



NATIONAL HIV/AIDS SECRETARIAT  
HEALTH SECTOR RESPONSE  
MINISTRY OF HEALTH AND SANITATION

***GUIDELINES***  
***FOR***  
***VOLUNTARY CONFIDENTIAL***  
***COUNSELLING AND TESTING***  
***IN SIERRA LEONE***

August 2003

## **Foreword**

The impact of HIV/AIDS on Sierra Leone threatens to undermine the development of the nation as it emerges from a decade of conflict and devastation. The Government of Sierra Leone and its partners in the private and NGO sectors are committed to fighting this threat. Knowledge about HIV/AIDS in Sierra Leone remains worrying low and most people do not have access to knowing their HIV status. Knowing one's status empowers people to make informed decisions about their lives and their futures. It is an essential first step in accessing care, treatment and support and is part of the basic human right to health.

The Government is committed to taking legislative, budgetary and administrative steps toward the progressive realization of that right, including supporting expanded access to VCCT services. It is also committing resources to community mobilization and advocacy normalization of VCCT and the importance of knowing one's HIV status. The current Ministry of Health response to the HIV epidemic in its national strategic plan highlights the introduction of voluntary counselling and testing services into the public health care system.

VCCT is the key entry point to care, treatment and support. Through VCCT, people learn whether they are infected, understand the implications of their HIV status, access important information and services for prevention, care and support and make more informed choices for the future. With the development of cheaper and effective medical care, the demand for testing is increasing rapidly, and there is an urgent need to increase access to VCCT for people who would benefit from these interventions.

The primary objective of the standard VCCT model – pre-test counselling, HIV testing and post-test counselling – has been prevention; many people need to know and understand their HIV status to motivate behaviour change and prevent transmission of HIV. However, availability of these services in Sierra Leone has been severely restricted, and when VCCT is available, uptake has been relatively low. Many people are reluctant to know their HIV status when the drugs needed for management of HIV-related illnesses and psychosocial support for coping with their diagnosis is unavailable to them. People have also been unwilling to expose themselves and their families to the discrimination and social marginalisation that many PLHA experience in the absence of community support and legal protections. The government is committed to the provision of VCCT as it can also lead to wider societal benefits in decreasing stigma and promoting normalization of finding out ones status.

With recent increases in funding and political support, the objectives of VCCT have become broader, with more attention to accelerated identification of HIV-positive people for targeted medical interventions and care. A large increase in demand for VCCT is anticipated when programmes supporting expanded access to ARVs are fully implemented.

New funding sources such as the World Bank's Multi-country HIV/AIDS Program (MAP) and the Global Fund to Fight AIDS, TB and Malaria (GFATM) as well as greater affordability and availability of ARV drugs underscore the need for accelerated scaling up of VCCT services, especially in clinical settings. When more people learn their HIV status and access a network of services through VCCT, prevention of primary infection, prevention of mother-to-child transmission (PMTCT) of HIV, treatment of AIDS-related illness and provision of more integrated and holistic care, treatment and support for HIV-positive individuals are all within reach.

The purpose of this document is to support efforts to increase access to VCCT and strengthen VCCT service delivery in Sierra Leone. It responds to immediate needs for norms and guidelines on setting up and delivering VCCT services and highlights linkages with essential related services.

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# Acknowledgement

Mr. Scott McGill, Senior Technical Officer VCCT and Psychosocial Care, Family Health International prepared this document.

## ***Development of the guidelines***

The participants of a Stakeholders Meeting held in Freetown, Sierra Leone on the 6th to 7th May 2003 provided input to the first draft of the guidelines.

This document draws on and consolidates existing guidelines for VCCT, current WHO policies and relevant experiences in all sub-regions. It reflects new debates on approaches to expanding access to VCCT and it provides recommendations for future development for VCCT in Sierra Leone.

In addition review of the first draft document and the AIDS Response Group (ARG) of the Ministry of Health and Sanitation of the Government of Sierra Leone made valuable feedback and contributions to the final draft document.

It is modelled and based on the draft WHO-AFRO Regional Guidelines.

## ***Documents consulted:***

The National HIV/AIDS Policy for the Government of Sierra Leone  
WHO AFRO Draft Regional Guidelines  
National Guidelines for VCCT in Ethiopia  
National Guidelines for VCCT in Kenya etc.  
Family Health International VCCT Reference Guide  
Sierra Leone Guidelines for Rapid Testing in VCCT  
A Toolkit for Voluntary Counselling and Testing for HIV, FHI (2003).

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## ***Objectives of the guidelines***

These guidelines are designed for use by policymakers and VCCT programme managers at national, provincial, district and site levels. Specific sections of the guidelines may be useful for staff delivering VCCT services as well as training of support staff for knowledge and sensitivity around VCCT issues and clients.

They are written as a practical guide for those providing voluntary HIV counselling and testing services in the following places and reflect current government policy: government, non-government and private health care facilities. They elaborate and reflect current government policy on testing and counselling produced by the National AIDS Secretariat in 2003. These guidelines are expected to standardize VCCT service delivery and ensure the standard of care meeting international requirements. All VCCT services must adhere to these guidelines, adapting delivery where required and indicated.

## **Definitions**

WHO defines **HIV counselling** as a confidential dialogue between a client and a care provider aimed at enabling the client to take personal decisions related to HIV/AIDS and to reach an understanding of what they can and should do about HIV infection should they be infected. This includes coping with associated stressors, fear, guilt, stigma, discrimination, care for a chronic condition and the possibility of an early death. Where someone tests negative it plays a crucial role in strengthening ways of remaining uninfected.

**Voluntary HIV counselling and testing** is the process by which an individual undergoes counselling enabling him or her to make an informed choice about being tested for HIV. This process is also aimed at helping them to cope with stress and make personal decisions related to HIV/AIDS.

HIV testing, for the person being tested has far reaching consequences beyond that of diagnosis. Although there are many benefits to knowing one's HIV status, in communities where HIV is seen as a stigmatising condition there may be negative consequences of testing. Therefore no one should be coerced into testing, but agree **voluntarily**.

HIV testing should only be performed after the client had given **informed consent** i.e. **informed** in that during discussion (**pre-test counselling**) the client has been made aware of all the risks and benefits as well as the alternatives to such testing in language that is understood. **Consent** means accepting to be tested for HIV in a situation free of coercion, where the client should feel free to grant or withhold consent.

**HIV testing** is the application of an assay (e.g. ELISA, Western Blot or a rapid test) for laboratory markers of HIV infection such as antigens or antibodies. In VCCT testing occurs with the intention of determining an individual's infection status at the time the test is performed.

**Anonymous testing** is HIV testing in which the blood sample and test results are identified by code only, not by name, with no personal identifiers to link the sample to the client.

**Confidential testing** is HIV testing in which only the client and the health professionals involved in the client's direct care know that the test was performed and have access to the results.

In VCCT services, HIV testing should be either anonymous or confidential.

**Post-test counselling** is provided for all people whether they test HIV positive or negative. The aims of post-test counselling are to **give the test result** to the client, **provide emotional support** to help the person cope with the result, discuss the physical, emotional and social implications of a positive result, discuss prevention for HIV-positive and HIV-negative individuals, and **refer** the client for any care or treatment indicated.

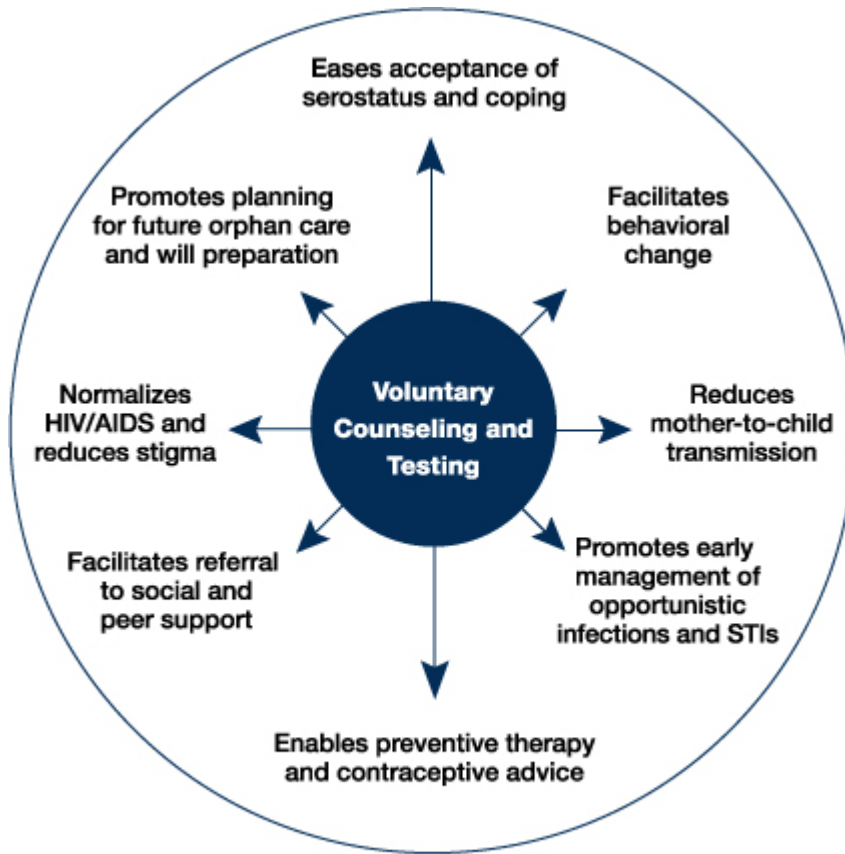
## ***Essentials of VCCT***

- VCCT is a preventive counselling service which typically includes laboratory HIV testing.
- VCCT is a vital point of entry to HIV/AIDS care, treatment and support services.
- There is demand (i.e. people want to know their HIV status), or demand can be created when comprehensive non discriminating (non stigmatising) services are made available both in high and low prevalence countries
- VCCT provides benefits for those who test positive as well as those who test negative.
- VCCT alleviates anxiety
- It gives people an opportunity to develop a more accurate perception of risk. As such it increases/decreases the client's perception of their vulnerability to HIV and enhances beneficial and appropriate responses to reducing risk.
- It promotes behavioural change, facilitates early referral for care and support including access to anti-retroviral therapy and assists reduction of stigma in the community.
- VCCT facilitates disclosure to partners

## ***The benefits of VCCT***

Knowing HIV status enables **individuals** to initiate or maintain behaviours to prevent acquisition or further transmission of HIV; gain early access to HIV-specific care treatment and support; access interventions to prevent transmission from mothers to their infants; better cope with HIV infection and plan for the future. It also helps **communities** to reduce the denial, stigma and discrimination that surround HIV/AIDS and mobilize support for appropriate responses.

