

REPUBLIC OF GHANA

**NATIONAL GUIDELINES FOR THE
IMPLEMENTATION OF HIV COUNSELING
AND TESTING
IN GHANA**

JULY 2008

FOREWORD

LIST OF CONTRIBUTORS

The Ghana AIDS Commission wishes to express its gratitude to the following persons whose efforts and contributions were essential in the preparation of these guidelines.

Dr. Edmund N. Delle	African Commission Health and Human Rights (Rabito Clinic)
Mrs. Esther Amoako	AIDS Alert, Ghana
Dr. Khonde Nzambi	CIDA-WAPTCAS
Dr. Claudes Kamenga	
Dr. Kwame Essah	
Dr. Phyllis Antwi	Family Health International, Ghana
Maj. Rtd. Regina Akai-Nettey	
Mrs. Nana Fosua Clement	
Prof. S. A. Amoa	Ghana AIDS Commission
Dr. Sylvia Anie	
Dr. Bob Verbruggen	GTZ - RAPA
Mrs. Joyce Ablordeppey	JHPIEGO
Dr. Kwaku Yeboah	
Dr. Mokowa Adu-Gyamfi	National AIDS Control Programme
Ms. Evelyn Quaye	
Dr. Araba Sefa-Dedeh	National Reconciliation Committee
Dr. William Ampofo	Noguchi Memorial Institute for Medical Research
Dr. Benedicta Ababio	
Mr David Logan	Policy Project, Ghana
Ms. Froeks Kamminga	UNAIDS
Mrs. Juliana Pwamang	USAID/Ghana
Dr. Morkor Newman	World Health Organisation

Thanks also go to all those listed below, who provided their expertise for the updating of the second edition of the National Guidelines for HIV Counselling and Testing and production.

Dr. Nii Akwei Addo	National AIDS/STI Control Programme (NACP), GHS
Dr. Nii Nortey Hanson Nortey	National Tuberculosis Programme, GHS
Dr. Margaret Lartey	Department of Medicine Korle-Bu Teaching Hospital
Prof. Adukwei Hesse	Executive Healthcare Consult
Prof Bamenla Goka	Department of Child Health, Korle-Bu Teaching Hospital
Dr. Lorna Renner	Department of Child Health Korle-Bu Teaching Hospital
Dr. Priscillia Nortey	Pharmacy Department, Korle- Bu Teaching Hospital
Dr. Richard Amenya	Ghana AIDS Commission
Ms. Phyllis Ocran	National AIDS/STI Control Programme, GHS
Dr. Bernard Dornoo	NACP/World Health Organisation
Dr. Sylvia Deganus	Tema General Hospital
Ms Veronica Gomez	Reproductive and Child Health Unit, GHS
Ms Gladys Brew	Reproductive and Child Health Unit, GHS
Ms Rejoice Nutakor	Reproductive and Child Health Unit, GHS
Dr. Sally-Ann Ohene	NACP/World Health Organisation
Dr. Stephen Ayisi-Addo	NACP/World Health Organisation

ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante Natal Care
ART	Anti-Retroviral Therapy
CICT	Client-Initiated Counseling and Testing
CSW	Commercial Sex Workers
CT	Counselling and Testing
DHMTs	District Health Management Teams
FP	Family Planning
GHS	Ghana Health Service
HAART	Highly Active Anti-Retroviral Therapy
HIV	Human Immunodeficiency Virus
NACP	National AIDS/STI Control Programme
NMIMR	Noguchi Memorial Institute for Medical Research
NPHRL	National Public Health and Reference Laboratory
NGO	Non-Governmental Organisation
PICT	Provider-Initiated Counseling and Testing
PLHIV	People Living With HIV
PMTCT	Prevention of Mother To Child Transmission
STI	Sexually Transmitted Infection
TB	Tuberculosis
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

TABLE OF CONTENTS

I	INTRODUCTION.....	8
II	GUIDELINES ON ORGANIZATION AND OPERATION OF VCT SERVICES.....	9
2.1	Setting up a VCT Site	9
2.2	Physical Setting.....	10
2.3	Equipment and Supplies.....	12
2.4	Staffing	13
2.5	Management Of The VCT Site	15
2.6	Operating Procedures For VCT	16
2.7	Services linked to VCT	16
III	GUIDELINES ON HIV TEST RELATED COUNSELLING	19
3.1	Confidentiality in VCT Sites	19
3.2	Legal and ethical issues.....	21
3.3	Pre-Test Counselling.....	22
3.4	Post-Test Counselling	24
3.5	Special Circumstances	24
IV	GUIDELINES ON HIV TESTING	28
4.1	Testing Strategies.....	28
4.2	Testing Algorithms	28
4.3	Test Kit Procurement And Availability	29
4.4	Quality Control	29
V	GUIDELINES FOR QUALITY ASSURANCE.....	32
5.1	Staff Competence.....	32
5.2	Client Satisfaction	33
5.3	Counselling And Testing Protocols	33
5.4	Data Management And Monitoring And Evaluation.....	33
	REFERENCES.....	3Error! Bookmark not defined.
	APPENDICES.....	35

I INTRODUCTION

Ghana has a national HIV prevalence of 1.9% (2007), with an estimated 264,481 people living with HIV/AIDS. The regional prevalence ranges from 1.7% in the Northern Region to 4.2% in the Eastern Region. According to the 2003 Ghana Demographic and Health Survey, only 8% of Ghanaians had ever had an HIV test. The Government of Ghana in its current HIV/AIDS Strategic Framework has identified HIV Counselling and Testing (CT) as a priority prevention intervention. The government calls for the availability and accessibility of good quality confidential HIV counselling and testing services throughout the country.

Counselling and testing (CT) is an important component of HIV/AIDS prevention and an entry point to care for people who are already HIV infected. Through CT, people can learn about and accept their sero-status in a confidential environment where they can learn strategies to prevent infection to self and others, receive emotional care and be referred for medical and psychosocial services when appropriate. CT also helps to decrease stigma as it encourages community acceptance of HIV/AIDS and people living with HIV (PLHIV). It is also a critical first step in interventions to prevent mother to child transmission (PMTCT).

CT can be either client-initiated or provider-initiated.

The client-initiated approach, traditionally known as voluntary counseling and testing, has been the primary model for providing HIV counseling and testing. In client-initiated counseling and testing (CICT), the individual of his own accord goes to a counselling centre and requests for the HIV test.

CICT does not yield adequate coverage in both high-income and resource-constrained settings. Uptake of CICT has been hampered by many of the same factors that limit uptake of other HIV-related services, including stigma and discrimination limited access to treatment care and health services in general, as well as gender issues.

The provider initiated counselling and testing (PICT) is the offer of HIV tests to all clients who utilise the health services. It presents an opportunity to ensure that HIV is more systematically diagnosed in order to facilitate patient access to needed HIV prevention, treatment, care and support service.

