



Guidelines for HIV Counselling and Testing in Ethiopia

**Federal HIV/AIDS Prevention and Control Office
Federal Ministry of Health
July 2007**

Acknowledgements

The Federal HIV/AIDS Prevention and Control Office (FHAPCO) is grateful to the following individuals and institutions for their inputs in revising the Guidelines for HIV Counselling and Testing Guidelines in Ethiopia.

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Dr. Aida Girma	FHI
Dr. Yassir Abduljewad	JHPIEGO
Dr. Seyoum Dejene	USAID
Dr. Assefa Alem	FGAE
W/o Rahel Gebre Mariam	CRDA
Mrs. Pamela Scott	PEPFAR Ethiopia

HAPCO also wishes to acknowledge the contributions of Regional Health Bureaus and Regional HAPCOs in the development of this guideline.

The printing of the Guidelines has been funded by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). The Federal HAPCO is grateful for the support.

FOREWORD

HIV counselling and testing (HCT) is a key strategic entry point to prevention, treatment, care and support services. This is critically important for individuals and couples to learn about their HIV status and make informed decisions about their future.

The current rapid development in counselling and testing has necessitated reviewing and updating the guidelines for HIV counselling and testing, especially in the area of policy and implementation. Improved availability of antiretroviral medications and better treatment of opportunistic infections have created the opportunity to expand provider-initiated testing and counselling in health facilities thereby increasing access. The success of the first phase of the Millennium AIDS Campaign (MAC I) Ethiopia demonstrated the potential to provide extensive counselling and testing services throughout the country.

These guidelines reflect a significant shift towards more diversified approaches, to include not only diagnostic and voluntary counselling and testing, but also expanded provider-initiated, couple, youth-friendly and home-based models. The government effort scaled up the numbers of sites and people tested, using existing and new cadres of community counsellors, who both counsel and conduct testing. Task-shifting has been one of the most important innovations in the area of counselling and testing, using community counsellors it has reduced the burden on health care workers and increased overall testing numbers. Infant diagnosis using virological tests (DNA-PCR) is another major new initiative covered by these guidelines.

These guidelines will complement other contemporary guidelines to form a holistic approach to implementation of HIV/AIDS prevention, treatment, care and support. I trust these guidelines will provide a valuable tool for practitioners and program managers in the field.

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Acronyms and Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
APCT	HIV/AIDS/STI Prevention and Control Team
ART	Antiretroviral Treatment
ARV	Antiretroviral Drugs
BCC	Behaviour Change Communication
CBO	Community Based Organization
CCE	Community Capacity Enhancement
CC	Community Conversation
EHNRI	Ethiopian Health and Nutrition Research Institute
FP	Family Planning
FMOH	Federal Ministry of Health
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HAART	Highly Active Antiretroviral Treatment
HAPCO	HIV/AIDS Prevention and Control Office
HBC	Home-based Care
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
IP	Infection Prevention
NGO	Non Governmental Organization
OI	Opportunistic Infection
OVC	Orphans and Vulnerable Children
PITC	Provider-Initiated (HIV) Testing and Counselling
PLWHA	People Living With HIV/AIDS
PMTCT	Prevention of Mother-to-Child Transmission
QA	Quality Assurance
RHB	Regional Health Bureau
STI	Sexually Transmitted Infections
TB	Tuberculosis
UNAIDS	Joint United Nations Program on HIV/AIDS
VCT	Voluntary Counselling and Testing
HO	Health Office
WHO	World Health Organization
Zonal HD	Zonal Health Department

INTRODUCTION

HIV Counselling and Testing (HCT) is the key entry point to prevention, care, treatment and support services, where people learn whether they are infected, and are helped to understand the implications of their HIV status and make informed choices for the future. Currently, most people remain unaware of their HIV status due various reasons. However, with the development of affordable and effective medical care for people living with HIV, demand for testing is increasing rapidly, creating urgent need to increase access. The availability of HCT services in Ethiopia has been uneven, and even when available, uptake has been relatively low. Many people are reluctant to learn their HIV status when medical care for HIV-related illnesses and psychosocial support does not exist, and in the absence of community support and legal protection when they face discrimination and social marginalization.

There are three types of HIV testing in the country:

- Client-initiated, or voluntary counselling and testing
- Provider-initiated testing and counselling
- Mandatory HIV screening

Ethiopia responded to the HIV/AIDS epidemic as early as 1985. The Federal Ministry of Health and the HIV/AIDS Prevention and Control Office (MOH/HAPCO) developed an HIV/AIDS policy, different guidelines (PMTCT, ART, IP, VCT etc) and strategic documents to create an environment conducive for the implementation of HIV prevention, care, and treatment and support programs. As part of this effort, the first counselling and testing guidelines were published by the federal Ministry of Health (FMOH) in 1996 and the second edition, currently in use, in 2002.

Rapid expansion of the ART program provided an unprecedented opportunity to rapidly scale up HIV/AIDS prevention, care and treatment services in Ethiopia. To guide this movement, the government, with partners, developed several guidelines and strategy documents, such as: *The Ethiopian Strategic Plan for Intensifying the Multi Sectoral HIV/AIDS Response*, *The National ART Implementation Guidelines*, *National ART Clinical Guidelines*, and the national and regional *Road Maps for accelerating access to HIV/AIDS treatment in Ethiopia*.

Since the national VCT guidelines were last published in 2002, new information as well as evidence-based best practices have become available to make counselling and testing more effective and accessible, creating a need to revise the existing guidelines to steer counselling and testing services to increase access and improve quality more effectively. This will be achieved by implementing various counselling and testing approaches and service delivery models that can appropriately address facility and human resource related needs while maximizing utilization of existing resources.

This new version aims to produce an evidence-based HCT guide responsive to the new needs created by counselling and testing scale up, consistent with current scientific knowledge in the field, and attempts specifically:

- To improve and maintain HIV/AIDS counselling and testing services at an optimum standard through development and implementation of a comprehensive strategy
- To provide guidance for the scaled up, as well as general provision, management and evaluation of, HIV/AIDS counselling and testing at all service levels
- To provide a framework for regulatory control of counselling and testing services
- To promote integration of counselling and testing into all prevention, care and support programs for HIV/AIDS clients and patients with other life-threatening conditions

PART ONE - POLICY AND LEGAL CONSIDERATIONS

1. POLICY, ETHICAL AND LEGAL CONSIDERATIONS FOR HIV COUNSELLING AND TESTING PROGRAMS

POLICY AND LEGAL Framework

The following policy, legal and ethical statements reflect existing Ethiopian HIV/AIDS policy and replace the 1996 and 2002 VCT guidelines.

Policy objectives:

To promote and provide standard HCT services to individuals, couples, and community groups of all ages regardless of gender, and especially to vulnerable and high-risk groups.

1.1 HIV Counselling and Testing

Counselling and Testing, as a crucial intervention component of the HIV/AIDS prevention, care and support program shall be promoted and made widely available, affordable and accessible to all individuals and communities.

Policy Statements

- HCT services shall be integrated into existing health and social welfare services and promoted in all settings: government, non-governmental, private sector, cooperatives, workplace, faith-based organizations etc
- HCT services shall be strengthened through effective networking, consultation and collaboration among stakeholders
- HCT services shall be standardized nationwide and shall be authorized, supervised, supported and regulated by appropriate government health authorities
- Informed consent for testing shall be obtained in all cases, except in mandatory testing
- Adequate pre and post-test counselling shall be offered to all clients
- Test results, positive or negative, shall be related to clients *in person*, who must be provided with post-test counselling
- No results will be provided in certificate form, however referral will be offered to access post-test services (prevention, care and support)
- Clients' confidentiality will be maintained at all times. Results can be shared with other persons only at clients' request or agreement, and with those involved in clinical management of clients. Clients can be referred on if required or upon request.
- Mandatory testing will be done on all voluntary blood, tissue and organ donors, who shall be informed about HIV testing and given opportunity to learn their test results
- Provider-initiated testing and counselling (PITC) shall be promoted as part of standard clinical management and care in all health facilities
- Non health personnel shall be promoted as counselling and testing counsellors provided they receive adequate training according to the human resource recommendations in section four of these guidelines
- Mandatory HIV testing is a violation of human rights, only permissible in exceptional cases by order of a court of law
- Affordable HCT services shall be available in public health facilities, NGO and private sectors

1.2 Couple counselling

Couple counselling is promoted to enhance safer sexual behaviour and to encourage disclosure between sexual partners. Couples counselling and testing should be encouraged, and services should address couples' needs flexibly. Both partners must consent to testing and agree to learn the results together.

Policy Statements

- Couples shall be encouraged to be counselled, tested and receive results together Partner notification shall be encouraged in cases where one partner receives the results alone
- The privacy and autonomy of the couple and individual must be respected. Informed decisions shall be encouraged among discordant couples to protect negatives and support positives
- Pre-engagement, premarital, and preconception counselling and testing will be promoted

1.3 Counselling women

Women are particularly vulnerable to HIV infection and face multiple challenges in making decisions concerning their reproductive lives. Counselling can empower women to make informed decisions that prevent HIV infection.

Policy Statements

Women shall be routinely offered HCT during pregnancy and labour with the right to refuse testing.

1.4 Counselling children and youth

Children and youth have unique vulnerability to HIV infection, and as their ability to comprehend HIV/AIDS issues differs from that of adults, this population demands special consideration. The welfare of the child should be the paramount guiding principle when considering testing; counsellors should determine reasons for testing with the parent or guardian.