### ***The benefits of VCCT***



Source: UNAIDS, "Report on the Global HIV/AIDS Epidemic—July 2002" ([www.unaids.org/barcelona/](http://www.unaids.org/barcelona/), accessed July 8, 2002).

Expanded access to and demand for VCCT services can reduce denial in communities and lead to greater understanding and acceptance of PLHA. Community support for VCCT services can promote awareness of the importance of knowing one's HIV status, and it can facilitate normalization of HIV while challenging stigma and supporting human rights.

The majority of people, even in countries with high HIV prevalence, are HIV-negative. HIV-negative and HIV-positive people alike need to know their serostatus in order to access medical and supportive services they might need as well as to prevent further transmission and acquisition of HIV. VCCT enables people to learn whether they are infected, understand the implications of their HIV status and make more informed choices for the future. This knowledge is important in assessing personal risk, changing risk-taking behaviour and initiating and making the most of prevention and care interventions.



## National and Local Oversight of VCCT Services

The MOHS, in coordination with the National AIDS Secretariat, shall convene monthly meetings of the National working groups to ensure national and local coordination of VCCT services in Sierra Leone. In order to ensure optimal use of limited resources and maximum impact of VCCT services delivery, services are coordinated at the national level by the staff of the AIDS Response Group.

This includes the following:

Standards and protocols for testing including approval of specific test kits

Official recognition of counselling including salaries and benefits commensurate with other professional categories, establishment of selection criteria, definition of different levels of counsellors, accreditation mechanisms, training and supervision programmes including development of standardized curricula as needed

Selection of common indicators for uniform monitoring and evaluation which can be integrated into national Health Information System

Preparation of common reporting forms for a centralized data collection and analysis system

Establishment of minimum standards regarding post-test referral networks defining required components and referral mechanisms

Government commitment to providing resources and funds for community mobilization and support for VCCT

Methods for sharing lessons and cross referral etc with other HIV services through, for example a National AIDS service organisation committee/network

- Every DHMT should select one person to be the coordinator of VCCT services for that area. In some cases, this may be nominated by the DHMT, but other persons concerned about HIV and AIDS may be selected. The VCCT Coordinator is responsible for ensuring that these national guidelines are followed and that all VCCT standards are met.
- The District VCCT Coordinator should convene a regular meeting of VCCT service providers in the district to review experiences, resolve any problems encountered in the delivery of VCCT, and make plans for additional expansion of VCCT services in the district. This meeting should be monthly if possible, or bimonthly at a minimum.
- A national VCCT supervisory checklist involving such issues as supply of test kits, allocation of counsellors, confidentiality of record keeping, etc shall be used by the VCCT coordinator in each district.

## ***Guiding principles of VCCT service delivery***

Demand for VCCT is growing, especially in Sierra Leone as people become more aware of HIV/AIDS, as the epidemic is emerging and people are becoming more aware of the benefits of knowing whether they are infected. Demand can be stimulated when comprehensive services are made available in a variety of settings. Through community mobilization and communication strategies, more people are learning that VCCT provides benefits for those who test positive as well as those who test negative, mitigating the impact of HIV and reducing further levels of transmission within a community. VCCT offers a holistic approach that can address HIV in the broader context of peoples' lives, including the context of poverty and its relationship to risk practice.

Optimal delivery of VCCT services requires a number of conditions in key areas:

### **The State's duty to treat**

Health care providers are bound by an ethical principle to do all that is necessary and available to provide the best possible care through the use of diagnostic tools and follow-up treatment. Discrimination on the grounds of HIV status is unacceptable.

A voluntary HIV test must be provided when requested or indicated and treatment or follow-up must be provided as necessary and available.

A basic package of care might include treatment of STI, TB preventive therapy, cotrimoxazole prophylaxis, palliative care and ART where available. This suggested package would vary depending on local resources and national policies.

### **Observing human rights**

The human rights principles most relevant to VCCT, and which every VCCT staff member and client should be made aware of and adhere to include:

The right to privacy for all clients

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

The right to found a family

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

The right to informed consent before a medical procedure is carried out

The right to information for making choices about one's health and well being.

### **Reducing 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 and discrimination and VCCT 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, VCCT programmes, which allow more people to know about their HIV status, can actually *decrease* stigma and discrimination, foster 'normalisation' and open the door for more effective HIV prevention and care.

This is very important for VCCT programmes. Fear of stigma and discrimination (including even divorce or exclusion from extended family and community) is an important reason that many people do not want to be tested for HIV.

The widespread availability of VCCT services has the potential to break through denial and stigma around HIV in communities.

### **Ensuring informed consent**

WHO advocates that HIV testing must always be truly voluntary. Everyone undergoing VCCT should be able to discuss the advantages and possible cautions of HIV testing, and the implications of a positive diagnosis on their personal and professional lives.

All VCCT clients must be able to opt out or refuse testing if they do not think that it is in their best interest.

To this end, VCCT providers in all settings must be trained to counsel for informed consent and must be effective advocates – especially in ANC settings – for the value of VCCT.

Autonomy and privacy in health care are fundamental and universal human rights, and mandatory testing is not acceptable. Mandatory HIV testing is neither effective for public health purposes nor ethical, because it denies individuals choice, and violates principles such as the right to health, including the right to privacy and the ethical duties to obtain informed consent and maintain confidentiality. Although the process of obtaining informed consent will vary according to different settings, all those offered the test should receive sufficient information and should be helped to reach an adequate understanding of what is involved. The three crucial elements in obtaining truly informed consent in HIV testing are:

- Providing pre-test information on the purpose of testing, and on the treatment and support available once the result is known
- Ensuring understanding
- Respecting the individual's autonomy.

Only when these elements are in place will individuals be able to make a fully informed decision on whether or not to be tested in light of their own circumstances and values. Once this is assured, the actual process of obtaining informed consent can be adapted to suit the different settings under which expanded HIV testing and counselling services will be implemented.

While WHO supports approaches to obtaining informed consent which can be flexible, accommodating time and resource limitations and the knowledge level of the client (e.g. in the case of repeat testing), the fundamental value to be applied is *respecting the choices of individuals* rather than adherence to a particular standard of informed consent. All approaches must ensure the client's **understanding and consent**. WHO recommends that HIV testing and counselling be offered whenever a patient shows signs or symptoms of HIV infection or AIDS, or wherever this will aid their clinical diagnosis and management. Under these conditions, the offer of HIV testing and counselling should be considered as the standard of care. However, routine HIV testing is **not** recommended for surgical patients in any setting unless HIV status has important implications for patient management. As with any other invasive test procedure, informed consent is required for an HIV test in the context of clinical care. Such informed consent should be obtained during the normal process of consultation between the health-care provider and the patient on the proposed course of treatment.

To the extent possible, VCCT should become a routine and necessary part of diagnostics, health care and health enhancement, maintaining informed consent and confidentiality. VCCT services, which allow more people to know about their HIV status, can actually *decrease* stigma and discrimination, foster 'normalization' – reducing or eliminating the distinction between HIV/AIDS and other illnesses – and open the door for more effective HIV prevention and care.

Informed consent is especially important to ensure that the client is not being coerced into testing by a partner or employer. The essential elements of informed consent are:

- Information about a testing procedure and the implications of positive or negative results
- Confirmation of understanding of the information on the part of the client
- Exercise of free choice on the part of the client (or guardian in the case of young children) to undergo HIV testing

Some clients will have attended more than once, and their levels of knowledge and understanding will be high; for these people, it may be appropriate to reduce the amount of pre-test counselling.

In the case of couple counselling, information can be shared and understanding confirmed with the couple, but informed consent should be obtained separately from each partner.

VCCT sites should endeavour to *document* that all persons being tested have voluntarily and freely consented to being tested. The most important aspect of informed consent occurs within the pre-test counselling session when the counsellor should explain the procedure and make sure that the client is requesting VCCT without any coercion. If possible, a form can be used documenting that the client has given informed consent to the procedure. When anonymous testing is used, clients are usually not willing to sign their name to an informed consent document. The patient needs to sign the form before testing.

### **Confidentiality and privacy**

It is important that counselling and testing centres adhere to policies which protect the confidentiality and privacy of clients. Those testing must be assured of the confidentiality of their test results. Although there are many benefits of sharing HIV test results with sexual partner/s and family members and involvement of partners and family members should be encouraged, the decision to do so should be made by the person undergoing VCCT.

There are two ways that this can be achieved. One way is through strict **confidentiality**, and maintaining very strict controls over access to the client's name and test results, and releasing results to others, such as other health workers, only if the client agrees. The other method is to practice **anonymity**, which is the method used when no names are taken, and only code numbers are used. In most countries with VCCT programs, it has been found that more clients will request VCCT when their names are not recorded, and anonymity is practiced, and thus it is recommended that anonymous procedures should be used at VCCT sites in Sierra Leone.

