THE REPUBLIC OF UGANDA

Ministry of Health

National Implementation Guidelines for HIV Counselling and Testing in Uganda

December 2010

National Implementation guidelines for HCT in Uganda, December 2010

The Ministry of Health welcomes feedback and comments from both users and experts in HCT. Please provide any feedback to:

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Abbreviations

AIDS	acquired immune deficiency syndrome
ANC	antenatal care
ART	antiretroviral therapy
ARV	antiretroviral drug
DHO	district health office/officer
ELISA	enzyme-linked immune-sorbent assay
FP	family planning
HBHCT	home based HIV counselling and testing
HCT	HIV counselling and testing
HIV	human immunodeficiency virus
HSSIP	Health Sector Strategic & Investment Plan
IDPs	internally displaced persons
ILO	International Labour Organisation
M&E	monitoring and evaluation
MoH	Ministry of Health
NGO	non-governmental organization
NHRL	national health reference laboratory
PHA	people living with HIV/AIDS
PMTCT	prevention of mother-to-child transmission [of HIV]
PTC	post-test clubs
STD	sexually transmitted disease
TB	tuberculosis
UAC	Uganda AIDS Commission
UNAIDS	Joint United Nations Program on HIV/AIDS
UNHCR	United Nations High Commission for Refugees
UVRI	Uganda Virus Research Institute
WHO	World Health Organisation

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Dr. Zainab Akol
Programme Manager
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Foreword

The Ministry of Health (MoH) acknowledges the development of the new *National Implementation Guidelines for HIV Counselling and Testing in Uganda* in response to the changing international guidance and recommendations in the HIV Counselling and Testing (HCT) arena.

Two decades after the introduction of HCT services in Uganda, there is still a large unmet need for the service by the general population and other special population groups. The MOH is at the forefront of national efforts to increase coverage and access of HCT services. As the main entry point to HIV prevention, care and treatment services, it is the interest of the MOH to facilitate the provision of quality HCT services through regular update and dissemination of HCT guidance to accommodate the need to expand HCT services equitably across the country.

These guidelines maintain the core concepts and principles of HCT service provision, including human rights and ethical considerations. The guidelines aim at enabling HCT service providers to reduce the missed opportunities for HCT through strategic communication, specific targeting of eligible populations, integration of HCT with key services and coordination of HCT services at national, district and service delivery levels. The guidelines place emphasis on the need to provide accurate HIV test results with a focus on circumstances for repeat HIV testing and HIV retesting

Through expansion of HCT services and linkage to critical prevention, care and treatment services, these guidelines will contribute to reduction in the effects of the HIV epidemic on individuals, couples, families and communities.

I strongly encourage all HCT service providers to do all that is required to adhere to the guidelines in this document.

Dr. Nathan Kenya Mugisha
Ag. Director General Health Services

Introduction

Background

Uganda has a mature generalised HIV epidemic with prevalence exceeding 6% and an estimated one million people living with HIV[1]. Sub-national longitudinal studies[2] and indirect estimates[3] indicate a rising rate of new infections with HIV incidence ranging from 0.2-2.0% in different regions of the country.

The goals of the *National HIV/AIDS Strategic Plan 2007-2012, (NSP)* are to reduce HIV incidence by 40% and expand and scale-up interventions to 80% of those in need of care and treatment by 2012. Knowledge of HIV status is key to the achievement of both these goals. A key objective of the NSP of scaling up HIV Counselling and testing (HCT) is to facilitate universal access to prevention, care and treatment through several strategic actions. These strategies include HCT capacity building, use of multiple HCT delivery approaches, access for vulnerable populations and enhanced coordination, supervision and quality assurance. In the *Health Sector Strategic and Investment Plan (HSSIP)*, the goal is to increase the proportion of Ugandans who know their HIV status from 38% to 70% and provide HCT services at 100% health centre IIIs by 2015.

HCT Services in Uganda

HCT has evolved and expanded since it was launched two decades ago, with Voluntary Counselling and Testing (VCT) as the main model of implementation. In 2002 the MoH developed the first VCT policy in order to place high-quality VCT services within the reach of every Ugandan. This worked well but only a small percentage of the population accessed HCT services. With the advent of ART and evolution of new innovative approaches, HIV dynamism and international policies, there arose need to broaden the base of counselling and testing in order to meet these standards. Consequently, the HCT policy was revised in 2005 to cater for new HCT approaches including provider-initiated HIV testing and counselling in the health care setting (PITC) and home based HIV counselling and testing (HBHCT).

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[1] MOH. (2006). *Uganda HIV/AIDS Sero-behavioural Survey, 2004-2005.* MOH and ORC Macro.

[2] Shafer LA, et. al. (2006). *HIV Prevalence and Incidence no longer falling in Uganda. A Call for Renewed for Prevention Efforts: Evidence from a Rural Population Cohort, (1989-2005) and from ANC Surveillance.* Toronto: 16th AIDS International Conference. Abstract THBLB0108.

[3] Stoneburner, R. et. al (1998). Simulation of HIV Incidence dynamics in the Rakai Population-based Cohort, Uganda. *AIDS* , 26-228.

Using the 2005 HCT policy guidelines, strides were made in the implementation of HCT services, with HCT service points more than doubling from 554 sites in 2007 to 1,215 sites in 2009. The 2005 HCT Policy laid emphasis on new models of HCT, expanded entry points into care, provision of services to children, use of lay workers and testing in the community.

Changes in HCT policy and programmatic requirements, emerging evidence and updates in HCT at international and Ugandan levels necessitated HCT policy review in 2010. Uganda is signatory to the Millennium Development Goals (MDGs) and other international declarations that focus on universal access to HIV prevention and care.

Policy Guidance

In line with the revised *Uganda HIV Counselling and Testing Policy 2010,* these HCT implementation guidelines respond to the emerging HCT policy and programmatic needs. The implementation guidelines will operate within the scope of the national and international polices; in alignment with national plans and in harmony with other MOH implementation guidelines, (Annex 1). These guidelines will be used in conjunction with operational guidelines for different HCT approaches, training materials, monitoring and evaluation tools and quality assurance procedures.

Development process of the HCT Implementation guidelines

These guidelines were developed following revision of the National HCT Policy in 2010. The writing process was led by a consultant supported by the HCT policy task force. In addition the national HCT guidelines were peer reviewed by two HCT experts. The guidelines were finalized through consensus building in a series of HCT stakeholder consultative meetings.

Target Audience

These guidelines are meant for policy makers, planners, researchers, service providers and beneficiaries.

Purpose

The implementation guidelines operationalise the HCT policy by providing guidance for standardized and high quality HCT services in Uganda.
These guidelines intend to explain and provide guidance on implementation of the policy statements, harmonise and co-ordinate implementation of HCT

services. The guidelines are written in line with the three broad and inter-linked sections of the HCT policy thematic areas namely; Ethical-legal issues, Service delivery and Health Systems

Section 1: Ethical-legal Issues in HCT

1.1 Overview

The provision of HCT services should follow a human rights based approach and should aim at reducing stigma and discrimination. The human rights based approach addresses several issues as outlined in the policy statements. For purposes of explanation, they can be summarised as follows;

a) The right to accurate information and access to HCT and related services

b) The right to quality services delivered under ethical requirements (The 3Cs of Consent, Confidentiality and Counselling)

c) The right to dignity (Non discriminatory and Stigma-free services)

d) Special groups: groups at increased risk of HIV acquisition but may also have limited access to HCT

1.1 The right to accurate information and access to HCT and related services

1.2 Delivery of quality Services under ethical requirements.

In HCT they are summarised into the 3Cs which also constitute the guiding principles of informed Consent, quality Counselling and Confidentiality

Consent for HCT

Like any other health services as provided by the law, Informed Consent for HIV counselling and testing should be obtained and evidence of this should be indicated through signing or thumbprint. In health care settings patients consent once for all services and therefore there is no need for separate consent for HCT. Informed consent is the voluntary agreement the client makes with the service provider having received and understood the purpose of the procedure or the exchange of information. In HCT settings, consent may be obtained from adults and assent obtained from children aged 12 years and above. Details on consent for children are provided in section 2.4.

Appropriateness
Counselling and testing services must be appropriate and sensitive to the client's circumstances including language, gender, age, development level and

reason for testing. HCT services will be appropriately adjusted to cater for persons with physical, mental and sensory disability.

Inability to make an informed decision

Unconscious patients: In situations where consent cannot be obtained from the client who may be unconscious consent will be obtained from the next of kin. In order to ensure confidentiality, HCT service providers will make all attempts to identify the next of kin who may not necessarily be the attendant. The next of kin is considered the client/patient's spouse or a close blood relative.

It is important for the service provider to give adequate counselling to the next of kin. The next of kin should be counselled and supported to understand the test results and cope with the impact.

Where consent cannot be obtained from the client or next of kin, the clinical provider will conduct testing when necessary for clinical decisions. But as soon as the client is able to understand, they should receive counselling. If a patient is unconscious and the next of kin asks the clinician to test the patient, clinicians must use their own discretion.