Policy Statements

- Persons 15 years and above are considered mature enough to give informed consent for themselves
- HIV testing for children under 15 shall only be done with the knowledge and consent of parents or guardians, and the testing must be done for the benefit of the child. However children aged 13-15, who are married, pregnant, commercial sex workers, street children, heads of families, or sexually active are regarded as "*mature minors*" who can consent to HIV testing

1.4.1 Child and Youth HCT

- In some special cases, such as child adoption, a counsellor may refuse a testing request when not in the best interests of the child
- Children who have been sexually abused and put at risk of HIV infection shall receive counselling, be encouraged to test for HIV and helped to access appropriate services
- The result of HIV testing is the property of the child tested and shall not be disclosed to third parties unless clearly in the best interest of the child
- Youth-friendly counselling and testing services shall be made widely available for this population

Diagnosis of HIV infection in young children

The diagnosis of HIV infection in young children is not straightforward, as maternal antibodies transferred passively during pregnancy can persist up to 18 months of age. Children fall into two categories concerning intervention: under and over 18 months of age

Children and infants under 18 months:

- Diagnosis of HIV-infection can definitively be made in children younger than 18 months by tests detecting the virus or its components (i.e. DNA-PCR). However, in the absence of DNA-PCR or molecular testing, an antibody test should be performed [even though this too cannot definitively diagnose HIV infection] to identify infection in children.
- *Diagnosing HIV infection in breastfeeding infants:* If a child is between 9-18 months when breastfeeding ceases, HIV antibody testing should be performed before DNA-PCR testing, because it is less expensive and often easier to perform than DNA-PCR testing; only those children who are HIV antibody positive need further DNA-PCR testing for definitive diagnosis of HIV.

Children over 18 months:

- HIV antibody or rapid HIV tests are used to diagnose HIV infection in children 18 months or older; a positive test confirms that the child is HIV-infected
- A negative HIV test result in a breastfeeding infant or child may not be conclusive; another test should be conducted at least six weeks after complete cessation of breastfeeding

1.5 HCT for individuals with physical disabilities and mental impairment

People with physical disabilities and mental impairment require special care when providing counselling and testing services, particularly regarding communication.

Policy Statements

- HCT service shall accommodate the special needs of people with visual and hearing impairments by adopting appropriate media of communication
- Individuals under the immediate influence of alcohol or addictive drugs (substance use) shall not be offered HIV testing due to a mental inability to provide informed consent
- HCT for a mentally impaired individual requires the knowledge and consent of his/her guardian, and should be for the benefit of the individual or patient

1.6 Ethics in Counselling

A code of ethics in HIV counselling and testing ensures competent professional behaviour, responsibility to the public, and supports providers in monitoring their own and their colleagues' behaviour.

Policy Statements

- All service providers shall abide by the rules, regulations and protocols contained in this document and other related guidelines
- All service providers shall observe the ethical requirements of confidentiality, informed consent, proper counselling, anonymity and privacy

- Shared confidentiality shall be promoted as an avenue to demystify and de-stigmatize HIV/AIDS
- Clients shall be encouraged to disclose their HIV status to their partners. When a client fails to disclose positive status to his/her partner for any reason, the endangered partner has the right to know the positive partner's HIV status. In this case, the counsellor must refer the situation to senior staff who will then decide concerning disclosure to the affected partner. The person or institution involved in this way will have legal protection.
- Diagnostic HIV testing can be done for unconscious patients without informed consent when necessary for clinical decisions, in situations where consent cannot be obtained from the next of kin.

1.7 HIV Counselling and testing training

Appropriate knowledge and skill through standardized training in HCT is essential for the provision of efficient and quality HCT services.

Policy Statements

- Institutions providing counselling and testing training shall follow the MOH national guidelines and training materials. Training shall only be accredited if it follows these standards
- Counselling and testing training shall be integrated in pre-service training curricula of health workers and other relevant professions
- Professional training in counselling shall be promoted and established at institutions of higher learning by the government and other relevant stakeholders

1.8 Research in counselling

Research can be used for program development and to improve the quality of services.

Policy Statements

- All HCT research shall conform to the relevant legislation and ethical standards of practice set by appropriate research ethical committees at various levels
- The Government of Ethiopia promotes and encourages research to improve access and quality of service delivery

1.9 Resource mobilization

Effective mobilization and utilization of resources are essential for making counselling and testing services available.

Policy Statements

- The government shall mobilize resources for counselling and testing services from public funds, community, private, implementing partners and other relevant agencies
- Institutional frameworks, support mechanisms and structures for HCT service implementation and monitoring and evaluation shall be provided by relevant government, community, NGOs, private and other related institutions

PART TWO - HCT IMPLEMENTATION

2. HIV/AIDS COUNSELLING AND TESTING (HCT) SERVICES

Client needs vary widely; therefore counselling and testing approaches and modalities should be flexible to respond appropriately. No single approach or service delivery model is suitable for all populations, or feasible in all settings. Choices and approaches will depend on the needs, availability of resources and accessibility.

2.1 HCT Approaches

2.1.1 Client-initiated voluntary counselling and testing (VCT)

Voluntary counselling and testing is initiated by clients seeking to know their HIV status. HIV testing in the context of VCT is considered public or social testing and constitutes a prevention strategy.

2.1.2 Provider-initiated testing and counselling (PITC)

This refers to HIV testing and counselling recommended during treatment by health care providers to enable specific clinical decisions to be made and/or specific medical services to be offered that would not be possible without knowledge of the person's HIV status. Provider-initiated HIV testing and counselling is voluntary and the "three Cs" – informed *Consent*, *Counselling* and *Confidentiality*– must be observed at all times. A brief counselling or pre test education/information should always accompany testing even for diagnostic purposes and patients should never be forced to undergo testing against their will.

In clients presenting *with symptoms or signs of illness possibly attributable to HIV*, it is a basic responsibility of health care providers to recommend HIV testing and counselling as part of routine clinical management. PITC also aims to identify unrecognized or unsuspected HIV infection in persons attending health facilities. Providers may therefore recommend HIV testing and counselling to patients who do not exhibit obvious HIV-related symptoms and signs. Such HIV testing and counselling is recommended by the health care provider as part of a package of services provided to all patients during all clinical interactions in the facility.

Either "Opt-in" or "Opt-out" strategies can be used in HCT:

"Opt-in" generally refers to counselling and testing where a client explicitly consents to the test.

With the "Opt-out" approach, individuals may specifically decline the HIV test having received pre-test information, without this decision affecting their clinical care

2.1.3 Mandatory and compulsory HIV testing

Compulsory HIV testing can only be performed for specific reasons with individuals or groups when requested by the court. In all cases of compulsory HIV testing, individuals shall be informed of test results.

HIV is a blood-borne pathogen readily spread by blood transfusion or tissue/organ transplantation; therefore it is mandatory to test blood or tissue for HIV before transfusion/transplantation/grafting. Mandatory screening of donated blood/organ/tissue is required prior to all procedures involving transfer of body fluids or body parts, such as artificial insemination, corneal grafts and organ transplant. Donors should be specifically informed about HIV testing of donated blood/organ/tissue.

2.1.4 Testing for medical research and surveillance

The main purpose of surveillance is to monitor trends of HIV infection and it should be linked either to consent or preserve anonymity. All studies must follow ethical standards set by the national research ethics guidelines.

2.2 HCT Service Delivery Models

HCT services can be provided through the following four models of delivery:

2.2.1 Integrated services

Integrated services are provided in public, NGO and private health facility settings, as designated VCT units or under other programs, such as TB, STI, PMTCT, paediatrics, OI and ARV drug management.

2.2.2 Stand-alone services

Stand-alone counselling and testing services are provided at sites outside health facilities; sometimes linked with care and support services.

2.2.3 Outreach and mobile services

Outreach HCT services should be considered for special populations such as people in remote rural areas, pastoralists, refugees and prisoners. Outreach HCT can be provided in mobile vans or in other premises, such as kebeles, churches and schools. These services can be integrated with existing primary health care services. Mobile VCT should be linked to the nearest care and support organization through a strong referral system.

2.2.4 Work place services

HCT services can be provided by trained practitioners in governmental agencies, NGO, and private sector institutions as part of comprehensive workplace HIV programs.

2.3 Operational Requirements

All HCT sites should fulfil minimum requirements regarding staff, space, equipment and supplies in order to provide quality HCT services as described by these guidelines.

Registration of HCT sites

Governmental health facilities providing HCT must be recognized by the respective authority – Ministry of Health, regional health bureau, zonal health department or woreda health office.

Private and NGO sites are expected to get proper authorization and registration by the above authorities so that standards are met and appropriate assistance is given.

2.3.1. Staff

Sites providing HCT services should ensure adequate staffing in accordance with demand for services and resources available. The staff must have received training as required by the FMOH.

Minimum requirement – one counsellor. If demand exceeds 15-20 clients daily, additional counsellors are required. One laboratory technician should be dedicated/ recruited to perform or supervise HIV testing (in situations where the rapid test is performed by the counsellors). A program coordinator (supervisor) is required for free standing sites.

2.3.2 Infrastructure

Infrastructure planning for counselling and testing must ensure adequate space and an environment that guarantees privacy and confidentiality. Provider-initiated testing and counselling can be offered in existing clinics with modifications to ensure privacy, either in the client flow or physical setting.

Minimum requirements -counselling room, VCT sign (to show location of the centre/clinic), waiting area, laboratory space, incinerator.

2.3.3 Equipment

Sites providing HCT should have the equipment and supplies necessary for the services. Some equipment may be shared with other services in a health facility setting. (Annex J)

2.3.4 Patient/client education

IEC materials should be available at all HCT sites particularly in VCT sites, to provide education to waiting clients. It is a cost effective intervention for providing information on HIV/AIDS prevention and treatment and services available.

2.3.5 Data management

All HIV counselling and testing sites should adopt the standardized data collection and reporting tools developed by the Ministry of Health so consistent standardized data is obtained at all levels of the health system. The healthcare facility should have staff assigned to compile and submit in a timely manner all HCT related data required by the reporting system. (Annexes M, N)

2.3.6 Referral linkage

HCT services are required to be linked to local referral services, to be able to track referrals, and to work cooperatively with internal and external post-test services. (Annex F)

3. STANDARD OPERATIONAL PROCEDURES AND PROTOCOL

HCT services begin with registration, followed by pre-test counselling and test consent. Test results are given in post-test counselling sessions. Clients may then be referred for follow-up support, at the CT site, to another facility, or to community services for care and support. (Annex E)

A user-friendly site guide, quick reference manual or CT algorithm should be adopted or developed to guide staff and clients concerning HIV counselling and testing services.