In some voluntary counselling and testing centres people do not have to give their names. Instead the person who wants to have an HIV test will be given an individual identifying number. Their blood sample will be labelled with this number and when they collect their HIV test result they will check their number against the number of the HIV test result. In some VCCT sites people may also be asked to choose a code name, for example their mother's name and place of birth – e.g. 'Susan Freetown' or 'Binti Kenema'. This will be checked together with the identifying number when they receive their HIV test result. This type of HIV testing is called **anonymous testing**. This approach may be useful for increasing uptake among young people and vulnerable or marginalized groups. The disadvantage of this approach is that follow-up cannot be done unless there is a way to continue using the codes and referral notes. The MOHS supports anonymous testing.

**Shared confidentiality:** There are several interpretations of this term. Many people use it to describe the situation where someone attending a VCCT service wishes to involve another person. For example in couple counselling or family counselling. In clinical settings 'shared confidentiality' between the client and relevant health workers to support the medical care. Although the term 'shared confidentiality' continues to apply to different circumstances there are 2 clear underlying themes:

- In general sharing HIV status with partner, family, trusted friend and community members and medical staff is usually of great benefit to the client – enhancing coping, combating stigma and preventing discrimination and isolation and ensuring optimum medical care

- Sharing of HIV status should always be voluntary and discussed with the client

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

**Confidential Procedures:** VCCT sites, especially those located within health centres and hospitals, should ensure that clients requesting VCCT services are not readily identified to the public or by other patients using the health centre by the fact that they have requested VCCT. Confidentiality in VCCT services involves not only using code numbers, but also managing the waiting room and client flow procedures in such a way to maintain confidentiality of the experience of being tested.

### **Disclosure of VCCT results**

In general, HIV test results should only be disclosed to the client. In the VCCT setting, disclosure of HIV test results to any party other than the client should not occur. If a VCCT counsellor feels that a VCCT client is endangering the health of others or his/her own health, the counsellor should consult with the counsellor supervisor to make an appropriate plan of action for intensified counselling and interventions.

### **Written results**

VCCT sites should not provide written results as routine; however, written results could be given on demand by client.

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

### **Accessibility**

VCCT sites should be easily accessible for people wishing to attend, e.g. convenient locations, flexible operating hours, friendly non-judgmental staff, a private and confidential service, comfortable and appropriate waiting area and same day testing where possible.

Where possible, service delivery must suit the needs of different client groups, such as evening hours for workers or professionals who have difficulties taking time off from work, or reduce the duration of pre-test counselling sessions for individuals with high levels of knowledge and understanding about the implications of a positive test result. Depending on the client group, VCCT providers should develop approaches that allow for optimal uptake of services.

Targeting specific groups for VCCT services will facilitate scaling up and may enhance cost-effectiveness. Specific groups might include symptomatic people or people attending TB services who could benefit from ARV interventions, pregnant women (already being served by VCCT in the context of PMTCT interventions), young people, marginalized groups such as sex workers and IDUs, workplace groups such as truck drivers. VCCT programmes should identify specific groups relevant to local context.

### **Quality assurance and control**

With expanded access to VCCT it is essential that the quality of both testing and counselling be assured with appropriate monitoring and evaluation as a key and routinely planned component of interventions. Accuracy and performance of test kits is particularly critical and must be ensured, and the kits themselves must comply with national standards. Systems for procurement and storage of supplies must ensure adequate conditions and minimal wastage. Counsellors and other health workers involved in VCCT must have appropriate training, clinical supervision and adequate support to prevent burnout and to ensure that a quality service is provided.

## **Referral network**

The core value of VCCT lies in its role as the entry point to an array of care, treatment and support services. There is little value in knowing one's HIV status if there is nothing to be done with that information. Linkages to other services must be made for the prevention of acquisition and transmission of HIV, for improved coping capacity, reduced morbidity, increased productivity, planning for the future and societal benefits.

Regardless of the VCCT service delivery setting, VCCT must be considered as part of the health service delivery system and integrated accordingly.

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

## **Involvement of PLHA**

PLHA are under utilized. They should be involved as much as possible in the planning, design and delivery of services. Their personal experience has been extremely valuable in peer counselling situations and in normalization of HIV/AIDS in communities. Involvement of people living with HIV/AIDS is not tokenism; it is essential to achieving a holistic understanding of and response to the epidemic.

## **Affordability**

The vast majority of people in Sierra Leone are unable to afford testing, so it must be subsidized or provided free of charge now and a system of cost recovery will be introduced later.

## **Registration and client flow**

When patients or VCCT clients request VCCT, whether in a health facility or in a freestanding VCCT site, they should be referred to the VCCT registration or appropriate health care reception. The receptionist should be trained to explain procedures to the client and explain how long the person will wait, though the receptionist should not engage in any counselling and should refer any questions to the counsellor. Educational materials about VCCT and HIV, such as posters, brochures, and video shows should be available while the client waits to see a counsellor.

## **Waiting Periods**

All VCCT sites should endeavour to provide "same day" or even "same hour" results to clients. This can be accomplished through the use of the latest generation of test kits. Clients should be able to receive their results within two hours; however, clients should not be forced to receive same day results.

During the pre-test counselling session, clients should be informed that their results will be ready within one to hour hours, and they should be encouraged to stay at the VCCT site for their results and post-test counselling. When a counsellor determines that a client is not ready to receive “same day” results, or if a client declines same day results, the counsellor should encourage the client to return on another day to be tested and to receive the results.

### **Minimum age**

Anyone 18 years of age and above requesting VCCT should be considered able to give full, informed consent. Young people under age 18 who are married, pregnant, parents, engaged in behaviour which puts them at risk, or are child sex workers should be considered “mature minors” who can give consent for VCCT. It is highly recommended that testing of minors under 18 who are not mature minors, especially those under 15, should be done with the knowledge and participation of their parents or guardians. Counsellors providing services to adolescents and minors should receive additional training on the unique issues relating to HIV testing and counselling for youth. VCCT sites should work to ensure that there are appropriate support services for minors who have received VCCT.

### **Testing of children**

When children who are brought to a VCCT 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 consideration when considering testing of children. Counselling should be provided to the parent or guardian, and referral for testing of the child should be made to appropriate medical or child welfare services.

### **Partner Notification**

All VCCT clients, both HIV+ and HIV-, should be 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. Learning HIV test results together is the best way to achieve partner notification. Especially for HIV+ clients who are reluctant or fearful about disclosing their results, the counsellor should offer additional, on-going counselling to assist the client to inform partners. If the client requests, a counsellor may inform a sexual partner of the client about the test results, in the presence of the client.

## **Client groups and special issues in standard VCCT services**

### **Premarital VCCT**

Premarital couple counselling for VCCT is a valuable intervention when *truly voluntary* and when adequate informed consent has been obtained *from both individuals*.

Premarital VCCT can enable couples to negotiate appropriate changes in sexual behaviour as well as plan together for their and their dependants' future, with the help and support from a counsellor. Serodiscordant couples can be identified and counselled on the implications of this status and to help prevent transmission to the uninfected partner.

### **Couples/discordant couples**

Although most people attend VCCT sites on their own, many people find it helpful to visit with their spouse or partner and see a counsellor together. This is called '**couple counselling**'. Offering VCCT to couples overcomes the problem of sharing test results. Seeing couples together also enables them to be counselled around issues of blame and prepares couples before they test to make risk assessments and plans together. Couple counselling has been shown to be more effective than individual counselling in helping people make long-term behaviour changes. Couple counselling is aimed at helping the couple to discuss together changes in sexual behaviour as well as plan together for their and their dependants' future, with the help and support from their counsellor at both pre- and post-test sessions.

Sometimes couples that are tested together will have different HIV test results. These results are called **serodiscordant**. This is because HIV is not transmitted every time someone has sex. However with time, most partners who test HIV negative in a serodiscordant couple will become HIV positive if they are having unprotected sex. This is why it is very important for couples to find out if they have serodiscordant test results so that they can be counselled about using safer sex methods (condom use, mutual masturbation, abstinence) to prevent transmission of HIV to the negative partner.

Serodiscordancy can be difficult for couples to understand and sometimes the partner who tests HIV positive can be blamed. It is very important for the counsellor to discuss all the possible test results including serodiscordance with the couple at pre-test counselling and help the couple to explore their potential reactions.

Barriers to couples testing together exist. Studies have revealed that communication difficulties between couples are common and women, in particular, often fear emotional and physical abuse or abandonment if they are found to be seropositive and their partner is seronegative.

### **Children**

*In any situation where a child is brought in for VCCT, the welfare and best interests of the child should be the paramount consideration.*

In general, HIV testing may be recommended in the following situations:

- Mother is HIV-positive and child is very young
- Child is sexually active
- Child is pregnant
- Child has been sexually abused
- Child is symptomatic and would benefit from medical care
- Child has been exposed to other risks (contaminated blood, perinatal exposure)

In any of these cases, counsellors, parents and guardians must weigh up the advantages and disadvantages of testing a child for HIV before informed consent can be obtained.

### **Counselling children**

Most HIV counselling focuses on disclosure to partners, rather than disclosure by parents to their children. Children are often traumatised when they learn about their parents' or their own HIV-positive status.



Providers need training to develop skills in working with young people and children in particular. Children over 5 years old may require grief and bereavement counselling pending the loss of a parent or family member, counselling on their own illness and prospect of death or counselling around physical and sexual abuse and incest. Effective counselling for children must be age-specific and requires specialized training, personal attributes and skills.

VCCT service providers and counsellors must be alert to the possibility that a mother is requesting an HIV test for her child in lieu of being tested herself. Every effort must be made to encourage a woman to consider her motivation for having her child tested in order to learn her own HIV status.