Mental health patients may neither be able to understand information nor be able to make rational decisions. In situations where the client may have cognitive disability, consent will be obtained from the next of kin. Where consent cannot be obtained from the client or next of kin, the clinical provider will conduct testing when necessary for clinical decisions, in the best interest of the client.

People with hearing disability that make it difficult for them to receive verbal information from the counsellor. Also people with speech disabilities may not be able to express their concerns about HIV and HCT to the counsellor well enough to clarify issues. HCT programs need to provide for sign language services through appropriate training of staff or collaboration and referral for sign language services.

People with visual disability or reading difficulties may not be able to use written information to prepare for HCT. HCT providers need to be sensitive to and provide verbal explanations to clients with visual disability.

Children with disabilities are entitled to HCT. Children 12 years and above with disabilities but not mentally impaired should provide assent with the approval of a parent or guardian. They should be taken through the whole process of pre- and post-test counselling like any other child. Parents or guardians of these children should be fully involved.

The counsellor should work together with a parent or guardian and any other person with skills to communicate with children with disabilities (if need arises)

to ensure effective communication during the counselling process. Counselling for the mentally retarded child should be given to the parent or guardian, who also consents on behalf of the child.

Consent in Special situations
For circumstances where testing shall be done to inform medical and other decisions the persons shall be informed and given opportunity to know their results and such circumstances shall include;

- blood and other tissue donation
- occupational and non-occupational exposure

For the exposed person, HIV testing for post exposure prophylaxis shall be done using the HCT protocol. However for the source person, testing will be done if required by court and the person be given an opportunity to know their results or decline if they are not prepared.

Confidentiality

Confidentiality means that personal and medical information, including HIV test results given to a health care provider will not be disclosed to others unless the individual has given specific permission for such release.

In HCT setting, confidentiality will be demonstrated by the privacy in the interaction between the client and the service provider. In line with the process of integration of services, there will be 'shared' confidentiality and referral among service providers in the best interest of the client. In line with the provision of Provider Initiated Counselling and Testing (PITC), the client/patient's HIV test results will be documented as part of the medical history on file.

Confidential rather than anonymous service provision enhances client care and support in HCT settings.HCT sites will ensure client confidentiality through adequate infrastructure, service provider training and quality assurance.

Counselling

Counselling is the confidential interaction between the client and the HCT service provider. Good quality counselling is non-judgemental, accessible and client centred[4].

Counselling in both Client Initiated Counselling and Testing (CICT) and Provider Initiated Testing and Counselling (PITC), counselling is provided on the premise that behaviour change will be more likely to occur when the client

[4] WHO. (2010). *Handbook for Improving HIV Testing and Counselling Services. Field Test Version.* WHO.

explores his/her own risk-taking, determines his/her own prevention goals and develops his/her own action plan. There will however be variation in the content and emphasis of the counselling sessions in the CICT and PITC approaches.

Counselling will be provided to individuals, couples and groups of clients. Counselling assures that clients are provided adequate and factual information to make a decision to test, assess their risk for acquiring or transmitting HIV and adapt risk reduction options.

Quality counselling results in appropriate, timely and acceptable referral and follow-up[5].

1.3 The right to dignity (Non discriminatory and Stigma-free services)

1.4 Special groups

All adults, youth and children should be offered HCT in order to make informed and appropriate decisions about HIV prevention and access to HIV care and treatment services. However, special groups within the general population may require specific consideration due to their potential for increased risk of HIV. Persons within these special populations may have a concentration of risk behaviours for HIV transmission (Most-at-risk populations, MARPS) or may have increased vulnerability due to a range of factors that reduce their ability to avoid HIV infection (vulnerable populations).

MARPS may include commercial sex workers and their partners, long distance truck drivers, fisher folk and uniformed services[6]. Vulnerable populations include discordant couples, young people, children, women, people with disabilities internally displaced persons, refugees and other persons of concern to United Nations High Commission for Refugees (UNHCR).

All HCT services shall be designed to address the unique needs of the persons categorized under special groups. Special groups shall have the right to information, education and communication on HCT adapted to their respective special needs.

HIV/AIDS programs will be designed to ensure that special populations have equitable access to HCT services. Where appropriate, these persons shall be encouraged to be tested with their sexual partners.

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[5] Ibid

[6] UAC (2009): *HIV Prevention Response and Modes of Transmission Analysis*. UAC, GOU

Couples*:* Up to 60 % of new infections in Uganda occur among married people and discordant couples may comprise up to 50% of these infections[7]. HCT is the most important strategy available to promote condom use in stable and especially discordant relationships.

Couples shall be encouraged to go for counselling, testing and receive results together. The privacy and autonomy of the couple and individual must be respected. In situations where a partner has tested alone, disclosure of HIV status, partner(s) notification and testing shall be encouraged.

Couples should be provided with information about where to obtain additional services, including family planning and PMTCT. In addition couples will be informed about and be supported to join support groups, including discordant couple groups, where applicable.

Children: Refer to Section 2.4.

Children who have been sexually abused

Sexual abuse is the involvement of a child in any sexual activity that occurs prior to the legally recognized age of consent (age 18). Sexually abused children should be counselled and tested for HIV and linked to care and support services such as medico-legal, psychosocial and follow up. The decision taken by the counsellor should be in the best interest of the child.

The counsellor should at all times keep up the relationship with the child and the parent or guardian and keep providing support.

Persons with Disability (PWD): People with disability (physical, mental or sensory) and disabled women in particular, are likely to have more sexual partners than their non-disabled peers. Disabled individuals are more likely to be victims of sexual abuse and rape than their non-disabled peers. At the same time disabled persons may have lower literacy rates, and depending on the type of disability communication of HIV/AIDS messages may be more difficult. Care and treatment services for disabled persons may also be physically inaccessible[8].

Provisions should be made for PWD to access HCT services in a manner that meets their specific needs. Providers should be trained to address the needs of PWD which may include incorporating sign language, assessing capacity of the PWD to consent for HIV testing and receive results, and providing appropriate referrals. Where possible, HCT facilities will be remodelled to allow access for the physically disabled.

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[7] ibid

[8] UNAIDS. (2009). *Disability and HIV Policy Brief, UNAIDS/WHO and OHCHR.*

Health workers: Health workers are a special category in relation to HIV/AIDS. In addition to sexual transmission, health workers are at increased risk of contracting HIV as an occupational hazard. Health workers living with HIV/AIDS may face discrimination and stigma at their workplaces which affects access to HIV services.

HCT for health workers should be provided in a manner that addresses issues of discrimination, stigma, confidentiality and privacy. Privacy should be ensured by having separate space, time dedicated to providers and choice of providers if required.

Health workers should act as role models and are therefore encouraged to access HCT and other related services for their own benefit and that of their clients/patients. Health workers should receive a full HCT package like all other clients.

Refugees, Internally Displaced Persons and other Persons of concern to UNHCR:

Emergency affected populations have more difficulty accessing quality HIV services and may be more susceptible to discrimination, violence and abandonment, upon disclosure of an HIV positive result. HCT for these vulnerable populations should always be voluntary and additional effort must be taken to ensure informed consent[9].

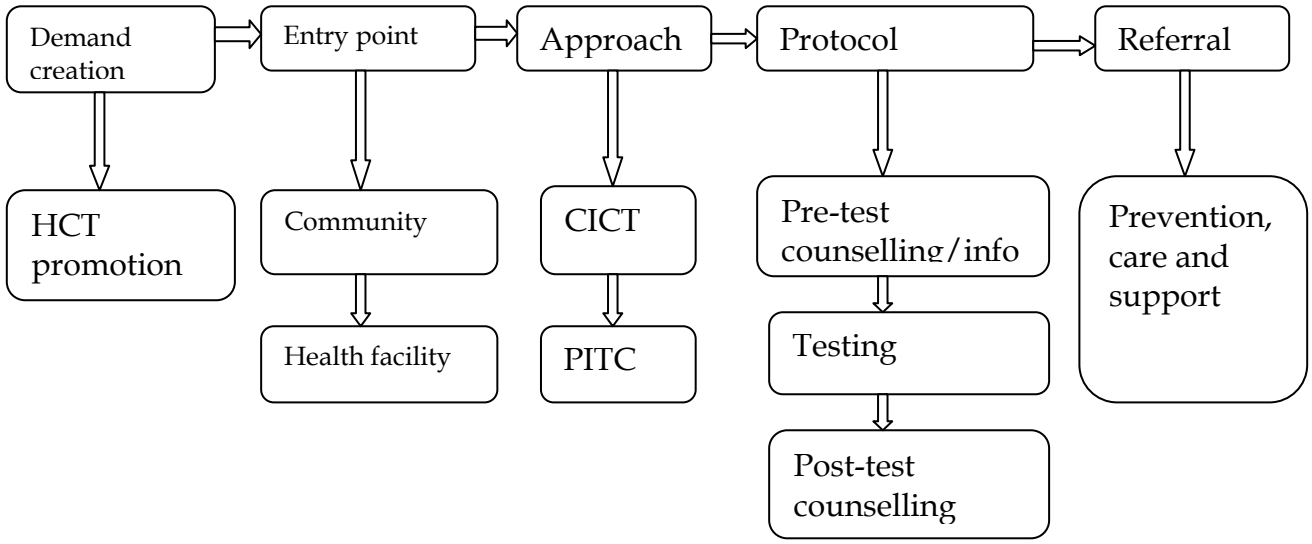
Provision of HCT to refugees and IDPs must be accompanied by ensuring access to HIV prevention, care and treatment services and referrals to supportive social, policy and legal environments for those testing HIV-positive and those at most risk of acquiring HIV.