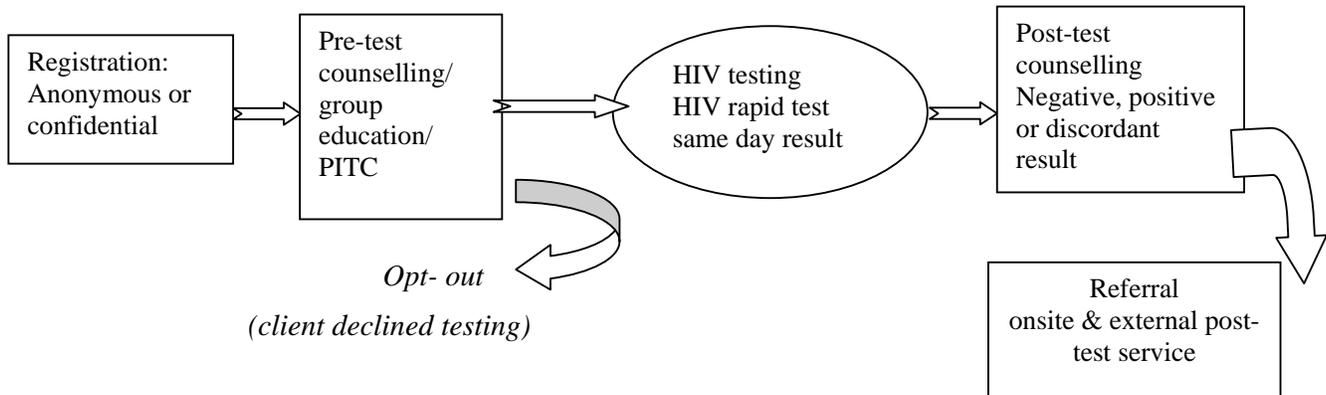
Same day results should be the principle goal of HCT service at all times irrespective of the type of delivery model. All HCT sites are encouraged to provide results as soon as possible after the test.

Client volume, type (whether couples, groups, positive results, other problems, etc) dictate the maximum number of clients served by a counsellor during one day. In order to ensure quality of service, for VCT the recommended minimum is 10-15 clients per counsellor per day.

3.1 HCT procedure/protocol

HCT service delivery starts with client registration, followed by pre-test counselling or group education/information, HIV testing, post-test counselling and referral.

Diagram showing HIV counselling and testing protocol and work flow



3.1.1 Client registration

Clients can be registered by code (anonymous) or by name (confidential). At VCT sites clients will be registered using unique identifiers (code numbers). (Annex A)

3.2 HIV counselling

HIV counselling is a voluntary dialogue between a counsellor and client, couple or a group of clients. It is a process of enabling clients to understand and make informed decisions on whether to be tested for HIV, to understand the results and facilitate future planning. The common components are pre-test, post-test and ongoing counselling.

3.2.1 Pre-test counselling

Pre-test counselling is given to individuals/couples before an HIV test, to ensure relevant knowledge exists to decide whether to be tested. This decision is normally reached during the counselling session, which provides opportunity for clients to explore their risk of HIV and learn about appropriate prevention strategies.

No HIV test should be provided without pre-test counselling or pre-test education/information. The patient should always be informed of his/her right to decline the test.

In provider-initiated testing and counselling, the pre-test session consists of education or information to individuals, couples or groups, and should be brief and focus on the benefits of testing and services available, like ART and PMTCT.

All sites providing HCT services, VCT or PITC, should ensure counsellors follow the standardized protocol to provide pre-test counselling/education.

3.2.2 Consent for HIV testing

To be beneficial counselling and testing must be voluntarily: people should be encouraged to seek but not be coerced into testing, only with full understanding of associated benefits, implications and consequences. Testing is the client's decision and should be ascertained by counsellors through written or verbal consent before the test. Counsellors should:

1. Ensure clients adequately understand benefits, implications and consequences involved in HIV testing before they give consent.
2. Recognise the right of clients to withdraw consent at any time, even after blood has been taken for HIV testing.
3. Recognise and promote the rights of those whose position to give valid consent to HIV testing is diminished due to age and/or mental impairment.

3.2.3 Providing HIV test results

It is the client's decision to learn the test results, which should never be issued in a public area but in privacy, in a session alone or as a couple.

3.2.4 Post-test counselling

All clients undergoing HIV testing should be provided with post-test counselling in person. The form of the post-test counselling session depends on the test result; this is often brief in provider-initiated testing. For positives, sessions will focus on providing support to cope and referral for care and treatment. Every opportunity should be given to the client to express his/her feelings about the results and related personal issues. The post-test counselling session should include the development of a risk-reduction plan specific to the client's results and personal life situation. The counsellor should help the client understand the importance of avoiding exposure to HIV.

Couples should be encouraged to receive results together.

In situations where the counsellor does not perform the test, results should be sent to the requesting counsellor/service provider, and not disclosed to clients.

All sites providing HCT services -VCT or PITC- should ensure counsellors follow the standardized protocol to provide post-test counselling.

3.2.5 Follow-up counselling

After counselling a client on test results, counsellors should take opportunity to review or share information that may not have been absorbed. Emphasis should be placed on prevention of further transmission, referrals to other services, involvement of partners and family members, coping mechanisms and identifying available support services and resources.

3.2.6 Repeat testing

Clients whose HIV test results are negative but who have had recent HIV exposure should be counselled to practice safe sex and asked to return for repeat testing at least three months after last exposure.

If the laboratory issues indeterminate results, the counsellor should explain to the client what this means, and the client should be asked to repeat the test in three months. If after three months results are still indeterminate, another blood sample should be taken and sent to a reference laboratory.

Some times counsellors may encourage a client to repeat the test with their partner, as if the testing were new, as a way of notifying the partner.

3.2.7 Issuance of written HIV test results

HCT sites should not provide written HIV test results to clients, to ensure confidentiality and avoid misuse of results. Clients requesting or requiring referral to other services should be referred to the appropriate institution. In cases where testing is ordered by a court of law, results should be communicated directly to the appropriate authority.

3.2.8 Disclosure of HIV test results to other people:

All clients, positive or negative, should be empowered to inform their sexual partner/s of their test result. When HIV-positive clients are reluctant or fearful to disclose their results, the counsellor should encourage additional counselling to help the client inform or bring the partner for testing.

If a client fails to disclose after repeated documented counselling sessions (2-3 within two weeks) and the counsellor feels the partner is at risk of infection, the counsellor should consult the supervisor, senior or immediate management staff for further action including revealing the result.

Disclosing HIV status to children is a process. Counsellors should be encouraged to answer children's questions truthfully from early age. Information should be given in a way a child can understand at a pace s/he can cope with. Prime responsibility for disclosing to the child lies with the parent or guardian; however, counsellors should support the parent/s or guardian in this process.

3.2.9 Quality assurance

Quality assurance (QA) for HIV counselling refers to periodic assessments of factors that affect the quality of HCT services: The QA team asks following questions time to time and addresses the gaps if any:

Have the counsellors received knowledge and skills training approved by the MOH?

Is there enough physical space for providing HCT ensuring privacy of the clients?

Is the client flow appropriate to efficient service provision?

Are the supplies available to provide HCT services?

Are clients satisfied with the services?

Are counselling sessions conducted following approved protocol?

There should be counsellor supervisors trained in HIV counselling and supervisory skills according to the national standards for training. Their roles and responsibilities are to:

- Determine if counsellors received standard trainings and refresher courses
- Monitor how well counsellors follow the counselling protocol
- Monitor whether clients feel their confidentiality is protected
- Make sure HIV test results are given in person during the post-test counselling session

3.2.10. Supportive supervision

Supervision of counselling services is a working alliance between a supervisor and a counsellor in which the counsellor gives an account or record of his/her work, reflects on it, and receives feedback and guidance. This can be done using different models such as:

- Individual supervision (peer or mentor based) or group supervision (group, pairs or triads, led or peer facilitated)

- Counsellor network (can be national, regional, or district based, or a counsellor support group)
- Regular monthly supervision from site supervisor
- Quarterly supervision from woreda supervisor
- Semi-annual supervision from zonal supervisor
- Minimum of annual supervision by regions and federal MOH HCT team

3.2.11 Referral and linkages

Provision of effective and quality counselling and testing services necessitates identifying, strengthening and formalizing referral networks and developing linkages with care and support programs.

A locally created and regularly updated referral directory of community and institutional care and support service providers, PLWHA associations or support groups should be available at the site. This referral directory should include the range of services offered, addresses and contact persons, available feedback mechanisms and other relevant information.

3.2.12 Family planning

Basic family planning information should be incorporated into all VCT counselling sessions, for all clients. Especially for HIV-positive clients, the risks of mother-to-child transmission should be explained as well as the benefits of family planning. 'Dual protection', the use of condoms for HIV and STI prevention and hormonal contraceptives for family planning, should be emphasized in the counselling session. When possible, family-planning services should be provided at the VCT site. If family-planning services are not available, or if the VCT counsellor does not have adequate time for family-planning counselling, VCT clients should be referred for family-planning services.

3.3 HIV testing

Quality testing is central in any counselling and testing program. HIV testing examines blood or body fluids for the presence of antibodies or antigens associated with HIV infection.

3.3.1 Types of HIV testing

The ELISA or rapid HIV tests used in all HCT sites in Ethiopia detect HIV antibodies; (however with these tests, recently infected people (within six weeks prior to testing) might test negative.

3.3.2 HIV rapid testing algorithm

HCT sites should use three rapid HIV test kits using the serial method. The kits in use at sites must have been validated by the Ethiopian Health and Nutrition Research Institute (EHNRI).

3.3.3 Specimens for HIV testing

Currently, recommended specimens for HIV testing remain whole venous blood, plasma and serum. Urine and saliva based tests should be used after EHNRI test validation.

Where testing is performed in the laboratory, specimens must be accompanied by a completed laboratory request form bearing the signature and name of the requesting clinician or counsellor who performed the pre-test counselling.

(Annex I)

3.3.4 Handling results

HIV test results should be sent to the requesting clinician or counsellor who performed the pre-test counselling.

In handling results, laboratory staff should adhere to the following:

- Absolute anonymity through the use of numbers and coding systems until results return to the counsellor
- A register should be maintained in the laboratory to record all incoming specimens by *date, time and requesting counsellor*

3.3.5 Infection prevention (IP)

Infection prevention measures are expected of all counselling and testing staff to protect their own well-being as well as that of clients. The national IP guidelines should be followed and practiced in all HCT sites performing HIV rapid testing.

3.3.6 Who conducts the HIV test

In order to expand availability and accessibility of VCT services to the public, counsellors trained in HIV rapid testing can perform HIV testing, using this method. These counsellors should undergo a standardized training in and should be certified to perform the rapid testing.