There are three types of PICT. These are routine offer, diagnostic and mandatory.

Routinely offered PICT is when CT is offered to all clients using the health facility irrespective of their reasons for doing so. Evidence from both rich and poor countries shows that the uptake of testing increases when testing is routinely discussed and offered, and particularly where it is well-integrated into antenatal care. Concerns exist that PICT could deter clients from utilising health services. Although limited, the available evidence from high prevalence areas does not support those fears. Thus all health care workers

should routinely offer HIV testing to all persons coming to the health facility. Note that routine offer does not mean routine testing.

Diagnostic PICT is where CT services are offered to clients who show signs or symptoms that are consistent with HIV related disease or AIDS to aid clinical management.

Mandatory testing is the situation in which HIV testing is ordered for specific purposes and situations.

It is desirable for everyone to know their HIV status as this provides enormous benefits in preventing the spread of HIV infection as well as increasing access to comprehensive care for those already infected.

II GUIDELINES ON ORGANIZATION AND OPERATION OF COUNSELLING AND TESTING SERVICES

2.1 SETTING UP A COUNSELLING AND TESTING SERVICE

Communities in which CT services are to be sited shall be involved in the establishment of CT services. Involving the community elicits community support and fosters community ownership of the programme. It is also a key element in reducing stigma and encouraging demand for CT services in the community.

It is essential that linkages and partnerships be developed with various organizations in the community not only to obtain support from them for CT services and consensus on the design of the service but to ensure appropriate referrals for HIV prevention, care and mitigation.

Establishing CT services shall involve three phases:

- Assessment
- Design
- Implementation

ASSESSMENT

Assessment shall involve a detailed situational analysis to assist in understanding what each partner expects from the CT services, to encourage the development of supportive services and to ensure that CT services are tailored to the epidemiological, cultural, behavioural and economic context of each site. The situational analysis shall use rapid participatory methods and key-informant interviews with all stakeholders, including potential clients and service providers.

DESIGN

In order to ensure consensus on the final design of a CT service, all stakeholders shall participate in the process of site selection, in determining the CT service delivery and in establishing policies, procedures and minimum standards for the service.

IMPLEMENTATION

This involves activities that ensure the efficient running of CT service delivery, e.g. Identifying or preparing sites through renovation and furnishing, conducting staff training, developing a support programme for staff and other care givers, developing quality assurance measures for counselling and testing, identifying and formalising referral networks etc.

2.2 PHYSICAL SETTING

CT services could be carried out in various settings depending on the demands and resources.

- **STAND ALONE SITES**
These are independent sites that are not part of a health facility
- **INTEGRATED (HOSPITAL, CLINIC AND HEALTH CENTRE SERVICES)**
Integrated are CT delivery sites that are part of existing health services. It may include the following
 - Integrated into general medical outpatient services to the public or as part of a specialist medical care e.g. STI clinic, chest clinic, antenatal and family planning services.
 - Private sector (clinics and hospitals)
 - Health Centres (urban and rural) including health services for vulnerable groups e.g. sex workers, street children etc.
 - Workplace clinics
 - Youth health services
 - Reference laboratory.
 - Blood transfusion services
- **MOBILE/OUTREACH SERVICES**
These are usually temporary rotating services for hard to reach groups e.g. rural communities with poor roads and persons who may not ordinarily access CT in a health facility. The overall purpose is to improve access to CT services by sending services closer to people. All NGOs intending to undertake outreach programmes shall inform respective District Health Management Teams (DHMTs) for clearance and support. The nearest accredited health facility shall serve as the referral site for follow-up services.

All these sites can provide adequate CT services and have both advantages and disadvantages. What kind of model a community opts for depends on government policy, stakeholders' preference, funding etc.

Communities/agencies/government offices that want to set up CT services need to study and choose the type of service they want.

SPACE FOR CT SERVICES

People who wish to know their sero-status have concerns about confidentiality and privacy. There is also evidence that assurance of confidentiality and trust facilitates disclosure of risky behaviours. Consequently service providers shall ensure that there is adequate space to provide CT services in a private and confidential manner. Thus it is recommended that adequate space be made available, depending on the setting, numbers of clients seen and financial resources. It is imperative that the CT rooms, reception area and laboratory appear attractive and comfortable to clients. A mobile CT service can take place in a classroom, church/mosque premises, community centre or open spaces with tents or screens etc. but this shall not compromise privacy, confidentiality and general quality of service.

The minimum recommended space for a site that sees 10-20 patients per day shall be:

- Two counselling rooms;
- One laboratory space (Optional);
- One to two waiting areas;
- One patient screening room (optional), e.g. to collect fees, to collect data for management information systems, to determine the purpose of the clients visit.

Counselling rooms

Counselling rooms shall be private, quiet, well lit and ventilated, and supplied with presentable furniture with a minimum of a small desk (placed in a non-obtrusive position) and three chairs. More chairs shall be provided if the demand for CT necessitates group pre-test counselling or family counselling. In addition, a comfortable private waiting area must be provided. Ideally this waiting room shall be equipped with a TV, VCR and relevant IEC materials.

2.3 EQUIPMENT AND SUPPLIES

The following equipment is recommended for the designated rooms.

COUNSELLING ROOM

- Three comfortable chairs
- Desk and chair
- Filing cabinets
- Storage space for communication material
- Storage space for blood drawing equipment (e.g. syringes, needles) and medical consumables
- Disposable container for sharp objects
- Fan
- Glass, water, tissues (optional)
- Data collection materials
- Veronica bucket
- Refuse bins
- Condoms
- Penis dummy (for condom demonstration)

RECEPTION/SCREENING ROOM

- Cash box
- Desk and chair
- Two upright chairs
- Filing cabinet
- Office supplies
- Facsimile machine (optional)
- Fan
- Computer for data entry (optional)

WAITING AREA

- Television and Video Cassette Recorder/DVD Player
- Two benches and enough chairs to seat 20 people at any given time
- Open display for educational material

LABORATORY

Testing shall be done in counselling rooms using simple rapid tests. Diagnostic and mandatory testing shall however be done in the laboratory. The following shall be available in a standard laboratory for HIV testing.

- Working counter
- Refrigerator/cold chain facility
- Desk and chair
- Sink with elbow taps
- Running water (hot and cold)
- Soap, hand drier and disposal hand towel
- Medical consumables, including gloves, needles and syringes or lancets, swabs, spirits, etc
- Lockable storage for test kit
- Standard waste disposal facilities
- Adequate light source and ventilation
- Fan (optional)

SUPPLIES

The quantity of supplies depends on the volume of clients expected and the testing protocols adopted. Additionally, if other medical testing is envisaged as part of the CT service, supplies needed for such tests will be necessary (e.g. STI screening)

- HIV test kits (minimum two tests with different testing formats and a referral lab with a third tie-breaker test)
- Gloves and all other medical supplies, including those for universal precautions
- Sharps disposal containers
- Disinfectant

2.4 STAFFING

The following complement of staff is recommended in a CT setting:

- Counsellors: During the start-up phase, each site shall have at least two counsellor. This number will increase as demand increases. Volunteer counsellors or part time counsellors shall also be encouraged.