[9] UNHCR. (2009). *Policy Statement on HIV Testing and Counselling in Health Facilities for Refugees, Internally Displaced Persons and other Persons of Concern to UNHCR.* UNHCR/WHO/UNDP.

Section 2: HCT service delivery

HCT is a core intervention in the comprehensive strategy of the government and its partners to address HIV/AIDS in Uganda. In line with universal access, HCT services will be promoted and provided at convenient locations for all eligible populations.

Figure 1: The HCT Journey



2.1HCT Approaches

2.1.1 Client Initiated Counselling and testing (CICT)

Definition: CICT (previously known as voluntary counselling and testing) involves individuals and couples seeking HIV testing and counselling services at community and health facility settings. Clients seek HCT services to make important decisions about their own or their families lives; support prevention decisions or as a first step to explain ill health.

Settings: CICT takes place at a variety of settings although services were primarily provided at VCT centres prior to HCT becoming widely available.

Procedure: CICT involves pre-test counselling that may be provided in individual, couple or group sessions. Following group sessions, individual or couple sessions, HIV testing and post-test counselling are conducted. The counselling for CICT is typically aimed at assessing individual and couple risk for HIV infection, identifying and supporting HIV risk-reduction measures.

2.1.2 Provider Initiated testing and counselling (PITC)

Definition: PITC is also referred to as routine offer of HCT and involves health workers offering HCT as a standard of health care to all patients attending health facilities regardless of reasons for the visit. PITC aims at identifying HIV infected individuals early in the course of their illness and linking them to care and treatment services.

Settings: PITC shall be provided at all health facility settings.

Procedure: PITC is offered to all clients by the health provider. Particular emphasis is placed but not limited to high prevalence clinics and wards. Such service points include maternal and child health services, adult and paediatric in-patient wards, TB, STI/STD and family planning clinics, and clinics managing survivors of sexual abuse. All health workers/service providers at the health facilities should have knowledge and skills in provision of PITC.

In clinics, the 'opt –out' approach is applied, where HIV testing is done with other relevant tests unless the client refuses. Refusal of testing should be documented in the client's records. Health workers need to be trained to provide adequate information, understand that HCT in this setting is not mandatory and patients should be informed of their right to accept or decline HIV testing.

Other types of HCT

Testing in research and surveillance settings: Unlinked surveillance or anonymous epidemiological testing, whether to assess HIV infection trends and impact, may be undertaken provided it complies with ethical principles of scientific research, professional ethics and protection of individual rights and confidentiality and safeguards anonymity.

All testing conducted in research settings should be pre-approved by the relevant ethical review boards. Whenever possible, individuals who are tested for surveillance purposes should be given an opportunity to know their HIV results.

2.2 HCT service delivery settings

HCT services may be provided in community setting or at health facilities. Regardless of setting, HCT providers should adhere to the recommended counselling and testing procedures.

HCT at community settings

- A *free-standing* site should be located in high-population-density areas with the aim to attract populations that otherwise would not attend HCT services. It should have an easy link with post-test services.
- *Outreach HCT services* from higher level facilities may be provided in smaller health facilities such as levels II and III. Outreach HCT services may also be provided by free-standing HCT facilities to health facilities or communities. Through regular visits to the outreach sites or through community camping where outreach sites are inaccessible.

  To increase HCT access for special groups, innovative means to reach out to these groups should be designed.

  Agencies providing outreach HCT should ensure that follow-up services for prevention, care and treatment are adequate. Creative and innovative approaches to providing follow-up services may be required in these situations. Outreach HCT services should, whenever possible include an integrated package of primary health services, including STD detection and treatment, child health screening and antenatal care. All outreach HCT services should utilise MOH forms.
- *Home based HCT (HBHCT) services* provide the advantage of reaching couples, men and eligible children in households. Services are provided at provided at the clients' home through one of two approaches:
    - for family members of clients in care and treatment programs, where such services offer the benefit of supported disclosure and adherence to ART and other medications and;

- 100% full access programs where HCT is offered to all adults and eligible children in high prevalence regions. HBHCT services should be arranged in collaboration with existing health facilities and community support groups to ensure on-going care for HCT clients.

- *HCT at the work place*. HCT services have been successfully introduced by employers at work places to provide high quality HCT services to employees, their families and surrounding communities as part of corporate social responsibility. Individuals and families are able to learn their HIV status and access prevention, care and treatment services.

  Services may be offered within the workplace health facilities or as outreach services in collaboration with public health facilities; or by private providers.

  It is recommended that organisations in Uganda incorporate the provision of HCT services in the work place policy as an integral component of staff welfare.

HCT at health facilities

- *PITC Services* are facility/hospital based located in an existing health facility, level IV health centre and above, where capacity and associated HIV/AIDS services are available. However, level III facilities with adequate capacity may provide PITC. The health facility may be either government or non-government.

- *Integrated HCT* sites may be stand-alone or co-located with a health facility. In addition to offering HCT services, referrals are made to related services—for example TB (tuberculosis), STD (sexually transmitted diseases), FP (family planning), PMTCT and HIV/AIDS care and support. These referrals are provided regardless of HIV test result.

- *HCT in private health facilities*. At a minimum such a facility should have personnel, space for counselling and an HIV testing laboratory. It should offer ongoing care and support for HIV/AIDS patients or should have an established referral system or links with other HIV/AIDS services. The facility should adhere to the national HIV testing algorithm, report using MOH tools and have a quality control link with established reference laboratories.

2.3 HCT in special circumstances

2.3.1 ***Testing in research and surveillance settings****:* Unlinked surveillance or anonymous epidemiological testing, whether to assess HIV infection trends and impact, may be undertaken provided it complies with ethical principles of scientific research, professional ethics and protection of individual rights and confidentiality and safeguards anonymity.

All testing conducted in research settings should be pre-approved by the relevant ethical review boards. Whenever possible, individuals who are tested for surveillance purposes should be given an opportunity to know their HIV results.

2.3.2 Mandatory testing

- Rape, defilement,
- blood and other tissue donation

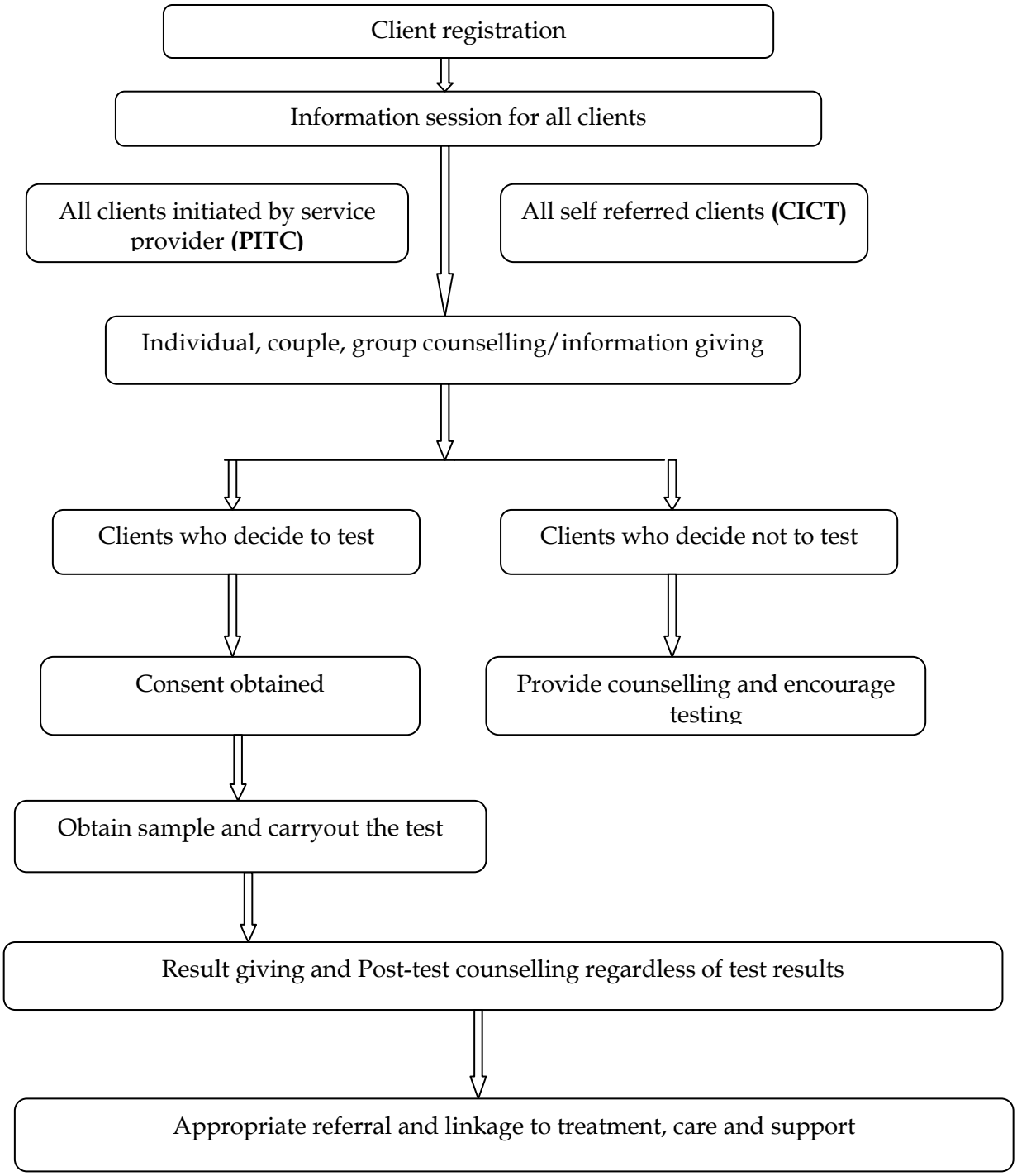
2.3.3 Other circumstances under which testing can be done are PEP/PrEP and SMC.