Regional health bureaus (regional labs or designated facilities) with the support of EHNRI, should be strengthened to train and certify counsellors in HIV testing and conduct post training supervision to maintain quality.

Laboratory personnel should provide supportive supervision and HCT program managers will coach and mentor staff on their roles and responsibilities.

3.3.7. Quality control of HIV testing

Only test kits validated by the Ethiopian Health and Nutrition Research Institute should be used by counselling and testing centres. Training and supervision of laboratory staff, accurate testing materials that are well stored and have not expired, and good maintenance of laboratory records are essential to quality HIV testing. Quality can be controlled and ensured by looking at:

- How consistently the protocol is used
- How valid the testing algorithm is in terms of specificity and sensitivity
- If the laboratory operating procedures are observed
- If infection prevention practice is in place

10% of negative and 30% of positive samples must be sent to the regional laboratory for external quality control *at sites which perform more than 500 tests per month*. For others, combined on-site evaluations with proficiency testing will be conducted once or twice a year. In addition, trained laboratory technicians may regularly retest samples tested by counsellors and other lab technicians as an *internal quality control*. Sites failing the proficiency tests need to receive additional technical supervision and support.

3.3.8. Supply management

To ensure a regular supply of test kits and other laboratory materials a well functioning management, storage and distribution system must be established and maintained at all levels. The system should promote proper quantification and timely procurement of test kits

required. Procurement should consider shelf life of kits to allow enough time to organize distribution to sites.

An effective mechanism of distribution of test kits should be established from EHNRI to regions and sites to ensure continuity of counselling and testing services; clients should never be turned away without services due to shortage of HIV test kits.

Regional health bureaus and zonal/woreda offices should build an effective distribution system for test kits and other lab supplies to the sites.

Counselling and testing sites are expected to:

- Keep sufficient supplies at all times
- Establish inventory management and regularly update stocks
- Conduct regular stock tracking at all levels to ensure continuity of services
- Track consumption and forecast needs for supplies
- Request test kits to respective offices ahead of time

3.4 HCT for Special Categories of People

3.4.1 HCT for children

Counselling and testing in the best interest of a child should improve a child's health, survival, development and social well-being. Children should participate in counselling depending on age and ability to understand about testing, and children's rights must be observed.

Children manifesting HIV/AIDS related symptoms should be tested. Parents of these children should receive provider-initiated counselling concerning testing their child, when the clinician believes it necessary, irrespective of the child's age and ability to understand. The child may not be informed of the results until s/he reaches an age of understanding, at which time s/he should be specially counselled. The parent or guardian should be counselled at both times. (Annexes K, L)

3.4.2 Informing HIV test results to mature minors

Mature minors should be informed their results like adults; children 13 years and older should be informed their results after proper counselling with the involvement of parents or guardians. Children under 13 and those who do not fit into the definition of mature minors should be informed about test results only with consent of parents or guardians and with proper counselling.

Notification to schools: An important step is to ensure that teachers and students are sensitized about HIV/AIDS to try to avoid stigmatization at school. Teachers should be trained in how to handle HIV-positive children. An HIV test is not a requirement for school enrolment.

Giving information about the HIV status of a child should be done only in the interest of that child and only to trustworthy teachers who have received training in HIV counselling.

3.4.3 Youth (13-30 years)

Youth are particularly vulnerable to HIV because of the strong influence of peer pressure and the development of their sexual and social identities which often leads to experimentation. As they are initiating sexual behaviour, counselling for safe practice is vital. Adolescents should

be counselled to delay their sexual debut and practice abstinence. While counselling youths the counsellor should:

- Be trained in youth-specific issues and how to be youth-friendly. Education materials that focus on youth issues should be available
- Provide ‘user-friendly’ service in a safe non-threatening environment
- Use language and situations youth understand
- Respect the dignity and confidentiality of every young person
- Use appropriate and multiple modalities for both in-school and out-of-school youth

Counselling and testing services to youth should be provided, where possible, by trained peer counsellors.

3.4.4 Pregnant women

HIV counselling and testing benefit women who are or want to become, pregnant. Individual or couples should be routinely informed about and have access to HCT services to make informed decisions about pregnancy and family planning. Women receiving counselling and testing in antenatal clinic settings should have their options discussed and be managed according to the national PMTCT guidelines.

3.4.5 HIV Counselling and Testing services for Most at Risk Populations

Populations most vulnerable to HIV infection include but are not limited to:

- commercial sex workers and their sex partners
- youth and street children
- persons detained in correctional facilities
- migrants and internally displaced persons
- individuals who abuse other substances such as non-injection drugs and alcohol

A comprehensive HIV prevention strategy must include combinations of interventions for these groups. Voluntary HIV counselling and testing should be adapted to specific populations using multiple approaches such as outreach.

3.4.6 Commercial sex workers

Counsellors must be sensitive to the problems of commercial sex workers while providing counselling; commercial sex workers are often under considerable pressure to perform risky activities e.g. sex without a condom, either through coercion or financial inducement. Counsellors should understand these issues (which should be addressed through their training) and help sex workers find ways to reduce obstacles they face when trying to reduce risk. The following strategies should be used:

- Sensitization of commercial sex workers (CSW) through distribution of HIV/AIDS educational materials or through VCT promotion
- VCT centres should be user-friendly and operate at hours convenient for commercial sex workers
- Encourage counselling and testing of CSW’ clients and of bar owners

3.4.7 Military or uniformed persons

Uniformed personnel in Ethiopia, (military or police), represent mobile high risk populations. Counselling and testing services for these groups should be developed with support from the military or police command and should include:

- Establishment of counselling and testing services in all military and police health facilities and in outreach programs to camps
- VCT promotion among uniformed personnel and stigma reduction
- Partner/spouse referral

3.4.8 Clients who require consent on their behalf

In the very rare circumstance where a patient is unable to consent to HIV testing, and the life of that patient or others depends on this knowledge, the attending clinician or next of kin may decide on behalf of the patient, that his/her blood can be tested. As soon as such a patient is able to understand, s/he should receive counselling. It is important for the service provider to give adequate counselling to the next of kin.

Unconscious patients should not be tested for HIV unless the clinician determines it necessary to establish diagnosis and make treatment decisions. The most senior clinician or counsellor in the institution should be consulted before testing an unconscious patient. The patient's next of kin should be counselled and supported before HIV testing is carried out and afterwards to understand the results and cope with the impact. Consent of kin should be obtained during counselling and clinicians should act accordingly.

3.4.9 Prisoners

Prisoners should be offered various opportunities to learn their HIV status and how to reduce their risk of infection. Counselling and testing in prisons should use different/mixed models, approaches, including provider-initiated testing and counselling for diagnostic purposes. Prisoners should not be subjected to mandatory testing unless ordered by a court of law. Ensuring privacy and confidentiality, establishing peer support systems and linking HIV-positive individuals with care and support; and treatment services are key elements in counselling and testing for prisoners.

3.4.10 Refugees and internally displaced populations

Refugees and displaced populations are vulnerable to HIV infection due to the economic and social insecurity related to their mobility. Most refugees, displaced persons, and asylum seekers do not have access to counselling and testing and do not know their HIV status. Providing HCT to refugee and internally displaced should use different/mixed models, approaches and context specific services for example, outreach VCT services through mobile units

4. HUMAN RESOURCE DEVELOPMENT

4.1 Counselling training, support and supervision

Increasing access to HCT requires flexible counselling approaches and widening the range of counselling and testing providers, including introduction of non-health professional counsellors.

Who should be a counsellor?

Those who received standard counselling and testing training:-

Influential respected community members

Dedicated school teachers

Motivated health workers

Peer counsellors/volunteers

PLWHA

Religious leaders

Dedicated adults who have completed 10th grade, for health facilities

Up to date training manuals for counselling and testing are needed for different levels of counsellors. All individuals trained in counselling and testing should be referred to as 'counsellors'.

Recognition and training of multiple levels of counsellors, such as counsellor supervisors, health professional counsellors, non-health professional counsellors with different levels of roles can enable effective provision of counselling and testing.

4.2 Counsellor support groups

There will be a strong national and regional network of counsellors constituting a professional association and a shared code of practice in order to standardize and monitor HCT service quality. RHB/HAPCO should provide strong support to establish counsellor support networks; to achieve legal status; enable meeting places and give other assistance.

4.3 Non Health Counsellors

Community counsellors shall be introduced to scale up rapidly the comprehensive HIV/AIDS prevention, care and treatment programs. These counsellors will perform HIV counselling and testing in all kinds of sites, such as health facilities, community and household levels, while supervised by trained and experienced counsellors.

FMOH in collaboration with partners developed selection criteria, and as feasible, regions/districts should set up joint selection committees, which includes representation from regional/district HAPCO and relevant NGOs, chaired by representatives of the regional/district health offices to identify, interview, scrutinize and select candidates.

Minimum requirements for candidates to be non-health professional counsellors are:

- Completion of 10th grade formal education
- Familiarity with local language and culture
- Residence in the community where s/he will work as a counsellor
- Being respected and known for his/her good social conduct by the community, e.g. school, church/mosque or community organizations
- Being self-motivated, hard-working and proactive
- Strong interest in HIV counselling
- Involvement in community-based interventions, such as Anti-AIDS club members, other voluntary activities, community-based care, etc
- Sound interpersonal relations and excellent communication skills

4.4 Training HCT personnel

Counselling and testing providers shall receive standard comprehensive training enabling them to provide counselling, constitute a professional association and do rapid testing under close supervision of lab personnel. Training will vary in duration from three days to four weeks with appropriate post training follow up and supervision according to the category of counsellor.

The training curriculum for all categories of counsellors must include:

1. Overview of HIV/AIDS and comprehensive prevention, care and treatment information
2. Principles of HIV counselling
3. Techniques and implementation of the rapid HIV test
4. Couple and child counselling
5. Program management/coordination and supervision, referrals, monitoring and evaluation related activities, such as record keeping and reporting formats
6. Provider-initiated approach for health professionals

The ‘non-health professional counsellors’ will be accredited to provide HCT service after successful completion of the practical training attachment.

The deployment of ‘non-health professional counsellors’ in public facilities will be conducted in phases based on available resources.