#### **Groups isolated from community support**

Isolation from the support of family and community as well as distance from public health infrastructure can create particular risks of exposure to HIV and may negatively affect coping capacity of those living with HIV. For these groups of people, efforts must be made to ensure that access to VCCT or other support services, including condoms, is available.

#### ***Long-haul truck drivers***

VCCT and related services should be accessible to residents of crossroads towns so that awareness about HIV and prevention is high and reduction of risk-taking behaviour is promoted. Truckers should have access to comprehensive HIV education and prevention services, including information about the benefits of VCCT and where they can access services. More work can be done with the trucking companies themselves; workplace policies on HIV/AIDS and referrals for VCCT should be done for all employees when they are at their home bases.

#### ***Displaced populations/refugees***

It may be possible to serve these temporarily or semi-sedentary populations when health care infrastructure is sufficient to provide access to follow-up referrals.

#### ***Military***

The Government of Sierra Leone has established policies on the area of HIV testing in the uniformed services.

#### **Marginalized groups**

Special training is required for working with marginalized groups to ensure that service providers are non-judgmental, compassionate and discreet. VCCT services should assess the needs of their client base to determine if specialized training will be needed for counselling staff.

#### ***Sex workers***

Hard-to-reach groups such as sex workers (SW) may have special needs for anonymity and extensive support for condom use as well as access to mobile services. In many countries, sex workers lack access to VCCT, and they are subject to stigma, discrimination, police violence and exploitation. Many SWs are young and some have additional problems of drug and alcohol use/abuse.

VCCT strategies should include sensitising VCCT personnel on sex work, making youth friendly services available and integrating VCCT with STI and SRH services. Peer educators should be identified among SWs and trained on promoting VCCT and condom use. SWs and their clients, bar owners and the police should also be sensitized on VCCT and condom use. NGOs, health providers and peers can provide ongoing support for SWs.

Clients of SWs are often willing to pay extra for unprotected sex. As most sex work is an economic survival strategy, it is difficult for many SWs to turn down the offer of more money, and the benefits of VCCT for this group may be compromised. However, VCCT services can continue to offer innovative services, information and skills which may in the long term empower women to insist on condoms regardless of the financial incentives to engage in unprotected sex.

When targeting sex workers for VCCT services, it is essential to target their client communities at the same time. Education and mobilization around the benefits of VCCT for the entire community will enhance sex workers' capacity to negotiate for safer sex, primarily through condom use.

### ***Injecting drug users (IDU)***

Although still relatively uncommon compared with many industrialized countries, injecting drug use is becoming more common among youth in African urban areas. Like sex workers, IDU are often considered to be living 'outside the law' and may require anonymous testing services as well as innovative approaches to follow-up counselling and support as well as advice on safe injecting.

### ***Street people***

Homeless populations of adults and children are becoming more numerous and more visible due to poverty, disease, hunger and civil unrest and disruption. Strategies must be developed to engage these groups and ensure that they have access to VCCT either through mobile services or innovative communication initiatives.

### ***Men who have sex with men (MSM)***

Same-sex sexual activity is profoundly stigmatised and in many countries is illegal. It will be important to ensure that this group has access to non-judgmental, discreet and confidential services. There are a great variety of identities and social roles that go beyond sexual practices. Sexual experiences often start in early adolescence and yet this is often not considered in services for young people. Lives of many MSM are characterized by violence and rejection, including rape. Secrecy and subterfuge are common denominators in many men's experiences. There are often a wide range of sexual relationships, including a regular stable relationship with a single partner, a regular relationship with one partner plus occasional partners, and irregular relationships with many partners. The vast majority of MSM have sex with women. Many MSM are at high risk of HIV because of unprotected sex, a history of STI symptoms, and poor knowledge of STIs. MSMs are extremely reluctant to discuss intimate details of their sexual lives and relationships and may be particularly resistant to the idea of revealing accurate and full disclosure of their risks behaviours because of fear of discrimination. These factors all impact to a greater or lesser extent on their access to and uptake of VCCT services and the need to adapt and target interventions.

### ***Alcohol use and misuse/drug use and misuse***

Alcohol and drug use, abuse and misuse are common and often under-reported. Alcohol in particular is an important risk factor for HIV infection through risky casual sex yet is seldom emphasized in HIV counselling and alcohol use and abuse is not usually included in risk assessments for HIV. Studies have shown that risky sex is much more likely to occur in association with alcohol consumption.

Strategies for improving access and acceptability of VCCT to people with drug and alcohol problems should focus on increasing awareness of VCCT counsellors about the importance of drug and alcohol issues, and drug and alcohol counsellors on HIV/VCCT issues. Advocacy for increased access to harm reduction services and integration of drug services and VCCT is important.

## ***HIV Counselling***

The following checklists provide an overview of the *recommended* content of pre- and post-test counselling sessions. Counsellors should adapt these checklists to conform to the specific needs of an individual or target communities.

### **Pre-test counselling**

VCCT clients must learn about HIV and understand the benefits of testing as well as the range of options and services available to them in order to make an informed decision about having a test. Pre-test counselling prepares people to accept the results and also learn about the possibilities for post-test support or ongoing psychosocial support if they choose not to undergo testing.

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

- Basic facts about HIV infection and AIDS
- Meaning of an HIV test, including the window period
- Reasons why the client is requesting VCCT
- HIV testing procedures at the site, including whether or not written results will be given

When rapid tests are used for same day results, a prevention counselling session should be held while the test is developing. Issues to be discussed in all events include:

- Basic HIV prevention
- Personal risk assessment
- Client's readiness to HIV sero-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 a positive HIV result
- Exploration of what the client might do if the test is negative and possible ways of staying uninfected
- Exploration of behaviour change
- The client's reproductive intentions, and the role of family planning
- Exploration of potential support from family and friends
- Condom use, including condom demonstration
- Any special needs discussed by the client

<b>Components of the pre-test</b>	
<b>Exploration – sharing information</b>	
<input type="checkbox"/>	<i>Check person’s knowledge/understanding about HIV, transmission and how to prevent it</i>
<input type="checkbox"/>	<i>Correct any misconceptions</i>
<input type="checkbox"/>	<i>Risk assessment – exploration of current sexual behaviour, needs and risk</i>
<input type="checkbox"/>	<i>Risk reduction – factors influencing sexual decision-making and behaviour change</i>
<b>Understanding – helping the client considers options</b>	
<input type="checkbox"/>	<i>Confidentiality and shared confidentiality</i>
<input type="checkbox"/>	<i>Testing: Process, meaning of possible test results, window period</i>
<input type="checkbox"/>	<i>Assess person’s views on testing and capacity to cope with a positive result</i>
<input type="checkbox"/>	<i>Discuss benefits and possible cautions of sharing test result with partner (may offer couple counselling and make an appointment for couple to return at a future date)</i>
<input type="checkbox"/>	<i>Discuss who else to share results with and who will provide support</i>
<input type="checkbox"/>	<i>Develop personal risk reduction plan - consideration of realistic options</i>
<b>Action – helping the person to make a plan</b>	
<input type="checkbox"/>	<i>Offer an HIV test</i>
•	<i>If test declined, offer follow-up counselling, screening for STI, other services, appointment for another session</i>
<input type="checkbox"/>	<b>Ensure that informed consent is given freely</b>
<input type="checkbox"/>	<i>Make a plan for follow-up:</i>
•	<i>If ELISA test is used, make appointment to receive result and post-test counselling</i>
•	<i>If rapid test is used, explain when the result will be available</i>

Balanced against the many advantages of VCCT there are some potential negative consequences of VCCT for the individual and his/her family. These should be reviewed with VCCT clients as part of pre-test counselling. One of the disadvantages of VCCT is that those who test positive may be discriminated against suffer abuse or abandonment or may have serious emotional reactions to a seropositive result. However such serious negative outcomes are rare. Furthermore they can be minimised with ongoing counselling and support and sensitive discussion around disclosure, especially for women. These negative outcomes following testing may also be more common in communities where the HIV epidemic is less well established or where the majority of PLHA belong to marginalized groups. Community advocacy and sensitisation prior to setting up VCCT services is therefore important.

### **Post-test counselling**

Post-test counselling is provided for all people whether they test HIV positive or negative. The aims of post-test counselling are to give the test result to the client, provide emotional support to help the person cope with the result, discuss the physical, emotional and social implications of a positive result, discuss prevention for HIV-positive and HIV-negative individuals, and refer the client for any care or treatment indicated.

**Readiness for results:** Prior to giving the test results, the counsellor should ensure that the client is truly willing and ready to receive their results, and understands what both positive and negative test results mean.

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

**Positive Living:** All HIV+ clients should be counselled about "living positively with HIV" which includes maintaining a positive attitude, avoiding additional exposure to the virus and other STIs, taking good care of themselves medically, a good diet, joining PLWHA organizations, and other social support groups.

**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. The counsellor should help the client understand the importance of avoiding future risky exposure to HIV.

#### **Window period**

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

**Partner Notification:** The counsellor should encourage the client to bring in their partner(s) for couple counselling and testing.

**Family Planning counselling and education:** Information on family planning, its role for both HIV+ and HIV- clients, and how to access services should be included in VCCT counselling sessions. If possible, FP services should be provided at VCCT sites. If the client is negative, during post-test counselling the counsellor should encourage good reproductive health seeking behaviour. The counsellor should reinforce the client's use of FP, if already using a method, and additionally counsel for condom use, if the client is at risk of HIV/AIDS. If the HIV negative client is not planning to become pregnant and is not using a method, referral to an appropriate FP service delivery point should be made.

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

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

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

### **Referrals**

The counsellor should make appropriate referrals to additional services as needed, such as medical, social, legal, spiritual, and psychological support if the counsellor determines that these services would be helpful. Especially for clients who are HIV+, post-test support services should include treatment services for TB, opportunistic infections, and other sexually transmitted diseases.