2.4 The HCT protocols and algorithms

The HCT protocol for HIV starts with client registration followed by pre-test counselling and consent for testing (see figure 2). Pre-test counselling prepares clients for the HIV test and also enables those who decline the test to receive counselling without necessarily testing. A specimen is then collected from clients who consent to testing and the testing procedure conducted.

Depending on the type of test (rapid, PCR etc) and the testing algorithm, the results of the test may be available within an hour or a few days. When the results are ready the client is provided with post-test counselling, during which the test results are given. Clients are then provided follow-up support, which may be available at the HCT site in the form of post-test clubs or ongoing counselling or they may be referred elsewhere for care and support.

Figure 2: HCT protocol



Client registration
Clients should register with their names to enable appropriate referral and linkage to services. All HCT sites must ensure confidentiality of client information. Where HCT is provided in health facilities HCT clients may register like other patients at the outpatient department to avoid being stigmatized.

Pre-test counselling/Information giving

Pre-test counseling may be provided to individuals, couples, parents/caregiver s and children. Where group counselling is provided, individuals need to be provided the opportunity to ask questions, receive personalised information and provide consent for HIV testing.

During pre-test counselling of a couple, the counsellor should ensure that the couple understands the importance of receiving results together. Similarly, people in polygamous marriages/relationships should be given options to come all together, in separate pairs with their partners

At minimum, the following areas should be addressed during pre-test counselling:

- benefits of knowing one's HIV status,
- benefits of couple HIV counselling and testing,
- an explanation of the HIV testing process and the meaning of results,
- The need for consent for an HIV test.
- a summarised version of HIV risk assessment and risk reduction,
- importance of disclosure including mutual disclosure,
- referral and linkage to prevention, treatment, care and support

HIV testing
HIV testing should be performed by a health worker trained in HIV testing

Specimens for HIV testing
Currently, the recommended specimens for use in HIV testing for HCT remain limited to whole venous blood, plasma, serum or dry blood spots. These specimens can either be drawn by using venipuncture or finger prick. Other specimens like urine and saliva may be used after NHRL validates the tests.

Handling specimens
Universal precautions should be observed during specimen handling. Standard operating procedures should be followed to ensure that accurate test results are obtained. Guidelines for sample referral and transportation should be followed.

HIV testing algorithms
HIV testing will be conducted according to a nationally approved algorithm. An algorithm is that combination and sequence of HIV tests that have been

tested and agreed by a reference laboratory to represent HIV testing for a given purpose. There are two common algorithms for HIV rapid testing namely serial and parallel, however serial is recommended for public health use while parallel is reserved for research settings.

Serial testing algorithms: In serial testing two different rapid tests are applied one after another. Each blood sample is subjected to one rapid test (screening test), and if it tests negative it is reported as HIV negative. But if it tests positive it is subjected to a second rapid test (confirmatory test), and if the second rapid test is positive the blood sample is reported as positive. Samples that show positive results on the screening test and negative on the confirmatory test should be subjected to a nationally approved third test (tie-breaker). The outcome on the tie breaker is declared as final test result.

Parallel testing algorithms: Parallel testing means two different HIV rapid tests are applied concurrently (in parallel) to the same blood sample. Samples that show HIV-positive results on both tests are reported as positive. Those that show HIV-negative results on both tests are reported as HIV negative. Samples that show positive results on one test and negative may be subjected to a nationally approved third test (tie breaker test). The outcome on the tie breaker is declared as final test result.

Post-test counselling

Post-test counselling is a face-to-face discussion between a provider and a client(s) with the aim of informing the client of their HIV results and assisting them to cope with the results. The results of the HIV test determine the counselling messages to the client. Confidentiality and privacy should be observed during result giving. Under no circumstances should results be given in a group. Results should be given to clients in written form.

Disclosure of HIV test results should be done to the client(s), however for PITC, when the client is too ill or unconscious; the provider should determine the possibility of the client improving and receiving their test results. Test results may be given to the next of kin who is appropriately identified.

Couples should be counselled together as agreed between the couple and counsellor during the pre-test session. Where individual members of a couple receive pre-test counselling and testing separately, the service provider should reinforce the benefits of, and support the disclosure of test results to the spouse or sexual partner.

The minimum package for post test counselling should include;

- assessing client's readiness to receive test result
- giving the test results clearly, without ambiguity
- assessing the client's understanding of the test result and its implications
- making ongoing plans for risk reduction, partner notification and testing
- making arrangement for follow-up support

- making plans for involving significant others and disclosure
- Referral and linkage to prevention, treatment, care and support

Retesting

Most persons do not require a retesting to validate an HIV negative result. However, it is important to identify individuals who truly require retesting[10]. There is need to reduce unnecessary retesting among individuals who have previously tested and learnt their results. Individuals testing HIV negative should be asked to come back for re-testing if:

1. they can identify a specific incident of HIV exposure in the three months prior to HIV testing
2. they have ongoing risk for HIV infection (e.g. sex workers; having a high-risk or known HIV-positive partner; having clinical indications for re-testing such as newly acquired sexually transmitted infections [STI])
3. Pregnant women in the first and second trimester and for every subsequent pregnancy

2.4 HIV Counselling and Testing for Children

Consent for HCT

Child consent: In Uganda the legal age for consent is 18 years. For HCT, the age of assent should be the age at which the child understands the results— considered 12 years. The right to opt out of testing should also start at age 12.

For children 12 less than 18 years the child can assent and the parent's consent may or may not be sought depending on the child's wish. Parent/guardian approval should not be mandatory at this age. Young people aged 12 – 18 years should have access to HCT services if they so desire particularly the emancipated and sexually active even without the consent of their parents and or guardians. However all young people 12-18 years of age are encouraged to consult with their parents and guardians regarding seeking HCT services and consent issues for purposes of obtaining ongoing support.

For children below 12 years the parent or guardian should consent and for those children without a parent or guardian the head of the institution, health centre, hospital, clinic or any responsible other may sign. If a child below the age of 12 asks for HIV testing, their parents or guardians should be fully involved. If it is established that they can understand the test results, they should be counselled, tested and given their results.

[10] ibid

If the parent or guardian is the one proposing the test, the counsellor should assess if the parent or guardian wants to do the test in good faith. If the counsellor is in doubt, the child should be allowed to decide.

The child should always be told about the importance of the significant other person who needs to know. As the child continues with the sessions someone else should come along—a guardian or someone else of the child's choice, for example, an older sister.

As far as possible, the child should be involved in the decision, along with the parent or guardian.

Counselling

Counselling children will be done according to the child's age.

- For children aged below 12 years: Counselling is offered to the consenting parent/guardian**.** The child only attends the session if the parent/guardian finds it appropriate for him/her to participate.

- For children aged above 12 years: Individual counselling is offered to the child unless the child prefers to have the consenting parent/guardian participate in the session.

Disclosure of test results

In post-test counselling of minors, counsellors should be careful in making a decision as to whom to give results. It may not be to the one who gave consent for the testing. Children should not be tested simply for the parents or guardians to know their own status but for the benefit of the child. Before disclosing results, the counsellor should assess if the parent or guardian is willing to discuss HIV and the test results with the child openly.

Disclosure should be done to the person with whom the child feels most comfortable, the counsellor should work with the parent or guardian to plan for the child's future care if the child is positive. For children who cannot clearly understand the results, the parent or guardian should be fully involved and should sign the consent. The counsellor should provide ongoing support and counselling until the child is old enough to be disclosed to.

Children aged 12 years and above should be given results after counselling. If the child sought HIV testing alone, the counsellor will discuss involvement of the parents or guardians to provide additional support for the child. Children below 12 years of age should be given results only with the consent of parents or guardians and with proper counselling.
In all groups mentioned above ongoing counselling and support should be provided by parents or guardians and the counsellor. Never should anyone lie to a child of any age about their HIV results.

Disclosure is a process that should be done at the judgment of the counsellor and parent/guardian. Counsellors should aim at disclosing the status of children by 10 years.