- Laboratory personnel: This individual shall be responsible for performing diagnostic and mandatory testing and also provide back-up services for trained counsellors in HIV testing.
- Community Volunteer: Such a person will be needed particularly for mobile/outreach programmes. His/her role is to link the service with the community and clinic-based facilities both for demand creation and support and care of CT clients. Additional roles may be in community mobilization and post-test clubs.

RECOMMENDED STAFFING

In low-volume settings where there are budgetary constraints, the following staffing levels are recommended.

- Minimum of staff to serve as CT counsellors must depend on workload, ideally there must be one counsellor for every five clients. These counsellors must have the capacity to serve as CT coordinators, community coordinators and even receptionists again depending on workload.
- Voluntary and/or sessional (paid according to sessions worked) CT counsellors may provide CT services, but there shall be at least one formally employed CT provider or counsellor per site, Volunteer/sessional counsellors shall be interviewed prior to assignment and given the same training and supervision as trained CT providers and counsellors. CT site coordinators shall assign the volunteer clear and regular duties and working hours.

SELECTION OF COUNSELLORS

- The management of the CT site shall participate in the selection of those to be trained as CT providers. Those selected shall be seriously interested in providing CT services, and shall be patient, understanding and respectful of clients.
- The CT site management shall be willing to allow those selected to devote most of their time to provision of CT services where necessary.
- HIV positive persons shall be encouraged to apply for positions as CT providers and counsellors especially if on ART and healthy.
- CT providers and counsellors do not necessarily require prior training as health workers, but may also be teachers, social workers, community workers and volunteer HIV and AIDS workers, or PLHIV who speak the local dialect.
- It is preferable that those selected as CT counsellors be willing to get tested themselves voluntarily both for their own personal risk reduction planning, and to understand CT as a consumer. However, being tested shall not be a prerequisite for selection as a CT counsellor.

TRAINING OF CT COUNSELLORS

All counsellors selected to provide ct services shall receive adequate foundation level skills training according to national training guidelines. .

- There shall be refresher training within twelve to twenty-four (12-24) months after the initial training. CT counsellors shall receive continuous supervision and training to improve their skills.
- All other staff working at CT sites shall receive adequate training so that they are qualified to perform their particular function. In addition all such staff shall receive education on good client care and basic information on HIV and AIDS and other STIs.

2.5 MANAGEMENT OF THE CT SITE

Clear roles and responsibilities

Management of the CT site shall draw up a clear statement of the roles and responsibilities of CT providers. If the CT counsellor is dedicated full-time to CT services, this shall be clearly spelled out. If the CT counsellor is dedicated only part-time to CT services, the timing of when these services shall be provided shall be clearly understood by the counsellor, site management, and other health professionals working at the same site.

OCCUPATIONAL RISKS

Every measure shall be taken to reduce the risk of occupational transmission of blood borne diseases. If adequately trained and appropriately supervised, CT counsellors may be asked to draw blood and conduct simple, rapid HIV tests. Counsellors who perform this work shall do so only after thorough training in these tasks as well as training in adherence to Universal Precautions. Protective material, especially gloves, shall always be provided.

Hepatitis B immunization is recommended for any healthcare worker at risk of exposure. In addition, the CT site shall develop a policy on provision or access to post-exposure prophylaxis in the event of a needle stick injury occurring for all staff.

PERIODIC MEDICAL SCREENING OF CT PROVIDERS AND COUNSELLORS

Recognizing that counsellors may be exposed to other diseases in the course of their work, efforts shall be made to ensure that CT counsellors receive routine preventive health screening at least once a year, especially for TB.

HIV positive are to be mindful of the fact that they are at higher risk of OIs. Counsellors shall be trained in measures they can take to reduce their exposure to communicable diseases. Counsellors shall have ready access to HIV testing and TB screening. Management shall ensure that HIV positive counsellors are not unduly exposed to TB and other infections because they are at increased risk.

ACCREDITATION OF CT SITES/INSTITUTIONS

All CT sites/institutions need to be accredited by National AIDS/STI Control Programme (NACP). This would provide quality assurance for CT. This shall be done through a process of monitoring and evaluation. Re-licensing shall be done every two years however certificate of accreditation may be revoked if national guidelines are not adhered to.

2.6 OPERATING PROCEDURES FOR CT

Operating procedures are basically the same in all CT settings. Differences or refinements that are imposed by location of the site will be noted in the guidelines where applicable.

REGISTRATION AND CLIENT FLOW

When patients or CT clients request CT in a health facility, they shall be referred to a counsellor on duty who is trained to explain procedures to the client and explain how long the person will wait. The client shall be registered and given their code number. Educational materials about CT and HIV shall be available while the client waits to see a counsellor.

When CT clients request CT in a stand-alone CT site, they shall be referred to the registration desk. The reception clerk shall be trained to explain procedures to the client and explain how long the person will wait. The client shall be registered by ID number and given their code number. Educational materials about CT and HIV shall be available while the client waits to see a counsellor. All staff who come into contact with clients shall receive basic training in CT, especially on issues relating to confidentiality, respect for clients, and shall be able to answer basic questions about CT and HIV. There shall be systems to effectively manage client flow for mobile services.

CLIENT ELIGIBILITY

All persons who have reached the legal age of consent in Ghana, i.e. 18 years are eligible to receive CT. (For guidelines on testing of children see pg 32)

FEES AND COST SHARING

If a health facility charges a fee, it shall be a fee approved by MOH. The fee shall be posted clearly so clients know in advance what the fee will be, and receipts shall be given. If a fee is charged, measures shall be put in place for free services for those clients unable to pay. Such measures may include “free days” or use of counsellor discretion to waive fees if there is perceived benefit to the client for testing. Overcharging of high fees shall be actively discouraged by the MOH or relevant bodies, since it could discourage clients from accessing CT services.

2.7 SERVICES LINKED TO CT

CT services shall be linked to other services such as Tuberculosis (TB), Sexually Transmitted Infections (STI), Family Planning (FP) and Pregnancy and Child care.

HIV TREATMENT AND CARE

CT sites must systematically refer all HIV positive clients to ART sites for continuing clinical care. This may include management with Opportunistic Infection (OI) medication and or HAART according to national guidelines.