#### **Components of post-test counselling with negative results**

- Review some of the issues covered in pre-test session, e.g. what HIV positive and negative mean, how the person anticipated coping with results and check the person wishes to receive the result*
- Give the result simply and clearly*
- Give time to let the person consider results*
- Let the person talk about his/her feelings about the results, making sure that the person considers the implications of the result*
- Check with open-ended questions that the person understands the meaning of the result:  
S/he is not infected with HIV (majority of people) **or**  
S/he is in the window period (a very small minority)*
- Discuss any other immediate concerns the person might raise*
- Discuss the importance of staying negative; provision of condoms and demonstration*
- Make a risk reduction plan, e.g. safer sex, sharing result with partner, partner attending VCCT, modifying use of drugs and alcohol, health-seeking behaviour such as screening for STI*
- Inform person that counselling is available in the future and that s/he may come alone or with a partner, close friend or relative*

### **Components of post-test counselling with positive results**

- Review some of the issues covered in pre-test session, e.g. what HIV positive and negative mean, how the person anticipated coping with results*
- Give the result simply and clearly*
- Give time to let the person consider results*
- Let the person talk about his/her feelings about the results*
- Check with open-ended questions that the person understands the meaning of the result*
  - *Refer to difference between HIV and AIDS*
  - *Give clear, factual explanations*
  - *Acknowledge the shock of the diagnosis; offer support*
  - *Encourage hope*
  - *Discuss benefits of knowing one's status re PMTCT, IPT, ARVs, social and emotional support services*
- Discuss how the person is going to get through the next hours and days*
- Check to see who is available to give immediate support*
- Discuss immediate concerns the person might raise*
- Discuss prevention of further transmission; provision and demonstration of condoms*
- Arrange to see the person again soon*

- When counselling the person with a positive test result, handle the situation very sensitively. Remember that the person is likely very anxious and that the purpose of reviewing pre-test is to prepare the person to receive the result and to remind him/her of some of the coping mechanisms s/he may have thought of to cope with the result. This is not meant to be a quiz to see how much the person remembers.
- In the case of indeterminate results, counsellors must not give a result, even if under pressure from the client, explaining the reasons for the need to repeat the test.

### **Special requests/issues**

#### **a) Testing only**

Sometimes people require an HIV test result (usually an HIV negative 'certificate') so that they can travel abroad for work or study. This 'certification testing' should be done with standard pre- and post-counselling.

#### **b) Counselling only**

Sometimes people attend VCCT services to learn about HIV but do not want to consider HIV testing. Others may decide after pre-test counselling that they do not want to be tested or that they want to go away and think about testing. The counsellor should support the decision not to test, or defer testing and encourage people to come back for further counselling (with or without testing) whenever they are ready. The counsellor should view counselling without testing as being just as important as counselling with testing. Unfortunately in some VCCT settings there has been pressure to report high numbers of people accepting VCCT with no credit being given to counselling alone. There is a need to increase awareness of the value of counselling.

## ***Making Referrals***

Providing *only* VCCT without appropriate linkages, referrals and associated prevention and care services will lessen the impact of VCCT services on HIV prevention, care and mitigation outcomes.

### **a) Ensuring linkages**

One of the most crucial activities to ensure the provision of an effective VCCT service is identifying, strengthening and formalizing referral networks and developing linkages with care and support programme providers. Referral for VCCT services is a two-way process that creates linkages both with the community and clinic-based organizations. It is also recognized that community care and support services contribute significantly to the continuum of care through home-based care, family care and volunteers.

#### ***Ensuring linkages with the community***

- *Mapping all possible linkages (hospital, police station, schools, youth club, community health worker, hairdressing salon, farmers' co-op, church, traditional court, traditional healer, traditional birth attendant, etc) in the community can be a useful tool planning collaboration*
- *Maintain linkages with community support groups*
- *In situations where VCCT services use an anonymous system, ensure that care and support organizations near VCCT sites accept clients identified by code rather than name. These organizations need to respect clients' wishes, including the fact they may not reveal their serostatus*
- *Refer clients to community PLHA support groups when available (or if not, consider facilitating the establishment of a PLHA support group as appropriate)*
- *Engage in community mobilization/support efforts*
- *Ensure that site staff meet community partners on a regular basis to create demand for VCCT and to support clients. Regular community meetings could be arranged to share information between interested parties*

**Community-based** linkages include:

- Church leaders
- Youth leaders
- Partners of PMTCT clients
- NGOs/CBOs (including home-based care networks and peer educators)
- Traditional healers
- Traditional civic leaders (chiefs)
- Nutritional support
- Legal support
- Micro-finance institutions for small loans and skills-building
- Post-test support groups (can be specific to group, i.e. pregnant women, post-partum women, young people, sex workers, etc); must be linked with services for optimal effectiveness

**Facility-based** linkages include:

- ART services
- TB services
- STI services
- Out-patient services
- In-patient services (where testing is available in the health facility)
- Private clinics



**b) Post-test support groups/clubs**

Post-test support groups or clubs are often a useful feature of VCCT services. If PLHA groups are already in operation in the community it will be important for VCCT services to form close links with these groups and make plans for referring people who might benefit from the support they have to offer. PLHA representatives can be members of the VCCT planning team and can ensure good links with post-test support groups.

## ***HIV Testing***

HIV testing is the process by which blood or body fluids are tested for the presence of antibodies or antigens associated with HIV infection. Most HIV tests depend on detecting antibodies in the blood and not detecting the virus itself. HIV tests used in VCCT sites all detect antibodies to HIV. This means that very occasionally people who have been recently infected (in the 6 week period prior to coming for testing) with HIV will not test HIV positive. This is when people are said to be in the 'window period'. Counsellors should discuss the window period with clients and offer a repeat test after 6 weeks for clients testing seronegative but who have had risky sexual behaviour or possible exposure to HIV in the 6 weeks prior to testing (see section on window period).

### **HIV testing of children under 18 months old**

Antibodies to HIV are passed from mothers to their babies through the placenta and may be present in the baby's blood for up to 18 months after birth. This means that it is not possible to determine whether a baby is HIV infected using HIV antibody tests until he/she is older than 18 months.

### **HIV antigen tests**

Under special circumstances (for instance in someone that has recently been infected or in a case of a child born to a mother who is HIV positive) tests which detect the virus itself and not antibodies to HIV are available. Three common tests for which detect the virus itself are:

- P24 antigen detection (P24 is a protein on the HIV virus)
- Isolation of the virus by culture
- Amplification of the HIV genetic information (polymerase chain reaction or PCR).

These tests are not commonly available.

### **Types of test kits**

An essential requirement of all testing in VCCT sites is accuracy of the test result. The rapid tests, which are recommended by WHO, have been evaluated at WHO collaborating centres and have levels of sensitivity and specificity<sup>1</sup> comparable to WHO recommended ELISA tests.

#### **a) Enzyme-linked immunosorbent assay (ELISA)**

ELISA-type tests are used in hospitals and clinics (including private clinics) where there is a laboratory. A blood sample is taken from the person's arm and stored in a glass tube. Results can take from a few days up to two weeks depending on where the testing is taking place. For example, if the testing site has limited laboratory facilities and must send blood samples to larger towns for processing, there might be delays in receiving results. This is one of the reasons for greater reliance on simple rapid tests which often deliver same-day results.

ELISA tests were originally developed for blood screening and these assays are suitable for batch testing (testing at least 40-90 specimens per run). ELISA tests are suitable for large VCCT settings but in many VCCT sites the ability to perform single tests or small numbers of tests is an advantage.

#### **b) Simple/rapid tests**

*The MOHS has established guidelines for the use of rapid testing.*

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<sup>1</sup> **Sensitivity** – (of a test) – is the proportion of people who have the disease who are correctly detected by the test.

**Specificity** – (of a test) – is the proportion of people who DO NOT have the disease who are correctly identified by the test.

Introducing 'rapid' testing can be an effective way to increase access to the VCCT services. The projected expansion of VCCT services will include provision of services at primary health care, community based sites and expansion into rural and remote areas, necessitating the use of non-laboratory based HIV testing methods. Rapid tests are recommended for VCCT services in all settings. Rapid tests are much simpler to perform; they can be done in clinics without laboratories and are as accurate as ELISA tests. Usually, a very small sample of blood is taken from the person's fingertip. Rapid tests will usually give results in less than 10 minutes so that people can learn their HIV test result in one day.

In Sierra Leone, VCCT services are scarce, infrastructure is often weak, and travel and lost work time for testing and returning for results can act as a barrier to uptake of VCCT. Many people who want to know their test result also find it less stressful if they only have to wait an hour or so rather than returning a week or two later. Consequently, rapid tests should become the preferred method of testing.

The Ministry of Health and Sanitation have approved certain test kits for use in VCCT and other services. VCCT services should refer to those recommendations when planning service delivery and procurement of supplies.

Many clients are very keen to get their test result quickly. Yet the waiting time for ELISA tests results has been seen as a time for reflection, which gives pre-test counselling more of an impact. If a counsellor feels that a client might benefit from this additional time when a rapid test is being used, the client can be encouraged to defer testing if they are uncertain about coping with an immediate test result.

### **Window period**

There is a time called the '**window period**' which is from the time of getting infected to the time when the body has produced enough antibodies *to be detected on an HIV antibody test*. This period is usually about four to six weeks. This means that a person who has just been infected may test negative for HIV because their body has not produced enough antibodies to be picked up by the test. Such a person *can still pass the virus to others*, if for instance he or she donates blood, has unprotected sex or to her baby if she becomes pregnant.

