - ✓ The client requests a release of record.
 - If a decision to break confidentiality is agreed to by a counsellor and client, it should be done only after thorough consultation with a counselling supervisor or other experienced counsellor.
-

A counsellor's confidentiality oath specifically states that they should:

- Keep strictly confidential any identifying information about a client, unless the client gives written permission to act otherwise;
- Take reasonable steps to ensure a client's record is identifiable only to that client;
- Destroy records no longer required for services being offered;
- Ensure security of records and prevent access to them by anyone not involved in the services being offered;
- Ensure that colleagues, staff and trainees understand and respect the need for confidentiality in the counselling services.

Personal conduct and integrity

- Counsellors must conduct their counselling activities in a way that does not damage the interests of their clients or undermine public confidence in either the service or their colleagues.
- Counsellors must maintain respect for clients in the counselling relationship by: not engaging in activities that seek to meet counsellors' personal needs at the expense of the clients; and not attempting to secure financial or other benefits, other than those contractually provided or awarded by salary.
- Counsellors should not exploit any counselling relationship for the gratification of personal desires. They must avoid sexual harassment, unfairness, discrimination, stigmatization, and derogatory remarks.
- Counsellors should refrain from counselling when their physical or psychological condition is impaired by the use of alcohol or drugs, or when their professional judgement and abilities are impaired for any other reason.
- Counsellors should appear professional and presentable in dress and manner.
- Because counsellors are responsible to the community, they should be aware of laws governing counselling in the community and be careful to work only within those laws.
- Counsellors must promote honesty, fairness, and respect for others, and avoid improper and potentially harmful dual relationships with clients.
- Clients should not accept clients with whom they have engaged in sexual relations or with whom they have a current personal relationship.
- Counsellors must not engage in personal or sexual relationships with current clients (i.e., dual relationship).

Respect for human rights

- Counsellors must recognize the fundamental rights, dignity, and worth of all people.
 - Like any other health professionals, counsellors are expected to provide services to people irrespective of race, culture, religion, values, or belief system.
 - Counselling is not about forcing people to conform to certain "acceptable" standards by which they must live. Rather, it is a process in which clients are
-

challenged to assess their own values and behaviours honestly, and decide for themselves how they might change.

Disciplinary measures

- Counsellors have a responsibility to other counsellors to point out wrongdoing if they observe it.
- Counsellors have a responsibility to maintain high standards of professional conduct toward clients and the institution where counselling services are performed.
- All personnel involved in HIV counselling should sign an oath of confidentiality. Corrective measures should be taken upon breach of this oath. Further disciplinary actions may be taken, depending on the ethical code addressing termination of services, justification for termination, and the mechanisms for doing so.

Other ethical considerations

Counsellors may encounter other ethical dilemmas not covered in this appendix. When facing an unfamiliar situation, counsellors should remain calm, use their best judgement, and use the counselling techniques they have learned. If counsellors are unsure how to respond in a given situation, they should seek help according to the rules and procedures of their counselling centre. Knowing when to ask for help, and being able to accept it, are essential qualities for a counsellor.

HIV counsellors might face a number of ethical issues, including:

- Client dependence;
 - Disclosure of test results to partners;
 - Provision of services to minors;
 - Appropriateness of gifts received or offered.
-

Human rights and Counselling and Testing

Human Rights Principles most relevant to C&T

The following are the human rights every client should have and be made aware of:

- The right to privacy;
- The right to non-discrimination, equal protection and equality before the law;
- The right to have a family;
- The right to the highest attainable standard of physical and mental health;
- The right to informed consent before a medical procedure is carried out.

The right to privacy

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

The recognized exceptions to the rule of confidentiality in the context of HIV/AIDS are the following:

- Where the unequivocal consent of the client is given to share the information;
- Where the information is to be given under compulsion of the law, for example as material evidence in court proceedings;
- Where information is being shared among medical professional colleagues in a research or health-care setting;
- Where cultural and social traditions permit shared confidentiality in the family and the community;
- In case of anonymous and unlinked testing.