<p>HIV counsellor training</p> <p><i>Health professional counsellors</i></p> <ul style="list-style-type: none"> ➤ Three week classroom session followed by one week supervised practical attachment. (15 days classroom sessions and five days practical attachment) ➤ Provider-initiated testing and counselling should be integrated in all counselling trainings for health professionals, and courses should last a minimum of three days ➤ Provider-initiated testing and counselling for health personnel should be included in pre-service training <p><i>Non health professional counsellors</i></p> <ul style="list-style-type: none"> ➤ Four weeks classroom session followed by two weeks supervised practical attachment. (20 days class room and ten days practical attachment) ➤ 1 month internship under supervision of an experienced counsellor at site <p><i>Non health professional counsellors with other qualified/professional background like teachers, theologians, psychologists, etc</i></p> <ul style="list-style-type: none"> ➤ Four weeks classroom session followed by two one-week supervised practical attachments (20 days of classroom sessions and ten days practical attachment) ➤ 1 month supervised internship with an experienced counsellor on site
<p>HCT trainer</p> <ul style="list-style-type: none"> ➤ Practicing or experienced counsellors with at least one week training of trainer course on training/teaching/facilitation methodology followed by teach back for practicing training skills ➤ People with professional training on counselling and experience in HIV counselling ➤ Persons interested to become trainers <p><i>Professional counsellors-people primarily trained in counselling as a profession with a recognized qualification</i></p> <p><i>Continuing education</i></p> <ul style="list-style-type: none"> ➤ On site skill reinforcement training/coaching and mentoring by supervisor counsellor based on needs and identified gaps ➤ Case conferences, refresher courses, experience-sharing forums <p>Possibilities for advanced training in counselling need further exploration</p>

5. MANAGEMENT AND COORDINATION AMONG VARIOUS LEVELS

5.1 Coordination of HCT Services

In order to ensure optimal use of limited resources and maximum impact of services, coordination should take place at national level. Key elements of HCT coordination may include the following:

- Standards and protocols for testing including approval of specific test kits
- Official recognition of counselling cadres including salaries and benefits commensurate with other professional categories, establishment of selection criteria, definition of different levels of counsellors, accreditation mechanisms, training and supervision programs including development of standardized curricula as needed
- Selection of common indicators for uniform monitoring and evaluation which can be integrated into the national Health Management Information System
- Preparation of standardized 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
- Linkage and referral with community mobilization and grass root support groups
- Methods for sharing lessons and cross referral etc with other HIV services through, for example partners in other parts of the nation and based on resources availability with international groups

5.2 Coordination among various levels

Site Level

Counsellors, peer supervisors, peer educators, and laboratory technicians (where applicable) are expected to work as one team responsible for any activity or issues related to HCT. Teams should:

- Establish site level management comprised of management and technical staff
- Adhere to the HCT procedures and protocol developed by the FMOH
- Ensure that HIV test results are given in person, not in writing or by phone
- Ensure clients received appropriate HCT services and referral
- Monitor day to day site activities
- Ensure adequate supplies are on hand and request supplies in time to prevent stock outs
- Identify agendas for operational research

Woreda/Zonal Level

It is expected to have at least one person responsible for HIV/AIDS related services at woreda/zonal level. The woreda/zonal health office should monitor HCT services as any other health service and support problem-solving on site.

The zonal health desk should have at least one person for HIV/AIDS related activities. The zone needs to design a strategy for managing all HCT sites in its catchment in collaboration with the woredas, which includes:

- Provision of test kits and supplies to the sites
- Conducting supportive supervision regularly
- Coordination of and support to on site training
- Ensuring sites report activities regularly
- Organization of HCT promotional activities

- Conducting zonal review meetings
- Providing experience-sharing opportunities
- Establishment of and support to the zonal counsellors' support group

Regional Level

At least one person from every region needs to be available and responsible for HCT related issues. The regional health bureau should monitor and manage all the sites in close collaboration with the zones and woredas, which includes:

- Conducting regional review meetings
- Providing experience-sharing opportunities
- Establishing a regional counsellors' support group
- Organizing continuous regional trainings using the trainers/universities in the regions
- Establishing and ensuring functionality of regional HCT technical working group
- Leveraging funds for HCT services
- Purchasing laboratory equipment and supplies
- Conducting regular supervision and constructive problem-solving
- Performing external HIV testing quality control and panel /proficiency assessment
- Translating and adapting the national implementation guides and training materials a needed

National Level

At least two persons should be available and responsible for HIV/AIDS and HCT-related issues. The HIV team should coordinate and manage the counselling and testing program in close collaboration with the regions and zones which includes:

- Development of policy and operational guidelines
- Continued support to the national HCT Technical Working Group
- Review and adaptation of alternative models of HCT provision both for prevention and diagnosis of HIV
- Development/adaptation of training materials and approaches
- Maintain a current national HCT information management system to correlate regional data in order for use by the nation
- Conduct national review meeting
- Provide experience-sharing opportunities
- Support establishment of national counsellors' support groups and associations
- Build capacity of the regional health bureaus and regional laboratories in terms of training, logistics management and monitoring and evaluation
- Strengthen and ensure functionality of the national HCT technical working group
- Leverage funds for HCT service including government budget
- Purchase and distribute laboratory equipments and supply as per the national LMIS

6. MONITORING AND EVALUATION

In order to create and sustain demand for counselling and testing services and to ensure the impact of HCT in the comprehensive response to HIV/AIDS, appropriate monitoring and evaluation is a key planned component of HCT interventions.

6.1 Comprehensive monitoring and evaluation framework

Monitoring and evaluation takes place at multiple levels and stages of a program where different information is gathered, compiled and analyzed to demonstrate how services are

being delivered and their outcomes. HCT monitoring focuses on program implementation, quality assurance, ethical issues and confidentiality.

6.1.1 Data collection and reporting

The following program indicators will be monitored and evaluated at program level. All HCT sites will collect data related to service uptake using recordkeeping and reporting formats approved by the Federal Ministry of Health.

A monthly or quarterly report should be completed and transmitted to appropriate authorities by the sites. The collected data will be analyzed and interpreted to help in planning and decision-making. (Annex P)

Monitoring Data Collection Tools, roles, responsibilities and frequencies (see implementation manual)

Data Collection Tools		Responsible	Frequency
Client Intake Record	CIR	Counsellor	Routine
CT Log Book	Log	Counsellor	Routine
	Book		
CT Data: Monthly Reporting Form	MS (C)	Counsellor and Peer Supervisor	Monthly
Lab Monthly Reporting Form	MS(L)	Lab Tech	Monthly
CT Site Supervision Instrument	SSI	Woreda/Zonal Health Desk	Quarterly
Client Exit Interview Questionnaire	CEI	Zonal Health Desk and Peer Supervisors	Minimally twice yearly Zone/Region
Key Informant Interview and FGD Topic Guides	KI	Zonal Health Desk	Minimally twice yearly Zone/Region
External Quality Control Checklist	QC	Lab Tech & Regional Lab	Quarterly
Lab Request Form		Lab Tech	Routinely on each client

6.1.2. Data flow system of CT program

The following chain of HCT data and information flow in HMIS will be established at the HCT site:

- All recordkeeping forms and formats will be completed at the site
- Periodic reports as described above will be completed at site and transmitted to appropriate authorities

At Woreda health offices and zonal health departments

- Data collected from HCT sites within woredas or zones will be compiled, collated and reported to respective regional health bureaus

At regional health bureaus

- Regional health bureaus will compile all regional HCT site data and report to the Ministry of Health

At the Federal Ministry of Health

- Final compilation of national HCT service data will occur at the MOH

The HMIS will ensure that at each level, feedback is provided, so the information flow will be two-way.

Data collected will be utilized to monitor progress in counselling and testing program implementation, quality control and other important issues

6.2 Program Implementation

- Monitor if activities are being implemented as planned and if not, why not?
- Is the service cost effective? How much does it cost clients to receive counselling and testing directly and indirectly (fees, travel costs, hours of work lost)?
- Is there a need for technical assistance or other resources?
- Use counselling and testing data to identify who is using the service (male, female, urban, rural and by age group)
- Determine trends in service utilization
- Number of users of services by sex (male/female)
- Is referral and follow-up counselling provided?
- Are resources like test kits, equipment, IP supplies, protocols, and formats consistently available?
- Monitor whether clients are consistently asked for consent and if their information is handled confidentially (*Ethical issue*)
- What mechanisms are in place to help counsellors deal with stress and burnout?

6.3. Evaluating the HCT program

Evaluation of HCT program assesses whether the program is effective in achieving its objectives in general (WHAT and HOW much change occurred at beneficiary level).

6.3.1 Process evaluation: Process evaluation uses information such as service delivery data, supervisory reports, client satisfaction, counsellors' views and quality assurance data, to ensure services are delivered according to plan.

6.3.2 HCT program outcome evaluation: Measures short-term and intermediate effects, effects of the program on beneficiaries, and is conducted by program staff. For example, how many of those who tested positive were brought under care and support or treatment. MOH, regional health bureaus or delegated institution will conduct outcome evaluations periodically, every six months or annually.

6.3.3 HCT Program Impact Evaluation: (long-term effects): It is more appropriate for national level programs to look at the synergistic impact of all prevention, care and support programs. For example, how many new infections were averted as a result of counselling and testing and other HIV/AIDS-related services? Information on the impact of HIV counselling and testing can be obtained from periodical surveys, the Behavioural Surveillance Survey and Demographic Health Survey.

7. INCREASING ACCESS AND SCALING-UP OF HCT SERVICES

There are many examples of high quality counselling and testing services in developing countries; however, these are often small-scale and not particularly relevant to the Ethiopian context. The extremely low counselling and testing coverage of most rural and pastoral regions of Ethiopia is prioritized in the nation's Strategic Plan for HIV Prevention and Care. There is urgent need for rapid scale up of HCT services in general, with particular emphasis on accelerating access to PMTCT interventions and ARV treatment.