Clients who test negative but who may have been exposed to HIV through risk-taking behaviour should be encouraged to return for a repeat test in 3 months. Clients who test negative with no possibility of recent exposure (in the previous 6 weeks) to HIV do not need to be encouraged to come for an additional test.

### **Related testing**

When possible, clients should be tested for syphilis in addition to HIV, using whole blood syphilis tests if available. Clients should be informed that syphilis testing is available, but clients can refuse syphilis testing. If a VCCT client is syphilis positive, they should be treated or referred immediately, if at all possible. Additional whole blood testing for other STIs should be introduced when possible and available. All HIV+ clients should be asked about cough and other symptoms of TB, and referred for TB testing if necessary.

## ***Suggestions for staff, space, equipment and supplies***

The following are suggestions for stand-alone or integrated VCCT services. These suggestions are not prescriptive but may help VCCT service providers make realistic estimations of requirements when setting up services. These checklists can be modified for very low volume sites, mobile services or VCCT services provided by home-based care teams.

### **Management of VCCT Sites:**

The person in charge of the clinic or department where the VCCT services are provided should manage VCCT sites located within health centres or hospitals. VCCT sites which operate as “stand-alone” sites should be managed by the director or person in charge of the site. A team approach to management, involving the counsellors, laboratory technicians, and others involved in VCCT service provision, is encouraged.

### **VCCT Team Training and Building:**

The emphasis in all VCCT sites should be on building a strong, multidisciplinary, multi-sectoral team for VCCT services. The team should include the site manager, counsellors, laboratory technicians, receptionists, volunteers, and if possible, persons living with HIV/AIDS. There should be consideration of including representatives of local organizations who provide related HIV/AIDS services in the community, and other community organizations and leaders.

### **Staff**

There is no specific staff for VCCT. The existing staff at the Hospitals will be used to carry out VCCT activities at the sites.

It is essential that the ranks of counsellors be expanded to accommodate increasing demand for VCCT services. However, the complexity of pre- and post-test counselling must not be underestimated; all individuals who provide counselling – on a paid or volunteer basis – must have adequate training to perform these duties in a professional and credible manner that will ensure quality of service and allow for clients to feel confidence in the counsellors’ skills, judgment and discretion.

- Broadening the definition and range of counselling cadres and providing HIV counselling training for a wide range of health workers and support staff is essential if VCCT services are to be available more routinely in health care settings.
- In Sierra Leone where demand for VCCT is increasing due to greater availability of care and support services and greater awareness about the value of knowing one’s status and the overall benefits of VCCT, services are encouraged to adopt a flexible approach to training and employing counsellors.

It is important that all VCCT staff – including all levels of support staff and security guards – receive training in sensitivity and confidentiality issues. Testing personnel who will draw blood for VCCT clients will need additional training in sensitivity to the possible elevated stress levels of VCCT clients and to the importance of confidentiality.

Training manuals and qualifications are in development.

## **Different levels of counsellors**

The recognition and training of different cadres of counsellors (such as counsellor supervisor, senior counsellor, basic counsellor) with different roles can enable the effective provision of VCCT and ongoing support, and help with special counselling needs such as adherence to medical care, without overburdening health workers. Some individuals who require counselling training will be medical personnel such as doctors and nurses, especially as VCCT in clinical settings becomes more common.

## **Supervision and support**

In addition to developing and expanding HIV counselling training, ongoing support and supervision for health care workers should be planned elements of VCCT services. Ensuring that counselling staff (including medical care staff in clinical settings) is motivated to promote VCCT and understand its benefits is important. Ensuring that all staff is supported sufficiently through stress management and mentoring strategies to prevent or mitigate the effects of 'burn-out' is essential.

Counselling support and supervision could include:

- **Counselling mentoring**

A more experienced counsellor can act as a mentor for a less experienced one. In a large VCCT site they may work in the centre. In smaller sites the mentor may visit the site periodically (e.g. one every 2-4 week) but also be available via telephone or email to discuss difficult cases or urgent problems. A formal review process can be built into this mentoring relationship.

- **Periodic counselling review meetings**

Many VCCT services have a counsellors meeting every 1-4 weeks where counsellors can discuss challenging cases and share experiences. For counsellors in isolated VCCT sites a meeting with counsellors in a mutually convenient location may be held 1-2 times a year. This regional or national meeting can also serve to update counsellors on new developments

- **Counsellor support groups**

Peer group support groups can help counsellors support each other in an informal environment where both social and work-related activities can be arranged. This mutual support can help to prevent burnout.

VCCT counsellors should have access to regular support supervision, with at least one supervisory session every two to four weeks. Such supervisory sessions may be provided in a group setting with other VCCT counsellors, although counsellors should have access to one-to-one support supervision when needed. Ideally, the group supervisory sessions should involve no more than ten VCCT counsellors.

All programs or projects providing VCCT should make appropriate arrangements and allocate resources for supervision of VCCT counsellors.

Those selected, as supervisory counsellors should be in a position to actually work as a supervisory counsellor. Those persons already in positions of management and those with many duties already should not be selected as supervisory counsellors.

Those selected, as supervisory counsellors should receive a course in support supervision and be interested in furthering their own training in counselling.

The primary responsibilities of these support supervisors will be to provide emotional support and professional feedback and guidance to VCCT providers. Their role will not be to provide administrative supervision.

These VCCT support supervisors may be MOHS staff and/or NGO staff. The District VCCT coordinator should oversee the provision of support supervision in each district.

General problems in administration or management of VCCT sites identified by the support supervisors will be reported to District VCCT Coordinator.

### Training of VCCT Counsellors:

- All VCCT counsellors should be trained using the National VCCT training guidelines and curriculum prepared and approved by MOHS. These guidelines should be used for all VCCT related training in Sierra Leone.
- Counsellors who meet certain qualifications may be trained in a shorter course which focuses on specific VCCT counselling, risk reduction counselling, use of rapid, whole blood tests, and management of VCCT services.
- All staff selected to serve as VCCT counsellors should receive adequate training so that they are qualified to perform the work. Plans should be in place for on-going training so that VCCT counsellors know that they will receive continuous, ongoing training to improve their skills.

### Selection and training of personnel to conduct testing:

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

### Training of Ancillary Staff:

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

<b>Staff</b>	
<b>A: Staff required for high-volume settings (10-20 clients per day)</b>	
<input type="checkbox"/>	<i>VCCT supervisor</i>
<input type="checkbox"/>	<i>Counsellors (1 for every 8-10 clients seen per day)</i>
<input type="checkbox"/>	<i>Testing personnel</i>
<input type="checkbox"/>	<i>Community co-ordinator (only for larger sites)</i>
<input type="checkbox"/>	<i>Receptionist</i>
<b>b. Staff required in low-volume settings (&lt;10 clients per day) or where there are budgetary constraints</b>	
<input type="checkbox"/>	<i>At least 2 counsellors (these individuals must have capacity to serve as VCCT co-ordinator community co-ordinator and even receptionist)</i>
<input type="checkbox"/>	<i>Sessional VCCT counsellors</i>
<b>Note:</b> <i>Where an integrated VCCT service delivery model is used, site management should allow those selected to devote most of their time to provision of VCCT services.</i>	

**VCCT supervisor**

Up to 50 % of this individual's time may be dedicated to the coordination of VCCT activities. Other responsibilities include supervision and support for counsellors. Site management should ensure that at least one member of staff has this qualification and that some portion of time is dedicated to this function.

**Counsellors**

During the project start-up phase, each site should have at least one counsellor dedicated to VCCT service delivery full-time. This number will increase as demand increases.

**Testing personnel**

These individuals are trained and allowed by national policies to draw blood and conduct simple/rapid HIV tests. These individuals may have the dual role of performing tests and counsellor (e.g., where clinical officers and nurses are employed as counsellors).

**Community co-ordinator**

At least 50 percent of this individual's time should be dedicated to VCCT. The role of the community co-ordinator is to link the service with the community and clinic-based facilities both for demand creation and support and care of VCCT clients. Additional roles may be in community mobilisation and post-test clubs. It may be possible to combine this role with that of the VCCT Co-ordinator.

**Receptionist**

The role of the receptionist is to welcome clients, register clients, collect user fees (if applicable), explain procedures, provide educational materials and enter data, where applicable. This full-time position is desirable but not essential.

**Sessional VCCT counsellors**

These individuals may provide part-time VCCT services, but there should be at least one formally employed VCCT provider or counsellor per site. Sessional (paid according to sessions worked) counsellors should be interviewed prior to assignment and receive the same training and supervision as employed VCCT providers and counsellors. VCCT co-ordinators should assign sessional counsellors clear and regular duties and working hours.

**Peer educators and supporters**

Counselling staff may benefit from the additional support of peer educators who can provide emotional support to clients prior to or following testing. These individuals are not counsellors and should not be referred to as such.

**Occupational Risks:**

Every measure should be taken to reduce the risk of occupational transmission of blood borne diseases and tuberculosis. If adequately trained and appropriately supervised, VCCT counsellors may be asked to draw blood and conduct simple, rapid HIV tests. Counsellors who perform this work should do so only after thorough training in these tasks. Protective material, especially gloves, should always be provided. Counselling rooms should be well ventilated. It is desirable that VCCT staff receive Hepatitis B immunization.

**Periodic Medical screening of VCCT providers:**

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

## Space

The issue of space is qualitative as well as logistical. People who wish to know their serostatus have concerns about confidentiality and privacy. There is also evidence that assurance of confidentiality and trust facilitates disclosure of risk behaviours. Service providers should ensure that there is adequate space to provide VCCT services in a **private and confidential** manner. Space should be made available as follows, depending on volume and financial resources. It is imperative that the VCCT rooms, reception area and laboratory appear attractive and comfortable to clients.