DETECTION AND TREATMENT OF OTHER SITES

CT services staff shall play an active role in the detection of other sexually transmitted infections and diseases. During registration CT clients shall be informed about STI services available on site and offered STI screening.

TUBERCULOSIS SCREENING AND REFERRAL

All CT sites shall maintain close links with the local TB control office, and all HIV positive CT clients shall receive counselling and health education about the risks of TB. TB screening shall be provided as soon as possible to all HIV positive CT clients. Staff of the TB control programme shall be trained in maintaining confidentiality of HIV test results, and the importance of maintaining a respectful attitude to all TB/HIV clients. (See Appendix 1 for the TB Screening Tool).

FAMILY PLANNING (FP) SERVICES

Basic family planning information shall be incorporated into all HIV counselling sessions, both for HIV positive and HIV negative clients. Especially for HIV positive clients, the risks of mother-to-child transmission and the benefits of family planning shall be explained. When possible, FP services shall be provided at the CT site. If this is not possible, HIV positive CT clients shall be referred for FP services. Both men and women shall be encouraged to access FP services to make informed decisions about contraceptive measures appropriate to their HIV status. Staff of the FP programmes shall be trained in maintaining confidentiality of HIV test results, and the importance of maintaining a respectful attitude to all FP/HIV clients.

PREVENTION OF MOTHER TO CHILD TRANSMISSION (PMTCT)

At integrated CT sites, counselling and testing of pregnant women serves as the first step in the provision of PMTCT services. Women who come for maternity services must be routinely offered HIV testing after education with an option to refuse. Clients shall be told that refusing HIV testing shall not affect access to services. They need to understand that the results of their test will be confidential, that no one including their partner can be notified of the results without their permission. Risk assessment and the benefits as well as the potential problems resulting from testing need to be emphasised so clients can give informed consent. The success of PMTCT programmes hinges on effective CT services. Refer to PMTCT guideline for more information.

NETWORKS OF REFERRAL AGENCIES AND SUPPORT SERVICES

Counsellors in CT sites shall be familiar with additional, follow-up services available in their communities, and shall be able to make specific referrals, based on the client's needs. CT services are an entry point for other 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, home based care, nutritional services and post-test clubs, etc.

In addition to the services listed above, CT clients may also need referral to agencies and organizations involved in the treatment of alcohol and drug dependency and mental health services. Some CT clients, especially those who are HIV positive, may also need nutritional education and food supplementation. Although the CT site may not be able to provide all of these services directly, CT staff shall take an active role in ensuring that such services are available to CT clients in need of such supportive and on-going services. CT providers shall actively work to ensure that they become part of existing networks of relevant services. When such networks do not exist, the CT site shall work to develop such networks and services to ensure that CT clients can receive on-going supportive services. Management shall budget so that there will be financial resources for such networking.

ALTERNATIVE THERAPIES

Counsellors shall refrain from marketing or referring clients to alternative unapproved therapies.

III GUIDELINES ON HIV TEST RELATED COUNSELLING

3.1 CONFIDENTIALITY IN CT SITES

Many people are afraid to seek HIV services because they fear stigma and discrimination from their families and community. CT services should always preserve individual needs for confidentiality as provided by law.

DEFINITION

Confidentiality refers to the client's right to expect that health care professionals will not disclose personal health information (including disclosure of HIV sero-status) without the person's consent. The right to confidentiality embraces intimate matters such as sexual relationships, illicit drug use, and health status that a client might discuss with a health professional. Confidentiality should be apparent in all activities of the CT site. All members of staff at the site should observe confidentiality.

CONFIDENTIALITY

- Encourages a relationship where clients can divulge information and feelings normally kept to themselves (some of which are often taboo).
- Helps clients admit that they have been involved in high risk behaviours associated with sex, alcohol and other drug use.
- Permits clients to remain in control and divulge sero-status to selected individuals.

When CT 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 interest of the client for the name to be taken so that appropriate referrals can be made, therefore it should be explained to clients that shared confidentiality may be sometimes required.

The client must be assured that confidentiality may be shared with other counsellors and other members of staff who may be involved in the client's care within the facility in order to ensure the continuity of care.

Confidentiality needs to be explained and agreed upon between the counsellor and client.

LIMITS TO CONFIDENTIALITY

Ethical and legal limits to confidentiality should be discussed during the pre-test counselling.

If disclosure is in the best interest of the client, is in the public interest, or is required by law, clients must first be notified and invited to disclose the information themselves. If the client is unwilling to disclose such information, the counsellor must advise the client that he/she is legally obliged to do so. Only relevant information may be shared in these circumstances. Counsellors should understand that such decisions should only be made

when prior consultations with a supervisor or senior colleague indicate its absolute necessity.

WHEN ADOLESCENTS ARE TESTED

The counsellor should encourage the young person to inform his/her parents/guardians about the test results. If the counsellor determines that it is in the best interest of the adolescent for the parent/guardian to know results, the counsellor should assist the adolescent client in every way possible to inform parents/guardians. If the adolescent is still unable to perform this function, the counsellor as provided by the law may inform the parents/guardians about the test results.

CONFIDENTIALITY DURING TRAINING AND/OR SUPERVISION

It is accepted that counselling practice can be improved when counsellors undertake supervision and belong to a support group of colleagues. During supervision or support group sessions the counsellor may discuss his/her caseload freely, however the identity of the client must still be protected and it should not be possible to identify the client.

CONFIDENTIALITY IN RECORD KEEPING

Clients' records must be stored securely. In a clinical setting only personnel with direct responsibility for a 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.

Where records are taken home, clients should be informed there are risks of breaches in confidentiality.

SHARED CONFIDENTIALITY IN REFERRALS

When CT clients are referred for additional services such as prevention of mother to child transmission, early detection, prevention, and treatment of opportunistic infections including TB, psychological and social services including home based care etc, it is usually preferable to give the client's name. The counsellor should ensure that the client understands the reasons for giving his/her name on the referral letter. Referrals to other services should be based on the client's specific needs, life situation and test results. CT 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. As much as possible, such referral letters should be addressed to a specific facility providing the additional services required.

INFORMED DECISION MAKING

When CT services are provided within a health facility, it is necessary to distinguish between client-initiated and provider-initiated ct. For CICT, the client shall be offered pre test counselling. For PICT, it is recommended that adequate information be given to the client before the test is performed. For those who decline the test, their decision should be respected. However subsequent efforts should be made to encourage the client to accept testing.

WRITTEN RESULTS

CT sites may provide written results which must be dated and signed. Positive test results must be provided to the client; on the other hand negative test results may be provided when required. However it must be explained to the client that negative test result is valid only up to the date of testing.

Clients requesting testing for official reasons such as employment or to obtain a visa where written results are required should be referred to the approved laboratory, hospital or clinic for this type of testing.