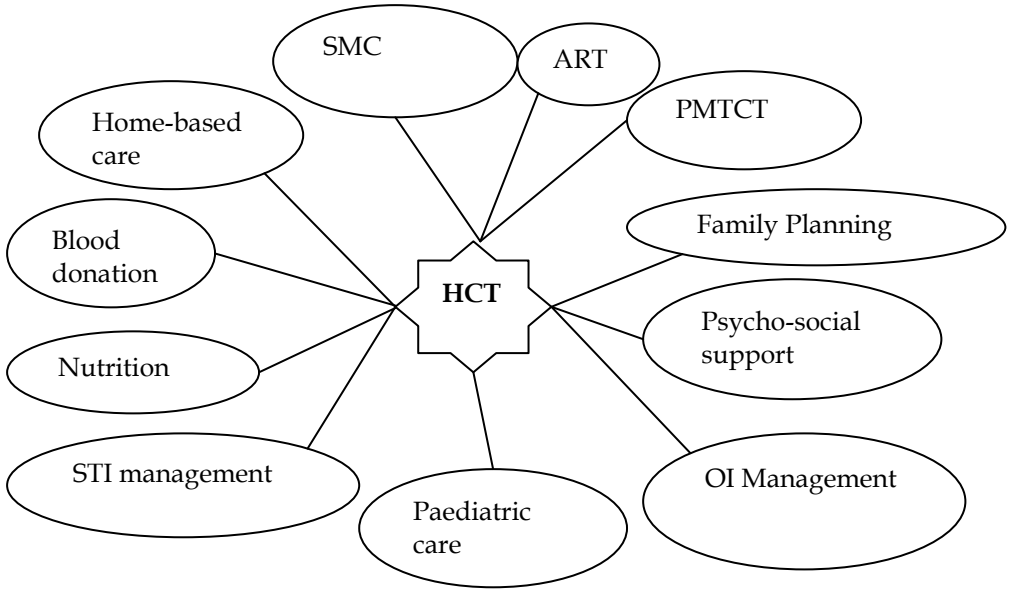
The process of disclosure is a responsibility of the parent/guardian with support of the counsellor.

2.4 HCT linkage to prevention, care and treatment services

All clients that have received HCT services should be linked to prevention, treatment, care and support. HCT service delivery points should ensure provision of effective referral and linkage mechanisms. Appropriate information about services to which the client is referred and linked should be provided; and mechanism for documentation, feedback and monitoring should be put in place.

A referral directory should be available that shows the scope and nature of services provided at various sites. The referral directory shall be regularly updated in consultation with the DHO and should have provision for linkage to community structures, including village health teams. MOH standard referral forms shall be utilized by all HCT service providers. A universal results slip shall be used for referral that documents the client's name, HIV test result and reason for referral. See 'Referral form' in the appendix X).

Figure 3: linkages and referral services



2.6 Integration

Integration is significant in HCT service delivery as it reduces missed opportunities, reduces HIV-related stigma and discrimination, improves utilization of services and competence of service providers and enhances convenience for clients. It also enhances programme effectiveness and efficiency.

Integration of services is important for early detection of HIV and access to other services. All service points such as TB, FP, STD, ART, PMTCT, Safe Male Circumcision (SMC) etc should have HIV Counselling and Testing incorporated.

For all these programs the guiding principles of HCT (the 3C's) should be observed

Integration with tuberculosis services

Key approaches for TB/HCT integration include the following:

- Actively promote HCT among TB clients by distributing information materials and health education talks by HCT counsellors in the waiting rooms of the TB clinic. Also during individual consultations health workers should routinely offer HCT to all TB patients as standard of care.
- Introduce on-site HCT services at TB clinics.
- Conduct clinical assessments for TB among HCT clients who test HIV positive.
- Refer suspected TB patients to the TB clinic for additional assessments.
- Improve access to a comprehensive package of care for TB clients.
- Train health workers and community service providers about the integrated approach.

Integration with services for sexually transmitted diseases

HCT providers should take an active role in assessing HCT clients for STDs. It is highly recommended that STD screening be offered to all HCT clients, and when possible, syphilis testing should be performed on the same blood sample as that used for HIV testing.

If possible, on-site syphilis treatment should be offered immediately to any HCT client testing positive for syphilis. During the visit, HCT clients should be informed about STD services available on site and the importance of syphilis testing.

Integration with family planning services

Basic family planning information should be incorporated into all HCT counselling sessions, for both HIV-positive and HIV-negative clients. Especially for HIV-positive clients, the risks of mother-to-child transmission should be explained and the benefits of family planning should also be explained. 'Dual

protection,' which is use of condoms for HIV and STD prevention and hormonal contraceptives for family planning, should be emphasized in the counselling session. Where possible, family-planning services should be provided at the HCT site.

In the event that family-planning services are not available, clients should be counselled and referred for family planning and vice versa.

Integration with maternal, newborn and child health (MNCH) services

All women should have access to HCT services before they conceive so that they can make informed decisions about pregnancy and family planning. Pre-pregnancy couple testing should be provided and couples encouraged to utilise this opportunity.

PITC should be offered as part of the MNCH care package (ANC, Labour & delivery, PNC). A strong link should be established between the general HCT clinic and the testing services being offered at the ANC, PNC and Labour ward to facilitate access by pregnant women and their male partners. HCT should be offered alongside other routine ANC laboratory tests at the first ANC visit or earliest contact; repeat testing should be offered after three months for women testing HIV negative[11].

In the Young Child Clinics all HIV exposed and suspected children must be referred for HCT services including their mothers. Refer children with HIV-like symptoms identified during immunization for HCT and related services. All HIV-positive children identified in HCT should be checked to ascertain if they received all immunizations; if not they should be referred for immunization.

Integration with safe male circumcision (SMC) Services

SMC reduces chances of heterosexual HIV transmission. Men and their spouses should have access to HCT services as an integral component of SMC services in order to make an informed decision to undergo the procedure and inform future HIV risk reduction plans[12] (Placeholder14, SMC Policy).

2.7 Strategic communication in HCT

Promotional activities are an important component of creating demand for HCT services through increasing personal knowledge of HIV status, raising awareness to decrease the risk of acquiring or transmitting HIV and increasing early access to prevention, care and treatment. Some of the promotional approaches include:

- Mass media through electronic and print

[11] MOH. (2006). *Policy Guidelines for Prevention of Mother-to-Child Transmission of HIV*
[12] MOH. (2010). *Safe Male Circumcision Policy* . MOH.

- Information, education and communication materials addressing all elements of the HCT service. These materials should be available at all HCT service points.
- Interpersonal communication and peer support programs to mobilize specific target groups including:
    - clients and patients seeking other services such as for sexually transmitted diseases (STDs), TB and antenatal care (ANC) as well as the general outpatient clinics;
    - hard-to-reach people such as commercial sex workers and their clients by approaching them at locations such as bars, hotels and discotheques;
    - Other special groups such as highly placed people and the elite, and health providers should be especially targeted using favourable environments.
- International, national and sub-national social events and testing days such as Youth Day, Valentine's Day and World AIDS Day.

Section 3: HCT Health Systems

3.1 Coordination

In order to ensure harmonised delivery of HCT, services will be coordinated at national, district, health sub-district and site level.

National level

At national level, the Uganda AIDS Commission (UAC) provides overall coordination of the multi-sectoral response to HIV/AIDS.

The MOH through the AIDS Control Program (ACP) coordinates HIV/AIDS health sector technical programs in Uganda, including HCT. Specific technical tasks are implemented through the national HCT coordination committee (CT 17), that comprises representation from key HCT service organisations, development partners and donors. Under CT 17 there are five sub committees namely;

- Policy and research
- Laboratory and logistics
- Quality insurance M & E
- Capacity building
- social mobilisation

Through the CT 17, MOH is responsible for HCT:

- coordination of HCT partners
- planning, policy formulation and setting standards
- capacity building
- advocacy and resource mobilisation
- equitable distribution of HCT services across the country
- supplies and logistics management
- quality assurance, monitoring and evaluation
- research

District and sub-district level

The District Health Team (DHT) guides and ensures effective implementation of HCT services in the district in collaboration with other relevant district committees. The DHT should assign an officer to coordinate HCT services.

The DHT is responsible for:

- coordination of HCT partners
- planning HCT implementation
- advocacy and resource mobilisation
- demand creation for HCT services
- supervising HCT service delivery
- managing HCT supplies and logistics
- data management and reporting

HCT service delivery points

HCT is provided by a range of providers at community and health facility levels. Each service delivery point should assign an HCT supervisor. With support of the DHT and coordination of the supervisor the service delivery point should ensure:

- quality service delivery
- internal support supervision and mentoring of service providers
- timely and accurate ordering of HCT supplies and logistics.
- effective referral and linkage for prevention, care and treatment services
- good data management and timely reporting
- community mobilisation for HCT
- coordinate community HCT services (home to home, workplaces, special events and outreaches)

3.2 Human Resource and capacity building

HCT must be performed by qualified personnel trained; HCT providers must be well trained in HCT using MOH recognized training standards. HCT service points should ensure deployment of competent staff with appropriate training: include counsellors, lab personnel, and counsellor/lab assistants

HCT service providers

HCT must be performed by qualified personnel who include counsellors, counselling assistants, laboratory personnel, clinicians, nurses, midwives and community counselling aides.