<b>Space (10-20 clients per day)</b>	
<input type="checkbox"/>	2 counselling rooms
<input type="checkbox"/>	1 laboratory space (if ELISA testing is the HIV testing method used)
<input type="checkbox"/>	1-2 waiting area
<input type="checkbox"/>	1 client screening room (room is optional: need to set aside a space to collect fees, data on client, determine purpose of visit)
<input type="checkbox"/>	1 well-ventilated pit latrine per site

## Equipment

<b>Equipment</b>	
<b>a. Counselling room</b>	
<input type="checkbox"/>	3 chairs
<input type="checkbox"/>	Filing cabinets
<input type="checkbox"/>	Storage space for communication materials
<input type="checkbox"/>	Storage space for blood drawing equipment (e.g., syringes, needles) and medical consumables
<input type="checkbox"/>	Disposal container for sharp objects
<input type="checkbox"/>	Glass, water, tissues
<b>b. Reception/Screening room (optional)</b>	
<input type="checkbox"/>	Cash box
<input type="checkbox"/>	Desk and chair
<input type="checkbox"/>	Two chairs
<input type="checkbox"/>	Filing cabinet
<input type="checkbox"/>	Office supplies
<input type="checkbox"/>	Computer for data entry (optional)
<b>c. Waiting area</b>	
<input type="checkbox"/>	Television and VCR (optional)
<input type="checkbox"/>	Two benches and enough chairs to seat 20 people at any given time
<input type="checkbox"/>	Open display for educational materials



## ***Logistics***

### **Procurement, storage and distribution procedures**

It is important to establish a delivery system that ensures a regular supply of test kits and condoms to VCCT outposts and no interruptions in supplies

The HIV test kit selection and HIV testing protocol to be used at the site has been decided according to government guidelines. If the site has decided to use rapid test kits, these will have to be procured according to MOHS rapid test guidelines.

### **Data management**

Systems for collection and analysis of all VCCT data are coordinated nationally, conforming to existing management information system of the MOHS. Standard forms should be used for all VCCT sites.

## ***Diagnostic testing in clinical care settings***

HIV testing should become a matter of routine whenever indicated by clinical signs and necessary to benefit health, but always be carried out voluntarily and with full informed consent.

*In clinical settings, informed consent procedures are often curtailed or ignored. All HIV testing in clinical settings requires the same standards of confidentiality and informed consent as ensured in traditional VCCT services. However, disclosure of HIV status to other health workers may be necessary to ensure optimal provision of care for PLHA.*

The major aim of VCCT in association with clinical settings is to identify and support PLHA who could benefit from HIV treatment and care. Knowledge of HIV status can not only enable PLHA to access a wide range of HIV treatment options but also ensure that people who test *seronegative* receive more appropriate care. Knowledge of status can ensure that seropositive people benefit from relevant investigations and more aggressive treatment, whereas those who test seronegative can be spared unnecessary medication.

The attending health care worker usually initiates the request for HIV testing and counselling based on suspected presence of HIV in a patient and relies on the confirmation of suspected HIV infection to guide clinical care.

### ***Situations indicating HIV testing in clinical settings***

- *The patient has clinical symptoms suggestive of HIV-related illness*
- *An HIV test is necessary to benefit the individual patient, either in terms of diagnosis or health care management*
- *Through IMCI protocols, a child may be identified with symptoms suggestive of HIV*
- *A guardian may bring a child for testing: the welfare of the child must be the paramount consideration here and health providers may refuse a test in cases where possible abuse or abandonment is suspected*
- *Testing may create opportunities for HIV prevention*

There are a number of advantages to integrating VCCT in clinical care settings. Referral for medical care is more rapid and there is less chance of people becoming lost to follow-up. Scaling up is also easier when infrastructure and staff are in place. Even in settings where antiretroviral treatment is not available, an HIV test can be an essential diagnostic tool, leading to better management of the patient's health, including diet, prevention of and treatment for opportunistic infections, palliative care and psychosocial support.

Once a diagnosis has been made and treatment plan set up, it is important to attend to a patient's psychosocial needs and other care and support needs, just as in standard VCCT services.

### **Special counselling issues in clinical settings**

Both medical and psychosocial considerations should be included in a comprehensive care package or treatment plan. Linkages with comprehensive VCCT services can also reduce the burden on clinical facility staff.

There is a range of issues that may need to be addressed by counsellors working in clinical settings beyond pre- and post-test counselling.

**a) Assessing 'readiness for testing'**

People who attend free-standing VCCT sites do so with the desire to be tested, whereas people attending medical services will have the prime objective of accessing medical care and may not have considered the benefits and implications of HIV testing. This highlights the importance of informed consent.

**b) Disclosure to partner, family member and carers**

Guidelines on disclosure should be followed; however, sharing information with other health workers on the HIV status of a patient may be necessary to ensure proper care and follow-up. Confidentiality of the patient must still be protected.

**c) Recognition and management of psychological/psychiatric illness**

Psychiatric and psychological illness including drug and alcohol problems is commonly seen in people with HIV. The identification and referral for treatment of people with psychiatric problems should be actively pursued as treatment could lead to an improvement in quality of life and may be important to help people access and adhere to ongoing medical care.

**d) Ongoing supportive counselling, including future planning**

Many medical services are not the ideal settings for ongoing counselling, so linkages with other counselling services, NGOs and peer and community groups can be important in ensuring continuity of care.

**e) Counselling around treatment failure, dying and death**

Counselling individuals and families about treatment failure, death and dying can be difficult for counsellors with limited training and experience. Referral to an experienced counsellor or counselling services away from the medical settings may be an option in some situations.

**Training health workers for VCCT service delivery**

Because many health workers and counsellors were trained before many of the current HIV treatment options were available, some remain overly cautious about promoting VCCT. There is a great need for health workers to demystify VCCT and to be advocates for its benefits, particularly for symptomatic PLHA who can benefit from medical care. Furthermore they should be flexible in their approaches to HIV counselling, identifying people who need more in-depth psychological support and allowing those who are well informed and have already considered the advantages and cautions of testing to have an accelerated approach to HIV testing.

## ***Prevention of HIV infection in infants and young children***

Preventing mother-to-child transmission of HIV and providing treatment and care to mothers and their infants can best be achieved by greatly increasing the access of women of childbearing age and their partners to HIV prevention, reproductive health and family planning services, and antenatal clinics. All health services concerned with women's health issues and PMTCT services in particular should ensure that women have the choice and ability to:

- Know their HIV status;
- Control their fertility;
- Terminate a pregnancy if they choose to – where this is safe and legal;
- Access ARVs for prevention of MTCT;
- Access other medical interventions such as OI and STI treatment and post-delivery IPT;
- Access psychosocial and spiritual support for positive living.

### ***Key components of PMTCT interventions***

- *Prevention of primary infection*
- *Prevention of unintended pregnancy in HIV-positive women through family planning or termination of pregnancy services*
- *Prevention of MTCT through ARV therapy and infant feeding counselling*
- *Long-term psychosocial support and care for mothers and family members*

### **Prevention of primary infection**

Interventions to prevent MTCT can only reduce the risk of HIV infection to children, so primary prevention of HIV infection in women of reproductive age and their partners is an important strategy in reducing HIV infection in infants. Men and women should have access to HIV prevention and reproductive health services, including diagnosis and treatment of sexually transmitted infections. VCCT should be available for young people and promoted for couples prior to marriage or conception to enable them to make informed long-term choices about their sexual and reproductive behaviour and to promote better communication and greater supportiveness among couples in general.

### **Prevention of unintended/unwanted pregnancy**

Although many women with HIV make informed decisions about pregnancy and are anxious to have children, some may become pregnant unintentionally and may not wish to continue with their pregnancy. Family planning services, counselling about reproductive health and termination of pregnancy should be provided, particularly for women with HIV, so that unwanted pregnancies can be prevented when and how women choose to do so.

### **Prevention of MTCT**

Interventions exist, including the use of ARVs and replacement feeding or exclusive breastfeeding, which can reduce rates of MTCT in women known to be HIV-positive. Other low-cost interventions, such as treatment of STIs, prevention of malaria, and avoidance of unnecessary invasive procedures during labour and delivery can benefit all pregnant women. Family planning should be provided for women in the postnatal period.

This is especially important if women choose not to breastfeed as they may have planned to rely on prolonged breastfeeding for infant spacing and will lose this benefit. Condom use during lactation is also recommended to prevent new infections, which will expose the infant to HIV.

### **Infant feeding options**

- **For HIV-negative women**  
*Exclusive breastfeeding for the first six months of life, followed by continued breastfeeding up to two years and beyond with appropriate complementary foods.*
- **For women of unknown HIV status**  
*Exclusive breastfeeding for the first six months of life, followed by continued breastfeeding up to two years and beyond with appropriate complementary foods.*
- **For HIV-positive women**  
*Replacement feeding with home-prepared formula or commercial formula where this is acceptable, feasible, affordable, sustainable and safe in the individual woman's circumstances.*  
***In most, these conditions are impossible to guarantee.***  
*Exclusive breastfeeding for the first months, discontinued as soon as it is feasible*  
*Expressed and heat-treated breast milk*  
*Modified animal milk*  
*Wet-nursing by an HIV-negative woman*  
*Breast milk banks, where these already exist*

### **Long-term psychosocial support and care**

This component of PMTCT recognizes the need to assure the long-term survival and well being of HIV-positive mothers in the post-natal period and thereafter. Long-term psychosocial support and care is gaining increasing attention on an ethical basis and for the practical consideration of ensuring care (through the long-term survival of the mother) for the increasing numbers of children who are being born free of HIV because of the success of PMTCT.

PMTCT programmes should seek to provide long-term treatment to HIV-positive women so that they can survive their own infections for a substantially extended period. In some settings, care, treatment and support are being provided for other members of the family as appropriate.