3.2 LEGAL AND ETHICAL ISSUES

The legal and human rights of CT clients should be protected at all times in the context of other individual, legal and human rights and public health interest. Clients using CT services especially those who test HIV positive should not be stigmatised or exposed to discrimination.

RIGHT TO PRIVACY

Privacy is particularly emphasized in the context of HIV/AIDS given the stigma and discrimination associated with HIV/AIDS. Adequate safeguards must be in place at the CT services to ensure that confidentiality is protected and that information about HIV status is not disclosed without the consent of the individual. There is a need to define how privacy should be protected (i.e. during testing, result disclosure, record keeping, etc.) There is a need also to define exceptions to this rule (i.e. immediate impact on the lives of others, rape etc.)

RIGHT TO NON-DISCRIMINATION, EQUAL PROTECTION AND EQUALITY BEFORE THE LAW

Participating in CT must not constitute a source of discrimination against the individual CT client; especially those found to be positive should not be denied services or other benefits on the ground of their HIV status.

RIGHT TO MARRY

An HIV+ client has a right to marry but should ensure that disclosure of his/her HIV status is made to his/her partner before marriage. Non-disclosure to a partner before marriage constitutes a violation of the partner's human rights. Willful infection of a partner with a venereal disease constitutes a criminal offence under the Criminal Code of Ghana.

RIGHT TO INFORMED CONSENT

It is generally recommended in the practice of medicine that for any medical procedure, informed consent be obtained. Given the risks associated with HIV/AIDS, obtaining informed consent must be given special attention, the risks and benefits of CT must be fully explained to the client to ensure informed consent. Informed consent may be verbal

or written. In adolescents and vulnerable groups a written consent must be provided. In case of written consent, forms must be signed or thumb printed by the client before testing.

PROTECTING HUMAN RIGHTS WITHIN A CT SITE

In addition to information giving, counselling, confidentiality and informed consent, protecting the human rights of CT clients can be promoted through the adoption of an ethical code of conduct for all those involved in CT services. Such a code should include a commitment to competence, respect for the rights of individuals, professional conduct and integrity in the discharge of duties.

3.3 PRE-TEST COUNSELLING AND INFORMATION

Individual pre-test counselling or adequate information should be provided to all those requesting CT who will need to be informed of the test results.

CLIENT-INITIATED COUNSELLING AND TESTING

Counselling should include the following components:

- Reasons why the client is requesting CT
- Basic facts about HIV infection and AIDS
- STIs and their relation to HIV
- HIV testing procedures at the site, including whether or not written results will be given
- Meaning of Test results including the window period. (explain the possibility of discordant results for couples)
- Basic HIV prevention
- Personal risk assessment
- Exploration of behaviour change and the development of a risk reduction plan (see risk reduction planning under “Post Test Counselling”)
- Client’s readiness to learn 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 disclosure plans possibly partner, family member, friend etc.
- Exploration of potential support from family and friends
- Condom use, including condom demonstration
- Any special needs discussed by the client
- Obtaining of informed consent
- Information on treatment, care and support services.

PROVIDER-INITIATED COUNSELLING AND TESTING

Information given to clients shall include the following four components:

- clinical and prevention benefits of testing
- right to refuse
- follow-up services offered
- in the event of a positive test result, anticipating the need to inform anyone at ongoing risk who would otherwise not suspect they were being exposed to HIV infection

TESTING DURING PREGNANCY AND FOR THE PREVENTION OF MOTHER TO CHILD TRANSMISSION OF HIV (PMTCT)(ROUTINE OFFER)

All pregnant women attending antenatal clinics should be routinely offered HIV counselling and testing services. Pregnant women attending antenatal clinics may not be expecting HIV testing therefore the counsellor must ensure that the mother thoroughly understands the benefits and risks of HIV testing, and understands the additional services they will receive if HIV+. Strict procedures for maintaining confidentiality of test results must be observed and mothers must be assured of such.

As much as possible, mothers should be offered the opportunity to learn their test results immediately, though they should also be given the opportunity to learn their test results on the next ANC visit if they are not currently ready to receive results. It is important for mothers to understand that they may be requested to have another test in the third trimester if they are negative at the first test.

Mothers who decline HIV screening should not be denied ANC services or coerced in any way to accept HIV testing. They should however be re-offered further CT on subsequent visits.

GROUP PRE-TEST INFORMATION SESSIONS

General information about CT should be provided to groups in the course of general health education talks, such as those held at outpatient health centres, ANC clinics, etc.

Group pre-test information sessions can also be used at CT sites or in situations where heavy client flow occurs. In general service provision it is a strategy that should be seen as an adjunct to the individual/couple pre-test counselling session. In this context it should not be seen as a replacement for pre-test counselling. The “standard” CT package of pre-test counselling followed by blood draw (where client decides to test) and post-test counselling should remain the “golden standard.” It should be clear that these group pre-test information sessions are a form of health education and not counselling per se. The context is not conducive for personal exploration of individual/couple risk assessment. Group dynamics can affect such and the impact of peer pressure or partner coercion should not be underestimated.

For special heavy volume homogenous groups (refugees/group screening among the military/schools) group pre-test information sessions may be provided. Clients should

still be informed that they are able to make an appointment for individual/couple pre-test counselling if required. After the group session those who want to test should be seen individually and given opportunity to give consent.

COMPONENTS OF GROUP PRE-TEST INFORMATION SESSIONS

- Introduction to staff member/s and welcome to the Centre.
- Outline briefly the services offered/explain purpose of group information giving e.g. health education/to respond to them in a timely manner/obtain consensus to continue etc.
- Topics to be covered: This includes all information given in pre-test counselling.
- Minimum numbers of clients to attend group sessions should be between 4 and 6 while maximum should be about 10 for generalized services and up to about 30 for special services e.g. refugee/military groups/students.
- Gender mix
Depending on clients present, same sex groups or around equal numbers of men and women are preferable. It is not appropriate to run a group with largely men and only one or few women. Always ask the group how they feel about the gender mix and obtain consent before proceeding. If any member of the group appears uncomfortable (especially women, be responsive and accommodate their concerns).
- Ensure that language used is understandable to all group members

3.4 POST-TEST COUNSELLING

GIVING TEST RESULTS

Information on HIV status should be given as soon as possible. Every opportunity should be given to allow the client to express their feelings about the test results and any other issue. 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. Counselling on positive living, risk reduction planning, window period and the possibility of further counselling sessions must be emphasized. Appropriate referrals must be made as needed.

3.5 SPECIAL CIRCUMSTANCES

PREMARITAL CT SERVICES

- Premarital CT should be encouraged in all sectors of society.
- Premarital CT should remain voluntary.
- Premarital CT should be tied to making better decisions about marital life.
- Confidentiality of results should be maintained.