The test results should be given to the client in person and privately to ensure confidentiality and adequate support. This includes all forms of testing, for all of the following people:

- Migrants, refugees, travellers;
 - Military personnel;
 - Pregnant women;
 - Children who are being adopted, or subject to custody or access orders;
 - Couples intending to marry;
-

- People seeking insurance, bank loans, and so on;
- Participants in certain sports, such as boxing;
- Hospital patients, such as before surgery or where health-care workers have suffered needle-stick injuries;
- Inmates of institutions such as prisons and facilities for the mentally ill, developmentally disabled, or people with severe physical disabilities;
- Employees with a particular emphasis on certain occupations such as health-care workers, pilots, entertainers, truck drivers, fishermen;
- People subject to punishment by law, such as sex workers, injecting drug users and men who have sex with men;

The right to non – discrimination, equal protection and equality before the law

Discrimination must not exist in a C&T setting, as it would deny intending clients' access to C&T and thus deny them the opportunity for behavioural change and coping mechanisms.

The right to marry and have a family

Mandatory premarital testing and the requirement of HIV free certificates as a condition to solemnising a marriage is discouraged. Similarly, coerced abortions and sterilization of HIV infected women violates their right to have a family.

The right to the highest attainable standard of physical and mental health

Quality C&T can contribute to the physical and mental health of those who wish to know their HIV status. It is an integral part for supportive medical care and is characterized by:

- Quality information from C&T promotion, testing facility and health personnel;
- Informed consent;
- Pre and post-test counselling.

The right to informed consent before a medical procedure

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

Protecting human rights within a C&T site

In addition to the strict observance of pre and post-test counselling, confidentiality and informed consent, protecting the human rights of C&T clients can be promoted through the adoption of an ethical code of conduct for all those involved with C&T services. Such a code of conduct should include a commitment to competence, consent, confidentiality, and respect for people's rights, professional conduct, and integrity towards clients.

Further thoughts on Stigma and discrimination

In the context of HIV/AIDS, stigma and discrimination refer to actions taken against individuals solely on the basis of their HIV status. Stigma, discrimination and C&T are related in two ways. First, we know that the presence of stigma in a community makes it more difficult to prevent HIV in general. Second, C&T programs, which allow more people to know about their HIV status, can actually *decrease* stigma and discrimination, foster "normalization" and open the door for more effective HIV prevention and care.

In terms of the first relationship, arbitrary discrimination against people living with HIV/AIDS, or even people *simply suspected* of living with HIV/AIDS, can have devastating public health consequences. As UNAIDS points out:

"Discrimination tends to instil fear and intolerance. It creates a climate that interferes with effective prevention by discouraging individuals from coming forward for testing and for seeking information on how to protect themselves and others, thus deepening the adverse impact of living with HIV/AIDS. Since the effectiveness of a prevention policy depends on reaching those who are at risk and encouraging them to adopt safer behaviour, it is essential to combat the discrimination that drives people away from those programmes."

UNAIDS (2002)

Counselling Check list

Pre-test counselling check list

- Welcome client
- Make introductions
- Warm up (Discussion on general things)
- Take time to know each other
- Reason for coming
- Discuss confidentiality and privacy
- Determine present knowledge of HIV/AIDS
- Provide further information on AIDS
- Relate current physical status to AIDS
- Discuss why testing is considered
- Explore meaning of possible results
- Assess ability to cope with results
- Risk assessment
- Window period
- Shared confidentiality
- Obtain informed consent for test
- Check if client want to know results
- Cover technical aspects of testing
- Inform about waiting period for results
- Determine who will be involved
- Do a complete need assessment and resource assessment of client
- Summary – Questions from client
- Date of next appointment

Post-test counselling check list

- Greet the client
- Warm up, make the client feel comfortable
- Briefly review what happened in previous session
- Actively include significant other person
- Check if client still want to know the results
- Reveal the results
- Observe the reaction and provide support
- Allow time for expression of feelings
- Assess psychological state
- Assess level of understanding and upgrade knowledge if necessary
- Identify problems
- Identify solutions/resources
- Draw up a plan of action
- Give information on HIV prevention/ Review HIV knowledge particularly window period
- Positive living lifestyle/ Care & Support
- Assess client's support network

Make date for next appointment (Follow up, check if “Crisis counselling” approach is needed)

Counsellor reflection form

1.2 Counsellor reflection form			
Counsellor code or name.....	Client code.....		
Date.....			
	Yes	No	N/A
Did I conduct a client-centred session that responded to the client's needs and concern?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did I explain confidentiality?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did I ensure the client's privacy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did I provide appropriate technical information?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did the client speak as much or more than I did?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did I perform a risk assessment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did I work with the client to develop a risk-reduction plan?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did the client understand the meaning of the test results?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did I assess and address the availability of the client's social support?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did I discuss relevant referral options with the client?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did I discuss disclosure of test results with the client?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did the client determine an immediate plan of action?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did I deal with the client's and my own emotional reactions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
What did I do well?			
What could I have improved on?			
Professional issues to follow up			

Client exit interview

Date:.....