The approach includes basic care for prevention and/or treatment of opportunistic infections and, when indicated, treatment with ARVs. Some programmes will include information campaigns to raise international awareness; the purchase and distribution of drugs to prevent MTCT and to provide treatment; advocacy for the elimination of laws and regulations that delay access to drugs, and acceleration of education and training programmes for expanded implementation.

### **Opt-in/Opt-out**

Women attending ANC for routine care may not have considered the risk of HIV infection may not be ready to undergo testing and may have misgivings about confidentiality procedures. Low uptake of HIV testing has been observed in many antenatal care settings that use an opt-in strategy for HIV testing, in which clients are counselled and offered the option to go for HIV testing and then asked whether they wish to be tested; these women then 'opt-in' to a testing and counselling protocol. To increase uptake, opt-out strategies, are an alternative approach to HIV testing. Using this strategy, clinics adopt a policy to provide testing for all women. All clients are offered HIV testing, though they may decline, and thus 'opt-out' during the informed consent procedure. The advantage of opt-out is that the time needed for counselling is reduced, and there is a significantly higher uptake of testing allowing greater numbers of women to benefit from PMTCT interventions.

- In some programmes, post-test counselling of HIV-negative women is not carried out in order to save time and resources. This may result in a missed opportunity for prevention counselling.

## **Special issues**

### **a) Involving men in PMTCT**

There continues to be a need for more emphasis on the important roles and responsibilities of male partners in PMTCT programmes.

Acceptability and uptake of PMTCT interventions has often been low, with many women declining HIV testing or failing to adhere to ARV therapy or appropriate infant feeding choices. In most settings, few men are aware that their partners have been tested during their antenatal care, few women share their HIV status with their partners and even lower numbers of men receive VCCT either alone or with their partner.

If women are tested alone they will often be unable to make changes in their sexual behaviour to protect themselves from HIV infection if they are HIV-negative or prevent HIV transmission if they are HIV-positive, negating the wider benefits of VCCT in this context. Furthermore if women are tested alone, this can prevent uptake of and adherence to PMTCT interventions and increase their isolation and vulnerability. If a pregnant woman is unable to share her HIV status with her partner this can leave her unsupported in coping with her own HIV infection or reluctant to take antiretroviral therapy or make infant feeding choices that would identify her as being HIV positive. If she discloses her status to her partner, who has not undergone VCCT himself, she may be blamed or suffer abandonment or physical or emotional abuse. In many cases, men do not attend antenatal care with their partners.

### **b) Testing during labour**

When offering testing during labour for women who have not been seen in ANC clinics, informed consent may be difficult to obtain. Some programmes that seek to increase enrolment in PMTCT interventions will offer testing during labour on condition that intensive post-natal counselling is provided for both seropositive and seronegative women. Every effort should be made to get girls and women into ANC clinics prior to delivery and tested prior to labour.

## ***Strengthening linkages with related services***

In addition to scaling up VCCT services in existing settings, increased access can be achieved by strengthening linkages with health services where people who are attending are more likely to have HIV infection such as TB and STI clinics. Three types of health service offer unique opportunities for expanding access to VCCT and strengthening linkages with essential services.

### **TB/HIV collaborative activities**

In areas of high HIV prevalence, the majority of PLHA have active or latent TB. Active TB poses an increased risk of TB transmission to others while causing rapid progression to full-blown AIDS in co-infected individuals. However if PLHA have latent TB they can be given isoniazid TB preventive therapy (IPT) to prevent them developing active TB at a later date.

Thus VCCT is an important entry point to a package of interventions aimed at reducing the dual burden of TB/HIV. These interventions should include TB-specific screening for early diagnosis and treatment of active tuberculosis and provision of isoniazid preventive therapy (IPT) for individuals with latent TB. Other interventions which help prevent transmission of HIV or improve the health of PLHA and indirectly support TB prevention and control comprise the package of post-test services such as treatment of other common HIV-related complications, syndromic management of STI, cotrimoxazole therapy (bacterial prophylaxis), counselling about sexual health and condom promotion, PMTCT, ARV therapy, application of universal precautions by health workers and IEC for behaviour change.

Current information shows that effective TB control leads to improved HIV/AIDS management, and that effective HIV prevention strategies lead to reduced TB transmission and disease. It follows therefore that the strategy to prevent and control TB in high HIV prevalence countries should be an integral part of the strategy for HIV/AIDS prevention and control.

When planning for expansion of IPT, it will be important to consider that while it is inexpensive and reduces the risk of developing TB in 40% of people who take it, there is variability in adherence including drug sharing which creates resistance. Screening for good adherence must be in place as well as simple recording tools for clinical management, support from PLHA and good systems for TB screening and isoniazid delivery.

### **Sexual and reproductive health care**

HIV testing and counselling are still rarely provided as part of sexual and reproductive health (SRH) services, except in clinics for the treatment of sexually transmitted infections (STI). HIV considerations play a critical role in family planning and reproductive health counselling services. The counselling process in this setting needs to address sexual and reproductive health care needs, as well as HIV prevention.

#### **a) Linkages between VCCT, STI and FP services**

There are a number of approaches to strengthening the links between VCCT and SRH services.

- All HIV-positive people should be referred for STI screening and treatment.
- All individuals diagnosed with an STI should be offered referral for VCCT.
- STI services should refer HIV-positive clients for appropriate counselling regarding reproductive choices, care needs of pregnant women and the SRH needs of young people.

#### **b) Young people**

Addressing the needs of young people in SRH settings should be a key priority for increasing access to VCCT.

A number of factors put young people at increased risk of infection including:

- Early sexual debut;
- Emotional/developmental issues;
- Low levels of condom use;
- Biological and social vulnerabilities;
- High rates of STI and low awareness about symptoms and where to seek treatment;
- Alcohol/substance abuse;
- Practice of heterosexual anal intercourse in some areas;
- Health-seeking behaviour (generally non-formal settings);
- Pregnancy and abortion care (generally presenting late for ANC or not seeking appropriate medical support for birth or termination of pregnancy due to fear).

Sexual and reproductive health services – especially where youth-friendly services are available – offer one of the key opportunities for engaging this group and providing VCCT.

### **Youth friendly health services**



#### ***Diversification of service delivery settings***

- *MCH clinics*
- *Private family planning services*
- *Youth centres*
- *Stand-alone VCCT sites*
- *Schools*
- *Mobile services*



#### ***Special skills required***

- *Communication with adolescents and young people*
- *Gender sensitivity*
- *Peer counselling by other young people*
- *Advocacy for promotion of A-B-C (abstinence/delayed sexual debut, be faithful to one uninfected partner, or use condoms correctly and consistently)*
- *Advocacy for inclusion of elders to support young person*
- *Sensitivity to special concerns of young people around disclosure and stigma*
- *Non-judgmental attitude toward youth and their emerging sexuality*

### **Paediatric/child care**

Primary health care clinics present a valuable opportunity to identify both mothers and children with suspected HIV infection and provide them with VCCT to initiate ongoing care, treatment and support. The WHI Integrated Management of Childhood Illness (IMCI) programme prescribes screening, treatment and referral algorithms for all common childhood illnesses. Health workers noting symptoms suggestive of HIV infection in children are advised to counsel the mother and test the child. Post-test guidelines for HIV-positive children recommend counselling, treatment of specific illnesses, initiation of PCP prophylaxis for children under one year and counselling on infant feeding options.

- If the child with symptoms suggestive of HIV infection is not accompanied by an adult caregiver, the child must be brought back with a parent or guardian so that informed consent can be obtained prior to testing.
- Training of community-based health workers and home-based caregivers in recognizing symptoms suggestive of HIV infection can increase demand for community-based VCCT services.

Wherever possible it is preferable to involve both parents so that counselling and testing can be offered to all relevant members of the family. This can help avoid blame and help families make long term plans.



## ***Monitoring and evaluation***

In order to create and sustain demand for VCCT services and to ensure the impact of VCCT as a vital tool in the response to HIV/AIDS It is essential to ensure quality to promote the effective and ethical adoption of voluntary HIV testing and counselling services. Quality is ensured through having appropriate monitoring and evaluation as a key and planned component of interventions. The development of a simple system for routine monitoring, and periodic monitoring and evaluation of the quality of the service is critical to the design and implementation of programmes.

### **Process monitoring**

Routine demographic data of clients should be collected to monitor the demand for services by particular client groups. This is important for planning future staffing levels and training needs. It will also highlight clients groups that do not access services – e.g. young men or married couples – so that modifications can be made to the services to make them more acceptable to this group/these groups.

### **Monitoring the quality of the counselling services**

To ensure continuing quality of the counselling service monitoring is advised. This will help to identify any problems that are occurring with the services and identify burnout in staff at an early stage so that additional supportive measures etc can be put in place.

### **Data Collection system**

The national system for collection and analysis of VCCT data should be followed. This system has been developed in collaboration with the existing Health Information System of the MOHS. This includes a standard data collection instrument which should be used at all VCCT sites, including government and mission hospitals and health centres, NGOs, PLWHA organizations, and private and commercial sites offering voluntary HIV counselling and testing. When using the VCCT data form, counsellors should inform the client that no names are recorded on the form to reassure the client of the confidentiality of the information. A **Coding System** is employed which is a standardized system of assigning codes to clients for identification purposes. These codes are available from MOHS. This is of particular importance in VCCT sites where names are not recorded. All data should be sent to the M & E Coordinator of ARG for data entry. A copy should be retained at the VCCT site for record keeping. A standard filing system for VCCT records should be developed and followed. All efforts must be maintained to keep VCCT records confidential and stored in a secure room with lockable cabinets.

## ***Resources and further reading materials***

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UNAIDS Tools for evaluating HIV voluntary counselling and testing [www.unaids.org](http://www.unaids.org)

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