- It is preferred and recommended that premarital CT should occur with the couple receiving their results together. However, no CT client should be coerced to reveal his/her results to a prospective marital partner or religious leader. If the clients are reluctant to reveal the results to each other, individual CT should be encouraged as a first step, with the hope that the couple will later request couple CT and/or that the couple will reveal results to each other prior to marriage.
- There should be thorough discussion in the pre-test counselling session about potential implications of test results on marriage decisions.
- Efforts should be made to protect the rights of individuals and couples who are HIV+, and to prevent negative outcomes for HIV+ individuals and discordant couples as a result of pre-marital CT.
- Additional counselling services are recommended, both individual and couple sessions, for those who test HIV+ during premarital CT.
- It is recommended that HIV negative couples receive counselling on how to avoid HIV infection in the future, including discussions of positive patterns of sexual life within marriage.
- The Ghana AIDS Commission in collaboration with the Ghana Health Service should put programmes in place to educate religious leaders, pastors, imams, etc about the benefits of pre-marital CT, location of services, and how to discuss pre-marital CT with couples, families, and the community. Education about pre-marital CT should emphasize that the role of religious leaders is to encourage couples to know their sero-status, not to demand testing.
- Written HIV test results, if required, should be provided to those requesting pre-marital CT. With consent, HIV test results should be revealed to the couple together so that they learn their own sero-status and that of the intended marital partner. Religious leaders should be educated about the fact the couple reserve the right not to disclose test results to a third party.

COUPLE COUNSELLING AND CT DURING MARRIAGE AND OR CO-HABITATION

Couple counselling should be encouraged, not only for those planning to get married, but also for those already married or co-habiting who wish to make informed decisions about having children, selection of family planning methods and generally for those who want to work on their relationships and plan their future. Couples should not be coerced into being counselled together but should be given opportunity to make informed decisions about it. Confidentiality is very important and couples should be informed about what it involves as well as its limits.

SHARING RESULTS

Couples who come together for CT should be given their results together, unless they express a preference to receive the results separately. A client's status should not be disclosed to their partner without their consent. Counsellors should ensure that both members of the couple have come voluntarily.

DISCORDANT COUPLES

Confidentiality should be maintained and the couple encouraged to disclose their HIV status to each other. There is need to discuss protective and safer sex practices and for the periodic testing of the HIV negative partner.

DISCLOSURE

Most clients who initially may be unwilling to disclose, would eventually disclose if they are made aware of the benefits of disclosure and supported to do so. Clients should also be made aware of the possible legal implications of their non-disclosure.

REFERRAL

Couples, both HIV+ and HIV-, should be referred for medical, social, spiritual, marital counselling and psychological support if the counsellor determines that these services would be helpful.

TESTING OF CHILDREN AND YOUNG PEOPLE

Testing of children and young people may be done for various reasons e.g. diagnostic, defilement and sexual abuse.

Children 14 years and under should be given counselling if necessary and the testing should have potential benefit for the minor. For children up to 14 years counselling of parents/guardians may be adequate, however the child depending on the age must be informed of the test and may be involved in the decision making process. For this category of children, an informed consent shall be provided by a parent/ guardian before the test is undertaken.

For young people between the ages of 15 and 18, counselling of the client is very important. CT services may be provided if the counsellor determines that the young person has sufficient maturity to understand the testing procedures and results and has adequate support in case they test positive. If the counsellor determines otherwise, then informed consent is required from the parent/guardian.

CT services should be provided only if there is a clear potential benefit for the child and the counsellor determines that there is adequate support and no potential for neglect or abuse of an HIV+ child.

ADOLESCENTS AND CT

Adolescents may be starting sexual activities and should be guided into safe practices. Adolescents can be encouraged to delay the date of sexual debut, practice abstinence or if engaging in sexual intercourse to use condoms consistently with all partners. All those involved in providing CT to adolescents should be aware that adolescent girls are more vulnerable biologically and socially to HIV transmission. The considerably higher rates of HIV infection in young women should alert counsellors to the special circumstances and needs of young girls.

Both the staff and site should be adolescent friendly, understanding, non-judgmental and accepting of adolescent language, dress and behaviour. All CT staff should be respectful of the feelings and emotional turmoil commonly experienced by adolescents. Counsellors should be prepared to link adolescents up with other social agencies especially local youth networks.

Adolescents who present themselves for should be helped to understand and appreciate the reasons and implications for the test and should be considered as 'mature minors'. It is advisable in these cases to obtain written consent. This has the effect of ensuring that the adolescent understands what is taking place. Where a parent or guardian has accompanied the adolescent they may only be present during the session with the consent of the adolescent.

Share confidentiality should be explained and agreed on when counselling young people who are not economically independent. This is because a positive test result is likely to require the support of other people including parents.

CT OF COMMERCIAL SEX WORKERS (CSW)

CSWs may have special needs because of the stigma and discrimination that is associated with sex work. CT counsellors should be sensitized on sex work and should provide non judgemental services by clarifying and working through their own values concerning sex work. Counsellors should encourage CSWs to be interested in issues concerning CT and assist them to undergo periodic testing and follow up visits.

When available on site, periodic screening and management of STIs should be offered. When such services are not available at the ct site counsellors should refer CSWs to such appropriate STI services. Counsellors should link up with peer educators among CSWs to encourage their colleagues to accept ct. Counsellors should facilitate the training of peer educators among CSWs if none exist.

CT FOR PRISONERS

CT for prisoners may present special challenges because of issues of confidentiality and access to other settings. Whenever possible, CT services should be sited at the prisons with the support of prison services. The prison service should be willing to help prisoners access to other support services for care and treatment. Prisoners should be given the opportunity to provide informed consent for ct services and confidentiality must be respected as for all other people.

CT counsellors who work with prisoners should note that in conducting risk assessment for HIV infection same-sex sexual contacts should be considered. This needs to be assessed sensitively since such contacts are often in secret and participants are not necessarily homosexual in orientation. However, it is an important source of risk for HIV and condom use needs to be emphasised and made easily available as a preventive measure.

Overcrowding is a common feature in most prisons and this means people with HIV in prisons are high risk for tuberculosis. TB screening and treatment should be available to

prisoners who test HIV positive and counsellors should advocate so that the authorities do not discriminate against them. (See Appendix 2 for TB Screening Tool for Prisons).

CT FOR PEOPLE WITH DISABILITIES

Ct sites must be accessible to persons with disabilities. Because of their special needs Ghana aids commission in collaboration with Ghana health service should encourage the training of peer counsellors and educators especially among the hearing, visual and language impaired.

For persons who request ct but are found to be mentally impaired, a legal guardian must provide informed consent after receiving counselling. This includes persons under the influence of alcohol or illegal drugs.