HCT Personnel must be well trained in HIV Counselling and Testing (HCT) using MOH recognized training curriculum.

An HCT provider must be competent and proficient in providing pre- and post-test information or counselling including HIV testing.

When staff is limited, appropriately trained assistants may provide these services under supervision.

HCT sites should ensure that all HCT providers have sufficient knowledge, skills and attitudes to offer comprehensive HCT services as per the different models available in the country.

All HCT providers must be trained using the nationally acceptable training standards for every HCT model.

HCT Provider qualifications

HCT service providers should have an educational background of at least 'O' level or its equivalent. This applies equally to those with or without a medical background.

Performing an HIV test

HIV testing may be conducted by laboratory technicians and other medically trained personnel or counsellors. Non-laboratory personnel should be supervised by a qualified medical laboratory technician.

In Uganda, clients must NOT perform their own HIV tests.

Training in HIV counselling and testing

All HCT providers must undergo the initial HCT training using the available national HCT training curriculum. This training should not be less than two weeks of classroom instruction and one week of supervised practical experience.

All HCT training must be conducted by trainers approved by MOH.

All HCT providers (including lay and medical personnel, lab staff, and those who have and have not participated in standard training) must:

- Meet minimum educational qualifications
- Demonstrate mastery of content of an MOH approved HCT curriculum,
- Complete 3 months of supervised practice with endorsement by a counsellor supervisor, and
- Pass a final assessment.

After earning the basic certificate to provide HCT, providers can then be oriented in the different models of providing HCT depending on their organization's or institution's mandate.

HCT providers should regularly update their knowledge through refresher and in- service training. Health workers are required to earn 24 hours of Continuing Medical Education (CME) per year as national guidelines. Non-medical HCT providers should participate in an equivalent number of hours of refresher training per year in order to assure highest- quality HCT services.

Qualification of HCT Counsellor Trainers

HCT Trainers should have the following qualities:

- Possess counselling skills
- Have experience of not less than 6 months; providing HCT services
- Have training of trainers (TOT) skills.

- Be oriented in the standardized HIV counsellor training courses approved by MOH.

Background education of counsellor trainers may be medical or non medical, but counsellor trainers should have strong background knowledge on HIV/AIDS.

The trainer's knowledge and skills should be regularly supervised, reviewed and updated so as to remain relevant.

2.8.6 Certification and registration of HCT providers

HCT providers shall be certified by the Ministry of Health, through accredited HCT training institutions in Uganda. The process of counsellor certification and enrolment in a national register will soon be determined by MOH.

HCT Provider Support Supervision

HCT providers need support to:

- Prevent burnout
- Share experiences and learn from each other
- Receive technical updates
- Provide quality control

HCT providers should also receive support and learn through regular de-briefing meetings with their supervisors.

Supervisors should be professionally competent and provide personal and professional support during supervision meetings.

Individuals to provide HIV counsellor supervision should be well trained using a curriculum approved by the Ministry of Health.

HCT implementing programs should institutionalize counsellor support supervision activities to provide regular support to HCT providers.

Referral

HCT providers should work within their skills levels and refer any client for further support to more professional counsellors.

HCT implementing programs should establish appropriate collaborative relationships with the professional counselling body in the country to ensure comprehensive support for HCT clients.

3.3 HCT logistics management

Procurement and distribution

The National Medical Stores (NMS) is responsible for procurement and distribution HCT and other laboratory supplies to district stores, through a laboratory credit line. The NMS will maintain a stock of rapid test kits for back-up distribution when needed.

The districts are responsible for distribution of supplies to HCT sites. The distribution mechanism from districts to facilities will be reviewed and strengthened through regular training of district and health facility staff.

Quantification of HCT commodities and supplies and assessment of the operation of the laboratory credit line shall be conducted annually. Reports on consumption of HCT commodities will be coordinated by MOH personnel at all levels, in collaboration with HCT implementing partners. There will be regular reviews for the quantification process and distribution of funds per health facility.

The Joint Medical Stores (JMS) on the other hand receives HCT supplies and health commodities from NMS for distribution to faith based (mission) partners.

Evaluation of test kits

There shall be periodic evaluations and quality assurance of the HCT methods. Protocols for quality standards for reagents will be developed, printed and distributed regularly to all the facilities doing HCT.

The quality of laboratory diagnosis of HIV will continuously be monitored. Poor performing laboratories will be identified and supported through corrective actions.

Evaluation of HCT algorithms

In order to regulate the number of algorithms that can be used in the country, HIV test kits and algorithms will be evaluated by the MoH, through the Uganda Virus Research Institute

Selection of test kits for HCT in public facilities

Issues to consider when selecting test kits from among those that NHRL has validated:

- cost,
- shelf life,
- ease of use,

- ease of storage,
- consistency of use in the country, considering that laboratory personnel perform better on kits they have been trained to use
- alternatives to use when there is a stock out of test kits

Procurement, storage and stock management of test kits

HCT supplies and commodities approved by the MoH are essential to delivery of quality HCT services. Effective supply chain management system is critical for maintenance of adequate levels of stock for sustained service delivery. MoH will ensure availability of adequate essential HCT supplies and commodities at all levels. Functional Logistics management systems shall be utilized at all levels

The quantity of test kits required will vary from site to site depending on the volume of clients expected, the testing algorithm adopted and the prevalence of HIV. Additionally if other medical tests such as for syphilis are provided as part of HCT service in stand-alone facilities the relevant supplies will be necessary.

An estimate of the expected volume of clients should be made. Factors to consider when making service uptake estimates:

- increase in demand as the centre gets known
- demand of outreaches and other institutions wanting to use testing facilities of your site
- effect of specific promotional activities
- the shelf life of the test kits purchased
- guidelines from the National Health Reference Laboratory (NHRL)

Training in logistics management

NMS provides training in logistics and stock management to district logistics staff. HCT providers receive training to build capacity to:

- forecast requirements for essential reagents and other supplies for HCT
- collect and use accurate supply chain information,
- store, manage and distribute commodities appropriately.

Record management

There shall be guidelines for proper laboratory reagent records, storage and practices. Simple and user friendly tools shall be put in place to ensure that all information is generated and used for improvement of services.

3.4 Infrastructure

At minimum, HCT services must have personnel, space for confidential counselling, and a laboratory or materials for conducting HIV testing. HCT will be conducted according to the service guidelines described in Section 2.3.

Hours and days of service

Where resources permit, HCT should be provided during all working days. In higher level health facilities (hospitals and health centre IVs), HCT should be offered daily and provided on all high prevalence wards and in the OPDs.

Effort should be made to recruit enough HCT providers who can work in shifts, thus providing HCT on weekends also. HCT may be provided after normal working hours to provide for special population groups, including commercial sex workers and their clients.

In health facilities where resources are limited and HCT is provided only on specific days, effort should be made to ensure that HCT services are provided on the same days as TB, FP, STD and SMC services. HCT outreach services remain an important complementary measure to reach communities that do not have stationary HCT sites. Of necessity many outreach services, because they are short staffed, can operate only on selected days of the week.

Hours and days of service are to be determined by the site management based on community social activities, in consultation with community leaders.

3.5 Financing HCT services

HCT should be considered a public health preventive service and should be free in public health facilities. The Ministry of Health provides free HIV test kits to all public HCT sites including NGOs.

Fees and cost sharing: When possible, it is recommended that HCT services be provided free of charge, especially in low-income communities. An affordable fee may be charged to enhance the sustainability of HCT services, but the fee should not be a barrier to access to services.

If a health facility charges a fee, it should be approved by the facility management. If it is a government facility, the fee should be approved by the DHO's office and guided by national policies. The fee should be posted clearly so clients know in advance what it will be, and receipts should be given. If a fee is charged, discounts or waivers should be put in place to render free services for clients unable to pay.

The site manager determines whose fees should be waived based on recommendation from the counsellor. Free days may also be considered as a way of attracting clients for whom a fee would represent a barrier to using HCT.

3.6 Planning, Monitoring and evaluation

Monitoring and evaluation of HCT services should be done in line with the Uganda PMMP[13].

Monitoring

A functional monitoring system is essential in delivery of quality HCT services. This requires appropriate tools for data collection and reporting. Storage, analysis and utilization of data are critical elements of Management Information System.

MoH shall ensure that standard HCT data collection and reporting tools are available and utilized at all HCT service delivery points. MoH standard mechanisms for HCT data storage and reporting should be adhered to by all implementers. Monitoring and Evaluation of HCT services should be in line with the National Monitoring and Evaluation Framework for HIV/AIDS in the health sector. HCT programs should document referrals to prevention, care and support services.

Management information systems (MIS): During the planning phase, a system should be established for routine MIS, to consist of client name, address, age, sex and brief risk-assessment data. Routine MIS forms should be adjusted to incorporate key HCT data. Any special information desired from HCT clients should be collected during special evaluations that are well managed and time limited.

Inputs and outputs: Monitoring should keep track of programme inputs as well as outputs. This information should be made available to programme managers at the site and at district and national levels to be used in the planning cycle of HCT programmes. This information is also vital on a day-to-day basis in forecasting and planning commodities.