The counselling and testing service scale-up can be ensured through combined mechanisms:

- Expand services to increase numbers through improved access using different models of service delivery, and including people in high risk environments
- Use current decentralization of health sector capacity-building and the health extension program; using the Community Capacity Enhancement-Community conversation strategy to create further demand and uptake by providing community-based care and support mechanisms for referral and networking, also community counselling
- Expand geographical coverage to rural, pastoral and other areas underserved by government, NGO, private sector
- Identifying and advocating for policy that enhances scale-up of HCT services
- Conduct community conversations to foster attitudes and behaviours that promote counselling and testing among community leaders and in communities
- Conduct intensive promotional campaigns using appropriate communication media to mobilize society towards routine healthy use of counselling and testing
- Mainstream HIV/AIDS in general and counselling and testing in particular in all tertiary curricula and all health and social welfare and pastoral services; particularly pre-service training of health professionals, teachers, clergy (pastors and dawas), some social sciences like psychology and sociology

8. ADVOCACY, COMMUNICATION and SOCIAL MOBILIZATION

To increase counselling and testing service utilization and achieve the national ART target set in the Road Map, strong advocacy and strengthening of counselling and testing at all levels, and synergizing strategic approaches and efforts of various sectors, including the media, are critically required. Furthermore, identification of appropriate channels of communication and strengthening of large-scale community conversations should be given more attention.

Counselling and testing promotional campaigns should aim at changing norms, reducing stigma, and increasing support for and utilization of counselling and testing services. Effective communication for increasing demand for HIV counselling and testing should:

- Address the benefits of HIV testing
- Encourage target populations to access and utilize counselling and testing services
- Encourage sustained behaviour change after a person has been tested
- Be incorporated into the broader national HIV/AIDS strategy
- Encourage counselling and testing as a routine component of health-seeking behaviour

Institutions and organizations involved in planning, coordination and implementation of counselling and testing services should conduct campaigns to educate people at all levels about the benefits. In light of the introduction of provider-initiated testing and counselling, campaigns should launch HIV testing and counselling as a routine component of health-seeking behaviour, so that when a client is offered an HIV test in a clinical setting, s/he readily accepts it. HCT sites staffs should be involved in promotion activities and designing communication messages.

ANNEX B.

INSTRUCTIONS: VOLUNTARY HIV COUNSELLING AND TESTING (VCT) REGISTRATION

- Use the form to record information about VCT clients
- Job title of person completing the form: VCT counsellor
- The form should be kept in the VCT room

DESCRIPTION OF COLUMNS

Region: Put region name at the top of the register on the space provided.

Woreda/sub city: Put woreda/ sub city name at the top of the register on the space provided.

Name of HCT centre: Put name of HCT centre at the top of the register on the space provided. Do not use abbreviation.

Code of the site: Record the site code designated.

Type of HCT model: Specify the type of HCT model. Write Integrated, Free-standing, Youth, Private, Mobile, Home-based, Work place. Specify if you select *other*.

Serial number: Beginning from first line of register use numbers to represent clients in order counselled: 1, 2, 3...etc

Date: Record date the client is pre-test counselled. Enter the date in Ethiopian calendar **and** a format of DD/MM/YY.

Code: Client/ Couple/ Counsellor; Record codes for the client, the counsellor and for the couple, when applicable.

Age: Enter age of client in years.

Sex: Write M for male and F for female.

Address: Region/ zone/ woreda/ sub city, kebele/ peasant association; enter address of client as stated by client.

Marital status: Record using acronym from textbox at the bottom of the register for client marital status.

Educational status: Record using acronym from textbox at the bottom of the register for the client's educational status.

Employment status: Record using acronym in the textbox at the bottom of the register for client employment status. Specify if you select *other*.

Pre-test counselling: Write Y (for yes) or N (for no) if pre-test counselling is provided or not.

Test result: Test 1, Test 2, Test 3, Final Test; Enter test result using acronyms from textbox at the bottom of the register.

Post-test counselling: Write Y (for yes) or N (for no) if post-test counselling is provided or not.

Partner tested: Write Y (for yes) or N (for no) if partner was tested or not.

No. of children tested: Record the number of children of the client tested at the VCT centre.

Referred to: Specify the place to which the client is referred.

Remarks: Record any information you believe relevant.

ANNEX D

INSTRUCTIONS: PROVIDER-INITIATED HIV TESTING AND COUNSELLING (PITC) REGISTRATION FORM

- Use this form to record information about PITC clients
- Job title of person completing the form: PITC counsellor
- This form should be kept in clinics where PITC is provided

DESCRIPTION OF COLUMNS

Region: Put region name at the top of the register on the space provided.

Woreda/sub city: put woreda/sub city name at the top of the register on the space provided.

Name of health facility: Put name of health facility at the top of the register on the space provided. Do not use abbreviation.

Department: Specify department where the PITC was provided (OPD, TB clinic, Inpatient etc).

Serial number: Beginning from the first line of register use numbers to represent clients in order they were counselled: 1, 2, 3... etc

Date: Record date the client is pre-test counselled. Enter date in Ethiopian calendar **and** a format of DD/MM/YY.

Patient's name Client code: Write the patient's name or code as applicable.

Card no.: Record the patient's card number from the patient's hospital card.

Age: Enter age of client in years.

Sex: Write M for male and F for female.

Address: Region/zone/woreda/sub city, kebele/ peasant association; Enter address of client as stated by client.

Marital status: Record using acronym in textbox at the bottom of the register for marital status of the client.

Educational status: Record using acronym in textbox at the bottom of the register for the educational status of the client.

Employment status: Record using acronym in textbox at the bottom of the register for the employment status of the client. Specify if you select *Other*.

Clinic diagnosis: Record using acronym in textbox at the bottom of the register for presenting diagnosis of the patient. Specify if you select *Other*.

Pre-test counselling: Write Y (for yes) or N (for no) if pre-test counselling is provided or not respectively.

Test result: Test 1, Test 2, Test 3, Final Test; record test result using acronyms in the textbox at the bottom of the register.

Post-test counselling: Write Y (for yes) or N (for no) if post-test counselling is provided or not respectively.

Partner tested: Write Y (for yes) or N (for no) if partner was tested or not respectively.

No. of children tested: Record the number of children of the client tested for HIV.

Referred to: Specify the place to which client is referred.

Counsellor's name and signature: Specify the counsellor name and include signature.

Remarks: Record any information you believe relevant

ANNEX E: VCT Client Record

RECEPTION						
Country	Region	Woreda	Site Code	Site type Circle one 1 Free standing (NGO based) 2 Mobile 3 Primary health care (health centre/ hospital) 4 Clinic 99 Other	Org type Circle one 1 NGO 2 Gov. 3 Private	Residence Circle one 1 Urban 2 Rural 9 Other
Client code	Return visit Circle one 0 No 1 Yes	New client code Circle one 0 No 1 Yes 99 N/A	Age	Sex Circle one 1 Male 2 Female	Counsellor code	
Date of visit (dd/mm/yyyy)					Partner code	Couple code
PRE-TEST COUNSELLING SESSION						
Session type Circle one 1 Individual 2 Couple 3 Group 99 Other	Marital Status Circle one 1 Married 2 Never married 3 Separated 4 Divorced 5 Widowed 99 Other	Couple Type Circle one 1 Married 2 Premarital 3 Presexual 4 Sex partner 98 N/A 99 Other	Education Circle one 0 Illiterate 1 Able to read 2 Primary 3 Secondary 4 Tertiary 99 Other	Employed Circle one 0 No (Inactive) 1 Yes (Active)	Occupation Circle one 1 Legislators, Sr. Officials, Managers 2 Professionals 3 Technicians, Ass. Professionals 4 Clerks 5 Service, Shop, Market, Sales	6 Skilled Ag. & Fishery workers 7 Crafts & trades 8 Plant/Machine Op., Assembly 9 Elementary occupation 10 Students 99 Other

Heard of the Service: Circle all that apply 1 Radio 2 Outreach 3 Posters 4 Other clients 5 Newspaper/magazine 6 Health institution 7 Telephone hotline 8 Anti-AIDS clubs 9 A PLWHA 10 Friends and family 11 CBO 12 TV 98 N/A 99 Other		Client referred by: Circle one. 1 Self – not referred 2 Public health institution 3 Private health institution 4 Military health institution 5 Friend or relative 6 Community-based organisation 7 NGO 8 School 9 Religious institution 10 Client 11 A PLWHA 99 Other		Primary reason here Circle one 1 Client risky/Had risk 2 Partner risky/Had risk 3 Doesn't trust partner 4 Ill/Symptoms 5 Premarital 6 Marital reunion 7 Family planning 8 Visa applicant 9 Referred 10 2nd Test (win.) 11 Confirm positive result 12 Get results of prev. test 13 Need counselling 14 Test before pregnant		15 Pregnant, must know 16 Plan for future 17 Death/illness of partner 18 Occupational exposure 19 Other blood/fluid exp. 20 Sexual assault 99 Other		Suspected expos. time Circle one 1 <1 month 2 1 to 3 months 3 4 to 6 months 4 Over 6 months 98 N/A					
Previously tested? Circle one 0 No 1 Yes, HIV+ 2 Yes, HIV- 3 Yes, inconclusive 4 Result not given 5 Didn't take results 99 Other		Date prev. test? _____ Month Year		Where prev. tested? Circle one 1 NGO 2 Public health Inst. 3 Private Health Inst. 98 N/A 99 Other		Ever had sex? Circle one 0 No 1 Yes		Condom use last 3 mos. Circle one 0 Never 1 Always 2 Sometimes 98 N/A		Used condom last sex? Circle one 0 No 1 Yes 97 Doesn't remember 98 N/A		History of STI Circle one 0 No 1 Yes 97 Don't know	
No. Casual partners last 6 mos. No. Steady partners last 6 mos.		Is client sex worker? Circle one 0 No 1 Yes 2 Counsellor thinks so 97 don't know 98 N/A		Is client pregnant? Circle one 0 No 1 Yes 97 Don't know 98 N/A		Result client expects Circle one 0 Negative 1 Positive 97 Don't know 98 N/A		Pre-test partner notification plan Circle one 0 Refused to notify 1 Agree to notify 2 Plan to notify 3 Unsure 98 N/A					