CT FOR REFUGEES AND DISPLACED PERSONS

CT services for the above should be sited at a place accessible to them. All principles for the provision of ct are applicable to refugees and the displaced. Because of their vulnerability, counsellors should ensure that there is no coercion to test for this population and that there is informed consent.

REQUEST FOR TESTING ONLY

When clients request testing but declines counselling, the counsellor should explain that CT services are provided as a package including both counselling and testing. The benefits of counselling should be explained, and the client should be encouraged to return.

If the client still refuses counselling, the client must be made to sign an undertaking absolving the counsellor of any blame that may result from the absence of counselling before the test is done.

COUNSELLING AT BLOOD TRANSFUSION CENTRES

Prior to screening and blood donation all eligible blood donors must be routinely offered counselling and testing. Blood donors who consent and test positive shall be notified to receive post-test counselling and be linked to treatment care and support services. Blood will still be taken from donors who decline counselling and testing services and the blood processed as per national guidelines. However such donors should be encouraged to access further counselling and testing services.

IV GUIDELINES ON HIV TESTING

4.1 TESTING STRATEGIES

For CT purposes, it is recommended that rapid tests are used as much as possible. Evidence and experience from other African countries reveal that clients and counsellors have high levels of satisfaction with a service that provides same day/hour results.

Approved, rapid, simple tests which give results in less than 30 minutes are recommended. Hospitals and health centres which can perform ELISA testing on a “same day” basis may continue to use these types of tests, though the emphasis should be on informing the client of test results in two hours or less (as desired by the client).

As additional tests are developed and made available, NACP in collaboration with the National Public Health Reference Laboratory (NPHRL) and Noguchi Memorial Institute for Medical Research (NMIMR) will evaluate the performance of tests. Such tests will not be introduced for CT purposes until approved by NACP, NPHRL and NMIMR, in consultation with other stakeholders and as recommended by World health Organization (WHO).

4.2 TESTING ALGORITHMS

The HIV test algorithm for Ghana is that recommended by WHO using antibody tests. A first antibody test is done using Rapid or ELISA depending on the level of the health facility and confirmed with a second independent antibody test. A positive result is declared to the client only when both tests are positive. This testing protocol used in Ghana is known as serial testing.

DISCORDANT RESULTS

Discordant result is when one test is reactive and the second test is non-reactive. In these instances a third different test shall be done. All clients who have discordant results on the first two tests should be asked for a venous sample for additional testing at a laboratory certified for quality control. The additional test should be performed before the test result is disclosed. This should be explained to the client and he/she should be asked to come back for the results.

An alternate method (parallel testing) in which 2 rapid tests are done concurrently is not in use in Ghana at present.

WINDOW PERIOD

The window period is the interval between HIV infection to the time when antibody is detected.

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. However, HIV negative clients with no recent possible exposure to HIV do not need confirmatory testing.

PERSONNEL TO PERFORM TESTS

HIV testing shall only be performed by trained service providers. These may include laboratory technologists/technicians, nurses, midwives and HIV counsellors. All precautions to protect against blood contamination should be observed.

SUPERVISION

Laboratory technologists trained in laboratory supervision should supervise all staff performing HIV testing. Such supervision should occur at a minimum frequency of once a month and more frequently if problems are identified.

RELATED TESTING

All clients tested for HIV should also be offered testing for STI. All HIV positive clients should be screened for symptoms of TB, and referred for TB testing (sputum microscopy and Chest X-ray). NACP and the National TB Control Program shall work together to extend TB testing to all health centres.

All patients diagnosed with TB shall be routinely offered HIV testing.

4.3 TEST KIT PROCUREMENT

Bulk procurement of HIV test kits shall be done by the MOH and all centres shall access test kits from national sources.

For quality assurance purposes all test kits shall be evaluated and approved by NPHRL.

4.4 QUALITY CONTROL

The NPHRL shall ensure quality control for HIV testing in all settings. Feedback of the quality control testing results shall be given to Regional and District Health Management Teams.

SAFETY PRECAUTIONS

Strict laboratory safety precautions shall be followed based on recommendations adopted by NPHRL.

COMMUNICATION

Communication between the CT sites and district or regional referral centres shall be facilitated to allow exchange of information.

STORAGE OF TEST KITS

It is recommended that test kits, which can be stored at room temperature, be used as much as possible. At all sites where test kits are stored and/or used, there shall be designated staff in charge of ensuring that test kits are stored properly and used prior to expiration.

FORECASTING OF MINIMUM STOCK LEVELS:

All levels shall forecast test kit needs and maintain a minimum stock level to avoid running out of stock completely. It is recommended that a minimum stock of one month's needs of test kits should always be available.

V GUIDELINES FOR QUALITY ASSURANCE

5.1 STAFF COMPETENCE

CT services require well-trained and motivated personnel. Quality assurance measures include appropriate selection and training of staff. Regular supervision and support of VCT site staff and counsellors are also essential in order to provide maximum benefits to clients. Counselling supervision is a form of quality assurance. Regular supervision and support are also an ethical necessity to ensure that no harm is brought to clients as well as a means of professional development and to prevent staff burnout.

SUPPORT SUPERVISION OF CT COUNSELLORS

A cadre of counsellors must be selected and trained for supervisory duties. If possible, they should have the following minimum qualifications:

- Should have had the recommended national CT/PMTCT training
- Should have counselled a minimum of 50 clients.
- Should have a minimum of 6 months experience in CT counselling after supervision period.
- Should be a practicing counsellor in his/her daily work
- Should have the interpersonal skills and qualities of a counsellor, and should be patient, understanding and respectful of clients and colleagues.
- Those selected as supervisory counsellors should be in a position to actually work as supervisory counsellors.
- Those selected as supervisory counsellors should receive a one week course in support supervision and be committed to furthering their own training in counselling.
- The primary responsibilities of these support supervisors should be to provide emotional support and professional feedback and guidance to CT providers. Their role will not be to provide management or administrative supervision.
- These CT supervisors may be MOH/GHS staff and/or NGO or other staff. The CT supervisors in each district shall be selected by the district/health facility. General problems in administration or management of CT sites identified by the support supervisors should be reported to site management.

PSYCHOLOGICAL SUPPORT OF CT COUNSELLORS

Recognizing that CT counselling is potentially stressful, all CT sites should put in place measures to provide psychological support for CT counsellors, such as regular support supervision sessions. HIV counsellors should have access to additional support to assist in dealing with psychological issues that occur as a result of their work. All CT counsellors and supervisors shall have opportunities for on-going personal growth and self-awareness to improve the quality of their counselling performance.

BURN OUT

CT counsellors shall recognise early symptoms of burn out in the staff and take appropriate steps to address it.