Initial assessment

Before starting a HCT site it is recommended that an initial assessment be carried out to determine the suitability of location, space, infrastructure and personnel, and the training needs of the providers. Programme planners and managers should consider

[13]UAC. (2007). *National Performance Measurement and Management Plan for HIV/AIDS in Uganda 2007/8-2010/15.* UAC.

the outcome of these assessments to determine what the resource needs are for setting up the programme.

Information collected during initial site assessment should be used as a baseline against which subsequent planning, monitoring and evaluation should be based.

Initial assessments should have two components:

Assessment of HCT-related services
An assessment should be carried out on a selected sample of potential HCT sites health facilities including NGOs and private facilities in the district. For each site the assessment should include the following:

- Exit interviews of a sample of clients attending the following HIV/AIDS-related services at the facility: TB, STD, FP, ANC and HIV/AIDS care and support clinic if available. The aim is to obtain an idea of the services received and client satisfaction and need for HCT services.
- In-depth interviews with the facility manager and with providers of the specific services listed above. The aim is to assess current constraints and opportunities as well as their views on how HCT services should best be delivered and their HCT related training needs.
- An observation of service delivery sessions of a sample of the above services.
- A review of the nature and quality of records.
- A review of the state of supplies for the above key services.
- Assess infrastructure like counselling rooms and lab.

Community Assessment: Community members' knowledge, attitudes and practices regarding HIV and HCT should be assessed. This will inform the programme of community knowledge of the benefits of HCT and the proportion of community members who have ever been tested. It will also provide information about their views and feelings regarding the introduction of HCT. Where resources permit this could be carried out as a quantitative survey on a statistically representative sample of community members.

Qualitative methods could also be used. For example, participatory rural appraisal (PRA) methods have been used to determine community views, perceptions and attitudes to HIV/AIDS and HCT in the district. Community members can be recruited to assist in gathering information using semi-structured interviews and focus group discussions. After such an assessment a community action plan can be developed and shared with stakeholders before service. See community mobilization, section 2.3.1.

Input indicators

It is important that programme inputs are clearly documented. Examples of input indicators include the following:

- Meetings held with district authorities and local NGOs to establish HCT sites in the district
- Equipment procured
- Counselling service providers trained by type and number
- Laboratory personnel trained in HIV testing
- Amount of money provided for operational costs of each site
- Quantity of supplies procured (including test kits)

- Counselling and laboratory personnel who have received refresher training
- Support supervisory visits from Ministry of Health, District, HSD supervisors.

Output indicators

HCT service indicators. To have statistical meaning and provide a basis for improved programming, the numbers of clients receiving HCT should be based on well-defined denominators.

Level of integration. Monitoring the level of integration of HCT with TB, STD and FP services is an important programme indicator. Proportions of STD, TB and FP clients receiving HCT should be periodically analysed to determine the trend.

Post-test club indicators: Centres with facilities for PTC should keep a record of the number of registered members (new and cumulative) and the number of members attending specific PTC services and activities. Centres with no PTC facilities should refer clients to other sites with these facilities and report the number referred for PTC. This may be done on a quarterly basis.

Information flow

Information should flow from the grassroots upward: from the HCT centre to the health sub-district (HSD), the district of health office (DHO), MOH, and ultimately to the Uganda AIDS Commission (UAC).

HCT data in a given district from all types of facilities (MoH, NGO, private) should be submitted monthly to DHO. Service statistics should be used to monitor utilization of HCT services at both local and central program management levels. HCT monitoring data should be aggregated without client identifiers. HCT date should, however, be disaggregated by gender, age and number of couples.

Counsellors and laboratory staff at HCT sites should collect and keep raw service data in MOH registers and client forms. Where possible, data management staff should enter these data in computers.

At the DHO, data are analysed and feedback is sent to the HCT site. Data from all HCT sites are merged and used for district-level coordination and planning. Merged district data is then sent to the national level, where it should be further compiled into a national report which should be disseminated widely to all stakeholders. Similarly merged national data should be sent to the district for information and motivation. At the district level HCT data management should be handled by trained HMIS officers.

Evaluation

Evaluation is important to assess feasibility, acceptability, and effectiveness of HCT interventions, and informs evidence based programming.

HCT related studies in Uganda shall be done with the knowledge and in consultation with the MoH. To inform the studies, MoH shall provide guidance on HCT priority research issues. All HCT research shall conform to the relevant legislation and ethical standards of practice set by appropriate research ethical

committees and bodies of government at various levels. There shall be regular dissemination of HCT research findings to all stakeholders.

Systematic evaluation of the HCT programme in a given location should be undertaken. This could consist of a client's survey of knowledge, attitudes and practices (KAP) as well as the client's intention to change behaviour. Such an evaluation could be carried out regularly for a limited period, for example, for 1 month every 2 years. In addition, ad hoc qualitative evaluations could be carried out to assess the quality of service delivery. Internal and external evaluation of quality of services should be done periodically. Tools such as a checklist of counselling content could be used to observe counselling sessions. Client exit interviews and mystery clients could also be used to assess client satisfaction.

Process evaluation
Process evaluation uses information such as service delivery data, supervisory reports, client satisfaction, provider views and quality-assurance data. It is important to elicit client feedback. Three useful methodologies for process evaluation include client exit interviews, mystery client surveys and observation of counselling sessions.

Impact evaluation
At each district, indicators of HCT impact should be developed that focus on client behaviour and on care and support issues. Ideally a survey should measure baseline levels of these indicators before HCT services start. However, because of the urgent demand for HCT services many of these services have been started before a systematic baseline survey could be carried out. It is therefore recommended that districts carry out cross-sectional surveys using these indicators in evaluations to be carried out once every two years.

Specific research studies
At district and national levels HCT stakeholders should develop an HCT research agenda. In addition to evaluating programme impact and process, specific research studies should be carried out to answer research questions regarding HCT. For example, operations research could be carried out to test the feasibility of new HCT protocols, such as finger stick testing protocol, or to examine provider and client acceptance of new services, such as TB prophylaxis.

Studies could be designed to test the impact of interventions such as training of counsellors on PITC. Cost analyses should be conducted to determine cost effectiveness of HCT and cost per client served.

3.7 Quality Assurance

Quality Assurance (QA) in the context of HCT refers to adherence to set standards; quality control and quality improvement. Performance monitoring enables identification of gaps and provides opportunity for improvement and achievement of intended results.

Counselling Quality Assurance

Counselling provides the backbone for support of clients' HIV prevention, care and support decisions. To ensure quality in providing services, the counselling staff should be well trained and supervised to provide client-centred, comprehensive and supportive services.

All HCT service providers should receive training and support supervision as described in section 2.8. Counselling sessions may vary in length depending on the client's individual needs, setting and counselling approach. However, all counselling sessions must be provided according to protocol, in an open, empathetic and non-judgemental manner.

In addition to regular support supervision, quality of counselling may be evaluated through self-evaluation, mystery clients, sit-in sessions, counsellors' meetings, fellowships, exit interviews, suggestion boxes, and community assessments.

Testing Quality Assurance

Validation of HIV test kits
All HIV test kits used in Uganda for various purposes including research should be validated before they are imported, on their arrival and during their use, as a quality control process. A new batch of test kits should be tested alongside the existing batch, using retained samples of known HIV status.

Testing materials and supplies should be are well stored, should not expired and should be handled by trained HCT service providers.

HIV testing standard operating procedures (SOPs)
HIV testing standard operating procedures should be available on site, displayed, read, understood and adhered to. Manufacturer instructions shall be carefully reviewed for any new information on the test kits.

HIV testing algorithm
Adherence to the approved HIV testing algorithm will be regularly assessed as a key QA measure.

Eternal quality control
Every HCT site should be linked to a higher-level laboratory, which should be equipped with more advanced HIV testing techniques for quality assurance,

training and supervision. For external quality control, 3% of HIV-positive and 3% of HIV-negative samples should be retained and sent to a higher-level laboratory for retesting and comparison between HCT site and reference laboratory results.

External quality control may also be performed through proficiency testing, where the UVRI creates blood samples of pre-determined HIV status, sends a panel of different samples to HCT sites for testing which then send back the UVRI. This approach compares concordance of HIV testing results between the national laboratory and HCT sites.

Where results issued to the client differ from the results obtained at the reference laboratory, appropriate follow-up remedial action is undertaken.

Supervision of laboratory work

To supervise the HIV testing process, a senior laboratory technologist should carry out the following:

- Observe the process and quality of performance of the laboratory test according to set standard operating procedures.
- Examine and support the process and quality of processing blood samples.
- Examine the process of recording and reporting HIV test results.
- Assess the state of storage and of requisitioning supplies.
- Ensure timely submission of quality-assurance samples to the quality-assurance centre.
- Assess if the equipment is functioning satisfactorily and determine the need for maintaining or replacing it.
- Document supervisory activities using a checklist.
- Assess human resource needs for lab HCT service provision and give recommendations to the service manager.
- Ensure that an institutional policy on accidental exposure exists and is well known to all staff.

Quality Data management

All data (manual or electronic) obtained from patients/clients will be kept confidential at all times. Access to HCT cards, registers, referral notes, care and integrated registers will be accessed by authorized health workers to make a decision on patient/client management.