POST-TEST COUNSELLING SESSION			
Couple discordant Circle one 0 No 1 Yes 98 N/A	Refused results Circle one 0 No 1 Yes 98 N/A	Condoms accepted Circle one 0 No 1 Yes 98 None available	Number condoms given _____
Risk reduction plan developed Circle one 0 No 1 Yes	Post-test partner notification plan Circle one 0 Refused to notify 1 Agree to notify 2 Plan to notify 3 Unsure 98 N/A	Client referred to: Circle all that apply 1 Follow-up counselling 2 Social services 3 TB clinic 4 Hospital 5 A PLWHA 6 STD Clinic 7 Family planning 8 Post-test club 98 N/A 99 Other	SERVICES RENDERED Circle one Refused services 0 No 1 Yes Counselled Circle one 0 No 1 Yes Gave test Circle one 0 No 1 Yes Received results Circle one 0 No 1 Yes Referred Circle one 0 No 1 Yes Condom demonstration Circle one 0 No 1 Yes Other: _____

Comments: _____

Counsellor's Signature: _____

ANNEX F: Client referral form

Site name: _____ Date of Referral: _____
Client Name/Code: _____ Age _____ Sex _____
Referred by: _____ (name of counsellor)
Date of HIV test: _____ HIV status (if required): _____
Referred to (name of institution): _____
Address: _____ Tel: _____
Dear _____

The referred client received HIV counselling and testing service at this centre. We are referring him/her for your kind attention for the following care/support:

- 1. Ongoing (follow up) counselling
- 2. Antiretroviral treatment
- 3. TB screening
- 4. OI treatment
- 5. PMTCT
- 6. Paediatric care service
- 7. Family planning
- 8. Adherence counselling
- 9. Food support or nutritional counselling
- 10. Home-based care
- 11. Medical care (unspecified)
- 12. Psychosocial support
- 13. Financial or material support
- 14. Orphan support
- 15. Income generating scheme
- 16. Other (please specify) _____

Date _____ Signature _____

Feedback to referring facility (cut and send this section back to referring facility)

Client name/code _____ Age _____ Sex _____

Date client reached at the service unit _____ Client's referral accepted __ Yes __ No

Care/support service initiated __ Yes __ No Other (specify) _____

Date _____ Signature _____

ANNEX H

INSTRUCTIONS: HIV COUNSELLING AND TESTING LABORATORY REGISTRATION FORM

- Use this form to record HIV information about HCT clients
- Job title of person completing the form: laboratory technician
- This form should be kept in the laboratory where testing is performed

DESCRIPTION OF COLUMNS

Region: Put region name at the top of the register on the space provided.

Woreda/ Sub city: Put woreda/sub city name at the top of the register on the space provided.

Name of health facility: Put name of the health facility at the top of the register on the space provided. Do not use abbreviation.

Testing site: Write the laboratory where the test is performed (OPD lab, Inpatient lab, VCT lab etc)

Serial number: Beginning from the first line of the register use numbers to represent clients in the order they were tested. Examples 1, 2, 3...

Date: Record date the client is tested. Enter the date in Ethiopian calendar **and** a format of DD/MM/YY

Patient's name/ Card No: Write the patient's name or card number as applicable.

Code: Client/Couple/Counsellor: Record codes for client, the counsellor and for couple when applicable.

Age: Enter age of client in years.

Sex: Write M for male and F for female.

Address: Region/zone/woreda/ sub city, kebele/ peasant association: Enter address of client as stated by client.

Requesting Unit: VCT/ PIHCT/ PMTCT/ TB: Enter the unit requesting the test

Expiry date of the kits used in this test: Record the expiry date of the kit used in this test as stated on the pack. Enter the month and year in European calendar and a format of MM/YY

Test result: Test 1, Test 2, Test 3, Final Test; Enter test result acronyms as given in the textbox at the bottom of the register.

Remark: Record any information you believe is relevant.

Laboratory Technician's Name and Signature: Write the laboratory technician's name and include signature.

ANNEX I

*HIV Counselling and Testing Services
Laboratory Request and Results Reporting Form*

Date _____

Name of health facility _____ Department _____

Region _____ Woreda/ sub city _____

Patient's name/code _____

Card no./ ANC card no. _____ couple code _____

Age _____ years Male Female

Sent from: VCT PITC PMTCT TB unit/clinic

Test requested by: Counsellor's name/code _____

Signature _____

Date _____ Time _____

HIV Test Results (check box)

<u>Test I</u>	<u>Test II</u>	<u>Test III if done</u>
Reactive <input type="checkbox"/>	Reactive <input type="checkbox"/>	Reactive <input type="checkbox"/>
Non reactive <input type="checkbox"/>	Non reactive <input type="checkbox"/>	Non reactive <input type="checkbox"/>

If any of the above test *not done* check the following Test I Test II Test III

(Specify reason) _____

Final result: Reactive Non reactive

Final result Not determined (specify reason) _____

Test result reported by _____

Signature _____

ANNEX J: Checklist for Equipment and Supplies for VCT

Item	Essential	Optional
Reception Area		
○ Table with drawers	✓	
○ Chairs	✓	
○ Registration/clients cards	✓	
○ Client record (intake) form	✓	
○ Behaviour change communication materials	✓	
○ Stationery	✓	
○ Timer Clock		✓
Waiting Area		
○ TV/VCR		✓
○ Radio Cassette Player		✓
○ Posters	✓	
○ Pamphlets	✓	
○ Chairs or benches	✓	
○ Drinking water		✓
Counselling room		
○ Table with lockable drawers	✓	
○ Three chairs	✓	
○ Counselling protocols and cue cards	✓	
○ Condom demonstration tools, e.g., model penis	✓	
○ Condoms Male	✓	
○ Female		✓
○ Referral notebooks	✓	
○ Stamp pads	✓	
○ Posters	✓	
○ Screens/curtains (if HIV testing is done in the counselling room)	✓	
○ If HIV testing in counselling room, supplies required	✓	
○ Stationery (include files, pens, notepads)	✓	
○ Tissue paper /paper towels		✓
○ Timer/Clock	✓	
Testing room		
○ Test kits	✓	
○ Lancets	✓	
○ Sharps disposal container	✓	
Item	Essential	Optional
○ Waste disposal bag (non sharps)	✓	
○ Pipettes	✓	
○ Tubes, needles, test tube racks	✓	

○ Centrifuge	✓	✓
○ Refrigerator	✓	✓
○ Incinerator	✓	
○ Gloves	✓	
○ Disinfectant + cleansing agent	✓	

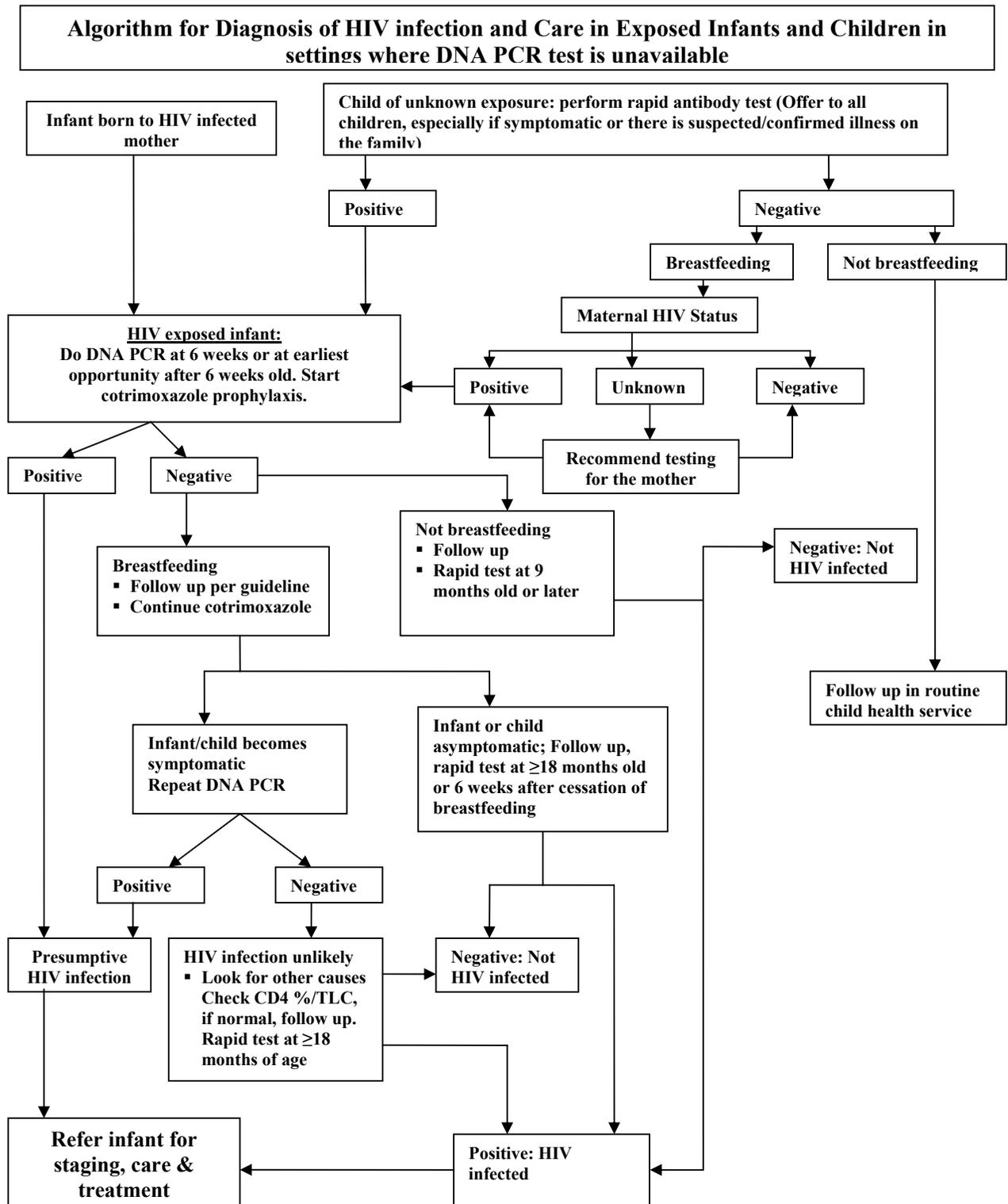
Item	Essential	Optional
○ Sundry supplies – cotton, dishes	✓	
○ Needles and syringes	✓	
○ Soap and water	✓	
○ Lighting	✓	
○ Protective wear	✓	
○ Stationery	✓	
○ Worksheets	✓	
○ Filing cabinet	✓	
○ Lab slips	✓	
○ Stamp pad	✓	
Management Information System (MIS)		
○ Client number stickers	✓	
○ Computer and accessories		✓
○ Stationery	✓	
○ Lockable drawer	✓	
○ Client # labels (stickers)	✓	
○ Chairs + table	✓	
○ Lockable cupboards for client records	✓	
○ Office supplies (pens, hole punch, staples, pencils, markers)	✓	

Essential: Essential items are those VCT providers *must* have.