REGULAR MEETINGS

CT sites shall schedule regular meetings (weekly or biweekly) to discuss issues relating to CT services, site management, community referrals and other relevant issues. Time should be set aside so that all counsellors and other CT support staff can attend such meetings together. Such meetings may also be used to provide in-service training for staff. Additionally, it is recommended that a monthly meeting be held with representatives of all CT sites in a district, to discuss issues relating to the provision of CT services in the district. All district CT supervisors should attend these monthly meetings.

SUPERVISION

All CT counsellors shall receive a minimum of one support supervision visit quarterly from the next referral level. Such sessions may be individual, peer to peer pairs, or in a group with other counsellors. When group supervision sessions are held, the supervisor should offer additional individual support supervision to any CT counsellor requiring or requesting it.

5.2 CLIENT SATISFACTION

In Ghana as in other countries where demand for health services exceeds the availability of services, it is often difficult to assess client satisfaction. This is because clients are often afraid of reprisals if they complain about the quality of the service. In spite of this client satisfaction surveys are needed for improvement in service delivery.

Various methods can be used to ascertain client satisfaction with services.

5.3 COUNSELLING AND TESTING PROTOCOLS

ADHERENCE TO COUNSELLING PROTOCOLS

The CT service shall be regularly evaluated to determine whether it is provided in accordance with the predetermined protocol and satisfies clients' needs. Results can be used to improve the quality of the service provided.

ADHERENCE TO LABORATORY TESTING PROTOCOLS

The recommended testing protocol for a ct service is designed to reach the maximum reliability and validity in accordance with local conditions, such as the type of equipment available, local HIV seroprevalence, and the resources available to acquire the recommended test kit.

Staff shall be trained and informed on the protocol adopted for the CT programme in Ghana according to national guidelines. There shall be a review of the guidelines and testing protocols regularly based on new evidence.

5.4 DATA MANAGEMENT AND MONITORING AND EVALUATION

The development of an accurate and up-to-date data shall be an important part of CT services. An information management system shall be developed to feed into an overall system of disease surveillance for the MOH/GHS.

Data MANAGEMENT:

Uniform data collection instruments shall be used at all CT sites in Ghana.

At the end of every month, data will be compiled and sent through the District level to the Regional and National levels.

RECORD KEEPING

For ease of data entry, the original of the data collection forms should be sent to the District Health Information Office for data entry. A copy should be retained at the CT site for record keeping. All efforts must be maintained to keep CT records confidential and stored in a secure place.

FEEDBACK

It is intended that CT data should be used to understand CT demand and utilization, for surveillance, and for the process of improved management of CT services. NACP will design feedback mechanisms to ensure that each level of services and management is informed twice a year regarding CT services. NACP should distribute CT reports to all relevant stakeholders.

MONITORING AND EVALUATION

The CT database should be used to monitor and evaluate CT services at each site, in each district, in each region, and at national level. NACP will develop a national monitoring and evaluation plan. Special studies may be required for specific issues, but in general the emphasis should be on using the CT database as much as possible in order to maximize on the investment in this system.

PUBLICATION

Use of CT data for publication must be according to national guidelines.

REFERENCES

- Guidance on provider-initiated HIV testing and counselling in health facilities. WHO/UNAIDS 2007
- National Guidelines for Voluntary Counselling and Testing in Kenya – Ministry of Health, Republic of Kenya. 2001
- A Guide to Establishing Voluntary Counselling and Testing Services for HIV – Family Health International, May 2002
- Voluntary Counselling and Testing (VCT) in Ghana. Prepared by Deborah Boswell for Family Health International/IMPACT, Ghana – March 2001
- Regional Guidelines for Voluntary HIV Counselling and Testing. (Draft). Generic document for the elaboration of National VCT Guidelines Feb 2003. WHO AFRO

TB SCREENING QUESTIONNAIRE

NAME:

AGE: SEX: DATE:

SYMPTOM SCREEN

Do you have any of the following symptoms? (Please grade the symptoms as indicated)

	No	Yes
Cough for more than 2 weeks	0	2
Coughing up blood	0	2
Sputum production	0	2
Loss of weight in last 3 months	0	1
Loss of appetite recently	0	1
Fever for more than 1 week	0	1
Chest pain	0	1

Total Score: (max 10)

PAST MEDICAL HISTORY

Exposure to a TB patient?	YES	NO
Have you been treated for TB in the past 5 years?	YES	NO
When:	 (year)
Duration:	 (months)

Variable	Conclusion
Cough for > 2 weeks	Suspect
Score of 7 or more on symptom screen	Suspect
Previous TB treatment in last 5 years	Suspect

CONCLUSION (Circle) **SUSPECT** **NON SUSPECT**

REQUEST SPUTUM SMEAR MICROSCOPY FOR ALL SUSPECTS

RESULTS

SPUTUM 1: Date..... POS NEG REF NPC DEA ILL
SPUTUM 2: Date..... POS NEG REF NPC DEA ILL
SPUTUM 3: Date..... POS NEG REF NPC DEA ILL

POS: positive smear result NEG: negative smear result REF: refused to provide a sputum specimen
 NPC: non productive cough DEA: died before sputum collection ILL: too ill to provide sputum

Appendix 2

TB SCREENING QUESTIONNAIRE FOR PRISONS

NAME: ID No.

AGE: SEX: DATE:

Date of Imprisonment..... Date of Arrival in this Institution.....

Expected Date of Discharge

SYMPTOM SCREEN

Do you have any of the following symptoms? (Please grade the symptoms as indicated)

	No	Yes
Cough for more than 2 weeks	0	2
Coughing up blood	0	2
Sputum production	0	2
Loss of weight in last 3 months	0	1
Loss of appetite recently	0	1
Fever for more than 1 week	0	1
Chest pain	0	1

Total Score: (max 10)

PAST MEDICAL HISTORY

Exposure to a TB patient?	YES	NO
Tested Positive for HIV?	YES	NO
Have you been treated for TB in the past 5 years?	YES	NO

When: (year)
 Duration: (months)
 Which drugs: H R E S Z other

Weight:kg Height:m BMI:kg/m²

Variable	Conclusion
Cough for > 2 weeks	Suspect
Score of 7 or more on symptom screen	Suspect
Previous TB treatment in last 5 years	Suspect

CONCLUSION (Circle) SUSPECT NON SUSPECT

REQUEST SPUTUM SMEAR MICROSCOPY FOR ALL SUSPECTS

RESULTS

SPUTUM 1: Date..... POS NEG REF TRF NPC REL DEA ILL
SPUTUM 2: Date..... POS NEG REF TRF NPC REL DEA ILL
SPUTUM 3: Date..... POS NEG REF TRF NPC REL DEA ILL

POS: positive smear result NEG: negative smear result REF: refused to provide a sputum specimen
 TRF: transferred to another facility before sputum collection NPC: non productive cough
 REL: released before sputum collection DEA: died before sputum collection ILL: too ill to provide sputum