C&T Centre.....

Location.....

Client age.....Sex.....

Marital status.....Occupation

Reason for visiting the site.....

.....

Type of counselling service (s) received.....

.....

.....

.....

Who provided the service (s)?

Counsellor Doctor Nurse Other health worker

Volunteer Other (specify).....

How many times have you received this type of service?

.....

How satisfied are you with the service(s) you have received?

Very satisfied Satisfied Somehow satisfied Not satisfied

Comments.....

.....

.....

How long did you spend with the counsellor?

Did the counsellor ensure that your discussion was private? Yes No



- Did the counsellor explain confidentiality? Yes No
- Did the counsellor introduce self and explain role? Yes No
- Did you feel the counsellor listened to you well? Yes No
- Did you feel that the counsellor understood your problems? Yes No
- Did the counsellor give you all the information you wanted? Yes No
- Did the counsellor help you to make decisions and plans? Yes No
- Did the counsellor inform you of other support services? Yes No
- Did the counsellor suggest you could return for further counselling? Yes No

Any further comments.....

Would you recommend this service to others? Yes No

Suggest ways in which the services could be improved:.....

Thank you

Name of monitoring officer.....

Position.....

Signature.....



Rapid finger-prick Testing for HIV Antibody

WHO cites the following as a guiding principle to be observed in the provision of C&T services:

“Offering HIV testing and counselling should become standard practice wherever they are likely to enhance the health and well-being of the individual. The objective is to enable the greatest possible number of people to benefit from the ever-improving treatment, care and prevention options and realize their right to the highest attainable standard of health care.”

The Ministry of Health has recognized the deficit in human resource capacity to provide C&T and other health services. In order to scale up these services, non-health worker cadres like community counsellors and trained counsellors have been trained to meet these requirements.

It is against this background that the National AIDS Council through its Technical Working Group on VCT and CHBC has recommended for the use of finger-prick blood draw, which is a simpler, less-invasive procedure that can easily be understood and performed by non-laboratory staff. The finger-prick method of blood draw for HIV antibody testing is not new to Zambia and some centres are already using this technique.

Along with the recommended policy change, the NAC Technical Working Group on VCT and CHBC recommends that three main activities must occur in order to implement finger-prick testing on a national scale. First, the national testing algorithm will need to be amended. Second, reference laboratories will need to have the necessary training and reagents to conduct quality control using dry blood spots. Third, appropriate materials and training will need to be provided to health workers and non-health workers to provide finger-prick testing.

The objectives of moving from venous blood draw to whole blood finger prick specimens are as follows:

Overall objective

- Universal access to Counselling and Testing in Zambia

Specific objectives

- To broaden the personnel cadres involved in HIV testing;
 - To include simpler methods of obtaining blood samples for HIV testing;
 - To ensure adequate quality assurance in rapid HIV testing using finger prick whilst conforming to existing national standards;
 - To add on an alternative second line rapid test within the existing algorithm to allow for finger prick testing.
-

Advantages of Finger Prick Method

- Simpler to use allowing non-health workers to perform both at facility and community level.
- The results will not be altered whether blood is drawn by finger prick method or by venous draw.
- Purchase for necessary consumables for finger prick is less expensive than current method.
- In communities, it may help to allay fears associated with Satanism and/or drawing blood for sale overseas as less blood is drawn.
- Storage of dried blood spots for quality control is easy, safe, and compact and refrigeration is not required. In addition transportation is easy.
- It is less invasive to the client than venous blood draw.
- It is quick and simple allowing more time for counselling and immediate results within the counselling environment.
- It improves patient flow and allows smooth integration of CT into other health services.
- Reduction in occupational exposure risk. Most occupational exposure occurs during vein-puncture. The risk of such exposure is substantially reduced with finger prick.
- It reduces the workload in the healthcare delivery system at various levels.
- It reduces amount of medical waste.