Data obtained from HCT services such as the number of clients counselled, number tested, discordance rates, and the number of negative and of positive clients should be collected and analysed in a timely manner, as it provides useful information for improving the service. At an appropriate time HCT data management system may be integrated in the traditional HMIS.

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Annex 1. Policy Guidance for development of HCT implementation guidelines

These HCT implementation guidelines will operate within the scope of the national and international polices; in alignment with national plans and harmony with other MOH implementing guidelines.

International guidelines

- Centers for Disease Control and Prevention (CDC) Recommendations on HCT, 2006
- WHO/ILO Discussion Papers on HCT
- WHO PITC Guidelines
- WHO re-testing Guidelines

National guidelines

- The Constitution of the Republic of Uganda, 1995
- The National Health Policy
- Decentralization Policy
- Health Sector Strategic and Investment Plan 2010/11-2015/16
- National HIV/AIDS Strategic Plan 2007/8- 2011/12
- Early HIV Diagnosis and Care for Infants (2008)
- The National Policy Guidelines On Post Exposure Prophylaxis For HIV, Hepatitis B And Hepatitis C, 2007
- The National Policy on Injection Safety and Healthcare Waste Management
- The National Antiretroviral Treatment and Care Guidelines for Adults and Children 2009
- Uganda Clinical Guidelines, 2003
- PMTCT Guidelines, September 2006
- National Infection Prevention and Control Guidelines, 2004
- The Home based care policy guidelines
- The Uganda National Laboratory Policy, 2009
- Safe Male circumcision Policy, March 2010
- TB/HIV Collaboration policy
- The Cotrimoxazole Prophylaxis guidelines

Annex 2: Glossary of terms

Acute HIV Infection

Acute HIV infection is a highly infectious phase of disease that lasts approximately two months and is characterised by nonspecific clinical symptoms. Acute HIV infection contributes disproportionately to HIV transmission because it is associated with a high viral load. HIV infection may not be detected on antibody-based HIV tests only. persons who are in the phase of acute HIV infection often have flu-like symptoms and may be core infectious than persons with chronic HIV infection.

Attendant

A person who cares for someone who is ill.

Care-giver

Any person other than a parent or guardian who care for a child, including a foster parent; a person who cares for a child with the implied or express permission consent of a parent or guardian or a person who cares for someone who is ill.

Client

An individual who seeks HIV counselling and/or HIV testing and/or support for HIV/AIDS and related conditions.

Client Initiated HIV testing and counselling

A type of HIV testing and counselling in which persons actively seek HTC, often at facilities that offer those services.

Couple counselling

This is counselling provided to sexual partners or intending sexual partners.

Discordant couple

Sexual partners with one testing HIV negative and the other testing HIV positive.

Discordant test results

When one HIV test in an individual is reactive and another test using a different HIV test in the same individual, is non-reactive.

Disclosure

A process where a client the results of his or her HIV test results with their partner, family, friend, community members or care-givers, that is in the best interest of the client and others for the purpose of obtaining their support from an emotional perspective as well as for healthy life style choices that include active prevention of the transmission of HIV to sexual partners or unborn children.

Discrimination

Making an unjust distinction in dealing with people on the basis of their revealed or assumed HIV status, which results in them being denied opportunities, benefits, care or services

Free-standing sites

This is a site offering HCT services that is not physically located in an existing health facility. It may have limited care and support services for HIV/AIDS. It should therefore have a strong referral system with other health services, and efforts should be made to offer other related services such as AIDS care and support, family planning and STD care in an integrated manner.

Generalized HIV epidemic

This is where HIV is firmly established in the general population. Although subpopulations at high risk may contribute disproportionately to the spread of HIV, and sexual networking in the general population is sufficient to sustain the epidemic. In this case HIV prevalence is consistently over 1% in pregnant women attending antenatal clinics.

Health-unit–based sites

These are sites located in an existing health facility, preferably at a level IV health centre and above, where capacity and associated HIV/AIDS services are available. However, level III facilities with adequate capacity should provide HCT. The health facility may be either government or non-government. HCT services at such a site should be integrated into existing health services on a daily basis. However, if a facility is short staffed, specialized HCT clinic days may be established.

HIV testing algorithm

A combination and sequence of HIV test assays that have been agreed upon b a reference laboratory to represent HIV testing for a given purpose.

Informed consent

A process by which a client voluntarily confirms his or her willingness to provide written or verbal consent to be tested for HIV or to provide information about his or her HIV status to a health care provider or researcher.

The agreement is obtained after the client has received information about the HIV test and understands the purpose of the procedure or after understanding the purpose of the exchange of the information as being in the best interest of his or her own health or that of the partner, or in the case of a pregnant woman, the foetus or the baby being breast fed.

Informed consent should be voluntary and conducted according to the legal and ethical requirements outlined in these guidelines.

Informed refusal

A process where a client with or without clinical signs of opportunistic infections consults a health care worker and is counselled and offered HIV testing which the client refuses. Such a refusal should be recorded in the client's file and signed by the client and the health care worker.

Integrated service delivery

This is a service delivery approach that encourages and allows the health care provider to review the client as whole, assessing needs beyond the primary reason for the visit. This provides the basis for providing additional services or referring the client to receive services from another provider or facility. Its aim is to increase the efficiency of service delivery and reduce stigma associated with HIV/AIDS.

Internally Displaced Persons

People odr groups of people who have been forced ot leave their homes or places of habitual residence, in particular as a result, or in order to avoid the effects of armed conflict, situations of generalized violence, violation of human rights or natural-or hman-made disasters, and wi have not crossed an international border.

Key populations at higher risk of HIV exposure

These are persons likely to be at higher risk of HIV exposure because of behavioural factors which include: sexual partners of HIV-infected individuals(discordant couples); people who provide sex in exchange for money, goods or other benefits (sex workers); people who inject drugs and their sexual partners, and men who have sex with men (MSM).

Persons at high risk may also include heterosexual persons who have engaged in unprotected sex with someone of unknown or known HIV negative status, or

have had sex with someone who has engaged in unprotected sex since their most recent HIV test.

HIV indeterminate status is the HIV status of an individual in whom the test results do not lead to a definitive status (where HIV negative or HIV positive).

Next of kin

Spouse or close blood relative

Non reactive

Refers to an HIV antibody or HIV antigen/antibody test that does not show a reaction to indicate the presence of HIV antibody and/or antigen.

Outreach sites

Outreach HCT services may be provided in smaller health facilities such as levels II and III and home based HCT models like HBHCT with a mechanism for ongoing support services for HCT clients.

Persons of concern to UNHCR

Refers to refugees, internally displaced persons, stateless persons and other persons of concern to UNHCR

Provider-initiated HIV testing and counselling

This is HIV testing and counselling recommended by health care providers to persons attending health care facilities, as a standard component of medical care.

Quality Assurance

Any arrangement that safeguards maintains or promotes the quality of HIV counselling and testing services according to defined national and international counselling standards.

Quality control

Effective management and standard operating procedures stipulated at each service point in order to ensure quality services according to defined national and international standards.

Reactive

Refers to an HIV antibody or HIV antigen/antibody test, which shows a reaction to indicate the presence of HIV antibody and/or antigen.

Refugees

People who are outside their country of nationality or habitual residence, and have a well-founded fear of persecution due to their race, religion, nationality membership of a particular social group or political opinion.

Repeat testing

Refers to a situation where additional testing is performed on an individual immediately following a first test during the same testing visit due to inconclusive or discordant test results; the same assays are used and, where possible, the same specimen.

Retesting

Refers to a situation where additional testing is performed for an individual after a defined period of time for explicit reasons, such as a specific incident of possible HIV exposure, such as unprotected sexual intercourse. Retesting is always performed on a new specimen and may or may not use the same tests as the one at the initial test visit.

Risk-reduction counselling

Counselling with a client that focuses on HIV risk behaviour and the acquisition or transmission of HIV with the goal of getting the client to assess their behaviour and reduce their risk of infection.

Shared confidentiality

Other health workers providing direct care to ma access a client's medical information with the client's consent and for the purpose of providing the continuum of care to the client

Sensitivity

This is the probability that an HIV test will correctly identify all individuals who are infected with HIV.

Sero conversion

When sufficient quantity of HIV antibodies are produced by an individual to become detectable on a given HIV antibody and/or antigen test.

Service provider

Any person qualified to provide a service for the benefit of the client.

Specificity

This is the probability that an HIV test will correctly identify all individuals that are not infected with HIV.

Stigma

These are negative attitudes or perceptions of towards individuals who are known or perceived to be infected or affected by a condition such as HIV/AIDS.

Trimester

Refers to three month intervals of a woman's pregnancy. The first trimester is the period of pregnancy from the first day of the last menstrual period through completion of 14 weeks. The second trimester is the period between the 15th and 28th week and the third trimester the period of pregnancy from the beginning of the 29th through the 42nd completed week of gestation.

Window period

The period of time from when a person is suspected to have been infected what HIV to when HIV antibodies can be detected by a given test. The window period varies from person to person and also depend o the test used. The mean time from exposure to development of antibodies is about one month. Most people will develop antibodies by 3-4 months.