Nonessential: Nonessential items are those that are good to have and a VCT site provider can acquire along the way as needed.

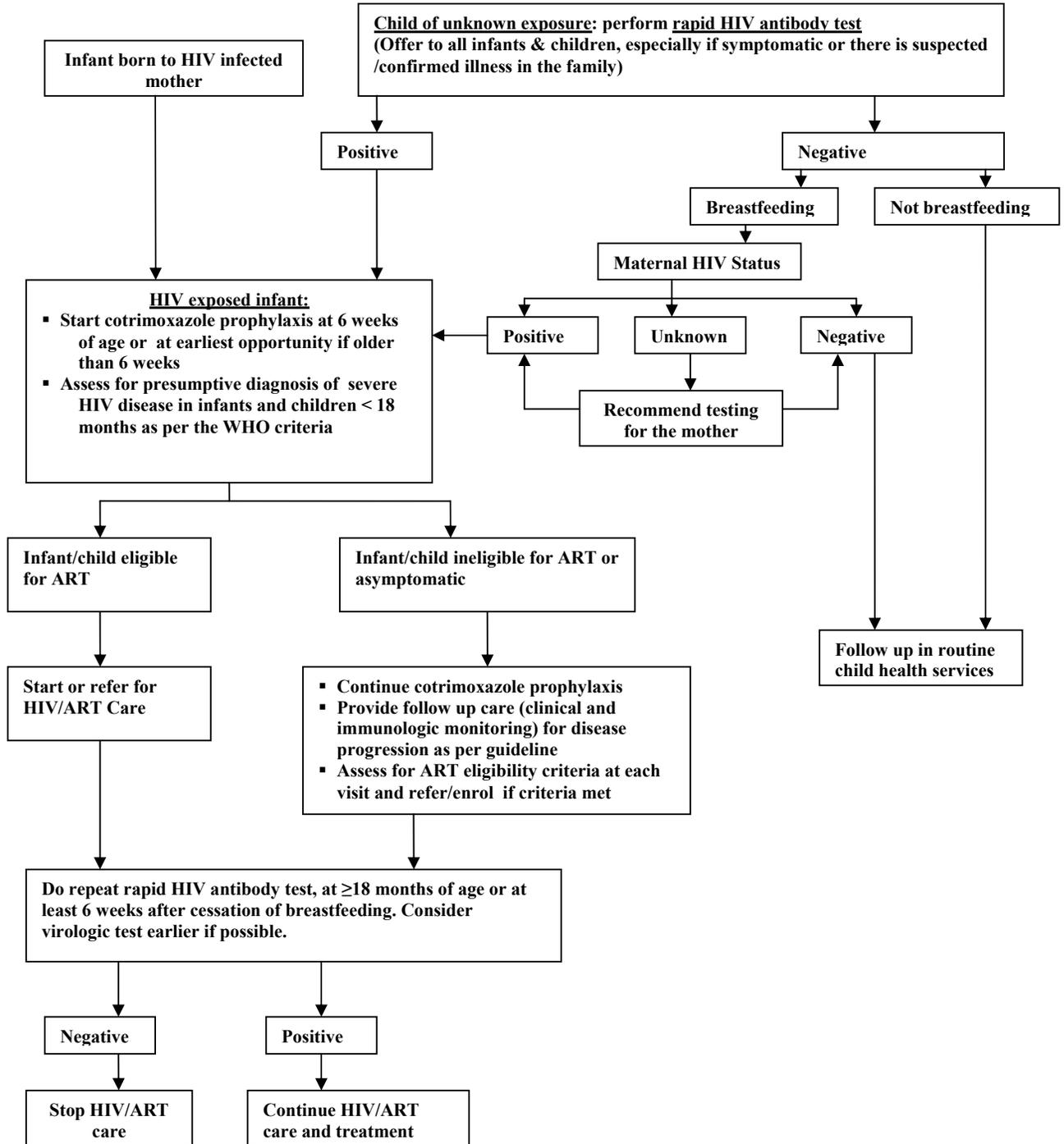
NOTE: Equipment like centrifuge and refrigerators can be listed as essential or non-essential depending on the type of HIV tests in use; some tests require refrigeration while others do not.

ANNEX K: HIV diagnosis algorithm in children where DNA PCR test is unavailable



ANNEX L Infant Diagnosis without DNA PCR

Algorithm for Diagnosis of HIV infection and Care in Exposed Infants and Children in settings where DNA PCR test is available



ANNEX M Monthly HIV Counselling and Testing Report Form

Region:	Woreda/sub-city:
Name of health facility:	
Month:	Year:

Voluntary Counselling and Testing (VCT)

Age Group	Number pre-test counselled		Number Tested			Number post-test counselled		Number Positive		Number positive referred	
	Male	Female	Male	Female	Total	Male	Female	Male	Female	Male	Female
0-4											
5-14											
15-19											
20-24											
25-49											
50+											
Unrecorded											
Total											

Provider-initiated Testing and Counselling (PITC)

Age Group	Number pre-test counselled		Number tested			Number post-test counselled		Number Positive		Number positive referred	
	Male	Female	Male	Female	Total	Male	Female	Male	Female	Male	Female
0-4											
5-14											
15-19											
20-24											
25-49											
50+											
Unrecorded											
Total											

Compiled by _____ Signature _____ Date _____

Checked by _____ Signature _____ Date _____

Reporting date _____

ANNEX N

FEDERAL MINISTRY OF ETHIOPIA

Instructions: Monthly HIV Counselling and Testing Data Reporting Form

Each counselling and testing facility reports HIV counselling and testing monthly data to the woreda/ sub city health office, zonal health department and regional health office.

Region: Enter the region where the facility is located.	Woreda/ sub city: Enter woreda or sub-city where facility is located.
Name of health facility: Enter the name of the health facility.	
Month: Enter the reporting month, use Ethiopian calendar.	Year: Enter the reporting year, use Ethiopian calendar and a format of DD/MM/YYYY

Table 1. Voluntary Counselling and Testing (VCT)

Number pre- test counselled	Record number of VCT clients provided with pre-test counselling during the reporting period, from the VCT register at the health facility.
Number tested	Record number of VCT clients tested during reporting period, from the VCT register at the health facility.
Number post-test counselled	Record number of VCT clients provided with post-test counselling during the reporting period, from the VCT register at the health facility.
Number positive	Record total number of VCT clients who tested positive for the reporting period, from the VCT register at the health facility.
Number positive referred	Record total number of positive clients referred during the reporting period, from the VCT register at the health facility.

Age Group

Count and enter individual category numbers making sure that each person is only in one category.

0-4: Children under 4 years of age

5-14: Children between 5 -14 years of age

15-19: Clients between 15- 19 years of age

20-24: Clients between 20-24 years of age

25-49: Clients between 25-49 years of age

50+: Clients above 50 years of age

Unrecorded: Patients whose age is not specified.

Sex: male/ female

Categorize into male and female for each columns. Count and enter the numbers.

Total

Count and enter the total number for each column.

Table 2: Provider-Initiated Counselling and Testing (PITC)

Number pre-test counselled	Record number of patients provided with pre-test counselling during the reporting period, from the PITC register at the health facility.
Number tested	Record number of patients tested during the reporting period, from the PITC register at the health facility.
Number post-test counselled	Record number of patients provided with post-test counselling during the reporting period, from the PITC register at the health facility.
Number positive	Record number of patients who tested positive in the reporting period, from the PITC register at the health facility.
Number positive referred	Record total number of positive patients referred in the reporting period, from the PITC register at the health facility.

Age Group

Count and enter individual category numbers making sure that each person is only in one category.

0-4: Children under 4 years of age

5-14: Children between 5-14 years of age

15-19: Patients between 15-19 years of age

20-24: Patients between 20-24 years of age

25-49: Patients between 25-49 years of age

50+: Patients above 50 years of age

Unrecorded: Patients whose age is not specified

Sex: male/ female

Categorize into male and female for each columns. Count and enter the numbers.

Total

Count and enter the total number for each column.

Compiled by: Refers to the person who filled in the monthly reporting form.

Checked by: Refers to the supervisor who checked the form.

Signature: Put the signatures of the persons who compiled and checked the report on the Spaces provided.

Date: Put the date the report is compiled and checked on the space provided

Reporting date: Record the date the data is reported.

ANNEX O: Staff for HCT services

Human Resource	Essential	Optional
Counsellors	✓	
Laboratory Technicians	✓	
Coordinator/Supervisor	✓	✓
Community mobiliser/coordinator	✓	✓
Receptionist	✓	✓
Senior Counsellor (supervisor)		✓

Annex P: Monitoring Indicators

Voluntary Counselling and Testing Indicators

- Type of service site (any changes – new services added, innovations etc.)
- Client's source of information about VCT services
- Client demographics (individual and couples)
- Number of clients who come to the VCT site requesting counselling
- Clients' informed consent and counselling offered before a client takes an HIV test
- Number of clients who receive prevention counselling
- Number of clients tested for HIV
- Number of clients declining to take the HIV test
- Number of clients who receive their HIV results the same day
- Number of client seeking VCT services as a couple
- Number of clients previously tested (as individuals, or couples – new partner or old partner)
- Non return rates (if clients are given appointment to return another day to learn their HIV results)
- Condom distribution (number of clients offered condoms, number of clients accepting or declining them).
- Number of clients who receive referrals and follow up
- Number of counselling sessions per counsellor per month
- Number of supervision sessions per counsellor per month
- Number of mentorship sessions per counsellor per month
- Number of clients accepting other services provided on site e.g., post-test club services, FP, STI, TB
- Established system for quality control and quality assurance for HIV testing
- Ensuring counsellors keep monthly reports on counselling and any other activities they get involved in

Provider-initiated Testing and Counselling Indicators

- Number of patients tested for HIV in TB, STI, and other clinics
- Number that received results
- Number with HIV-positive result