Disadvantages

Quality Assurance on dried blood spots involves an additional step in extracting blood from the filter paper requiring more labour and reagents

- Small sample volume limits further use of same sample for rechecking and future epidemiological research.
- Finger Prick methodology used at community and facility level will require a strong monitoring and supervision system.

Discussion

It is clear that there are certainly more advantages than disadvantages in using finger prick as a way of scaling-up testing for HIV-1/HIV-2 antibodies in Zambia. A key advantage of using finger prick with rapid tests is that the reliance on laboratory services for obtaining test results is significantly reduced if the minimum standards for ensuring the quality of test procedures and record-keeping are observed. This is of major importance because it allows HIV testing and counselling to be decentralized to community services away from major urban centres.

Quality Assurance system

While scaling up C&T services we are mindful that quality assurance should not be compromised at any cost.

Three methods have been used to establish competence of staff and testing sites in the planned ZVCTS QA system:

Proficiency Testing: Sending of a panel of specimens with known reactivity to participating laboratories, which will test the specimens and send results to higher level laboratories. This will be done at district level.

Re-testing: Re-testing by the reference lab of 5- 10% of specimens, randomly selected from all samples tested at that site.

On-site monitoring: An on-site review of all aspects of the quality system at a site using a checklist. This will be done at district level.

Introduction of finger prick blood collection will only affect the second method. Currently, serum samples are collected and stored at C&T sites for QA re-testing. With the finger prick method, blood for re-testing is collected as dried blood spots (DBS) on filter paper.

Alternative HIV Testing Algorithm

The National testing algorithm involves the drawing of blood for testing using Abbot HIV 1-2 assay (rapid test) as the first line test and Genie II HIV 1-2 assay as a second line or confirmatory test. Any discrepant samples are then subjected to a third test by using Bionor, which is an intermediate ELISA. The 'tie-breaker' third test is done at the reference laboratory.

Under the current algorithm, the first line test (Abbot), allows for the finger prick method. However, the second line test, (Genie II), requires that venous blood be drawn. In addition, the Genie test also requires refrigeration making it very inaccessible in remote and rural areas, and even in some urban townships.

Genie II requires the use of serum/plasma, therefore the need for venous blood draw. This creates a challenge for its use in most health facilities and especially rural areas where there is a critical shortage of health workers.

It is important therefore that as we consider the use of finger pricks in HIV testing, an alternative HIV testing algorithm be used that will not have the limitations mentioned above.

We recommend the following algorithm as an alternative

- Abbot HIV 1-2 assay as a first line test
 - Uni-gold HIV 1-2 assay as the second line test
 - If results are discrepant, a venous blood draw would need to be done in order to store a sample for the tie-breaker test
-

Training

It is envisaged that all medical and non-medical health workers who will use the finger prick method operate under close supervision of a laboratory technician. Laboratory technicians and technologists who have themselves been trained by ZVCTS will carry out training for the finger prick method.

The selection criteria for those to be trained in finger prick method are as follows:

- Must be working in the field of HIV/AIDS;
- Must have some previous training in counselling and fully understand the ethic of confidentiality;
- Must be able to read and write in English in order to ensure appropriate use of the test;
- Must have a working relationship with a health facility for supervision purposes;
- Must have no criminal record;
- Reference for the trainee must be obtained from management of their work place.

Supplies for the finger prick method

The supplies needed for finger prick method are minimal and lay people can easily be trained. This section gives a comparison of supplies needed both for finger prick method and venous blood draw.

Supplies needed for finger prick method	Supplies needed for venous blood
Sterile Lancets or Autolets	Centrifuge
Filter paper collection device	Test tubes
Sterile gauze pads	Needles and Syringes
Sterile disposable powder-free gloves	Alcohol wipes
Alcohol wipes	Sterile powder- free disposable gloves
Adhesive bandages	Micro-pipettes
Biohazard disposal bags	Pipette tips
Sharps container	Sterile gauze pads
Disinfectant	Biohazard disposable bags
Capillary Tubes	Sharp container
	Disinfectant

Monitoring and Evaluation Indicators

Example of service delivery and program monitoring indicators in C&T

- Proportion of people in the community who know about the HIV C&T services;
- Number of people counselled and tested at the site (per month, per year);
- Proportion of people counselled and tested who have returned to receive their test results;
- Proportion of people testing HIV positive who have been referred to appropriate care and support services;
- Proportion of people counselled and tested who state that they intend to inform their partners;
- Proportion of people counselled and tested who have informed their partners (partner notification);

Example of effectiveness indicators: intermediate program outcomes

- Changes in HIV/STI related risk behaviours among HIV C&T clients and their partners;
- Changes in behaviour among people stating that they know their serostatus (collected through behavioural surveillance surveys, for example);
- Changes in STI trends in sub-populations reached by HIV C&T program;
- Reduced stigmatization of, and discrimination against, people in the community affected by HIV/AIDS;
- Increased community support for PLWHA.

Example of effectiveness indicators: expected program impact (long term effects)

- Changes in trends in HIV incidence/prevalence in the population of sub-populations serviced by HIV C&T programs;
 - Reduced mother-to-child transmission of HIV in women childbearing age targeted by the HIV C&T programs;
 - Sustained changes in societal norms in the community reached by the HIV C&T programs.
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UNAIDS/WHO Policy Statement on HIV Testing**The Context**

As access to antiretroviral treatment is scaled up in low and middle-income countries, there is a critical opportunity to simultaneously expand access to HIV prevention, which continues to be the mainstay of the response to the HIV epidemic. Without effective HIV prevention, there will be an ever-increasing number of people who will require HIV treatment. Among the interventions that play a pivotal role both in treatment and in prevention, HIV testing and counselling stands out as paramount.

The current reach of HIV testing services remains poor: in low and middle income countries only 10 per cent of those who need voluntary counselling and testing, because they may have been exposed to HIV infection, have access to it. Even in settings in which voluntary counselling and testing is routinely offered, such as programmes for prevention of mother-to-child transmission, the number of people who avail themselves of these services remains low in many countries. The reality is that stigma and discrimination continue to stop people from having an HIV test. To address this, the cornerstones of HIV testing scale-up must include improved protection from stigma and discrimination as well as assured access to integrated prevention, treatment and care services. The conditions under which people undergo HIV testing must be anchored in a human rights approach which protects their human rights and pays due respect to ethical principles. Public health strategies and human rights promotion are mutually reinforcing.

The conditions of the '**3 Cs**', advocated since the HIV test became available in 1985, continue to be underpinning principles for the conduct of HIV testing of individuals.

Such testing of individuals must be:

- **Confidential**
- Be accompanied by **counselling**
- Only be conducted with informed **consent**, meaning that it is both informed and voluntary.

Up to now the main model for HIV testing has been the provision of client-initiated voluntary counselling and testing services.

Increasingly, provider-initiated approaches in clinical settings are being promoted, i.e. health care providers routinely initiating an offer of HIV testing in a context in which the provision of, or referral to, effective prevention and treatment services is assured. To reach people in need of treatment, tens of millions of tests will have to be conducted among those who may have been exposed to HIV.

Ensuring a rights based approach

The global scaling up of the response to AIDS, particularly in relation to HIV testing as a prerequisite to expanded access to treatment, must be grounded in sound public health practice and also respect, protection, and fulfillment of human rights norms and standards.

The voluntariness of testing must remain at the heart of all HIV policies and programs, both to comply with human rights principles and to ensure sustained public health benefits.

The following key factors, which are mutually reinforcing, should be addressed simultaneously:

1. Ensuring an *ethical process for conducting the testing*, including defining the purpose of the test and benefits to the individuals being tested; and assurances of linkages between the site where the test is conducted and relevant treatment, care and other services, in an environment that guarantees confidentiality of all medical information;
2. Addressing the *implications of a positive test result*, including non-discrimination and access to sustainable treatment and care for people who test *positive*;
3. *Reducing HIV/AIDS-related stigma and discrimination* at all levels, notably within health care settings;
4. Ensuring a supportive *legal and policy framework* within which the response is scaled up, including safeguarding the human rights of people seeking services;
5. Ensuring that the *healthcare infrastructure* is adequate to address the above issues and that there are sufficient trained staffs in the face of increased demand for testing, treatment, and related services.

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