

HIV/AIDS-VCT

National Guidelines for Voluntary HIV/AIDS Counseling and Testing

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NATIONAL GUIDELINES FOR VOLUNTARY HIV/ AIDS COUNSELING AND TESTING



Government of Nepal
Ministry of Health and Population
National Center for AIDS and STD Control
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Acknowledgement

The National HIV/AIDS Strategy (2006 - 2011) continues to emphasize Voluntary Counseling and Testing (VCT) as an important component and pivotal entry point for comprehensive HIV/AIDS prevention, care, support and treatment services. The national strategy recommends the continued expansion of VCT services, the expansion of trainings and the updation of guidelines to further strengthen VCT operations in different settings and for different target groups. For this purpose, a National Working Group including all stakeholders provided important technical inputs into these updated VCT guidelines 2007. The 2007 guidelines build on the experience of VCT operations of the past four years and include new developments in HIV counseling and testing based on global experiences and recommendations. The guidelines were reviewed and finalized through a series of workshops with the contribution of many national and international experts.

It is most opportune to bring out the updated National Voluntary HIV/AIDS and Testing Guidelines 2007 as we embark on the next phase of the National HIV/AIDS strategy. I sincerely hope these National Guidelines for Voluntary HIV/AIDS Counseling and Testing will be useful in strengthening and expanding VCT services in the country.

We all know that an endeavour of this kind draws upon the contribution and goodwill of many persons. The National Center for AIDS and STD Control would like to express sincere appreciation of the important contributions of all people past and recent, national and international who have participated at various stages in the development of the National Guidelines for Voluntary HIV/AIDS Counseling and Testing.

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The National Center for AIDS and STD Control would also like to thank all members of the National Working Group for their active contribution and support in updating the guidelines, UNDP, UNFPA, UNAIDS, UNICEF, GTZ, ASHA project, Shakriya Sewa Samaj, and FPAN.

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Preface

Prevention of HIV/AIDS is a priority for the Government of Nepal. With the implementation of the National HIV/AIDS strategy 2006-2011, Nepal is striving to achieve the targets set in the Millennium Development Goals (MDG) and the goals of Universal Access (UA) to HIV prevention, care and treatment.

Even though the HIV prevalence is still low in the general population (0.55%) and Nepal's epidemic is considered to be concentrated, major efforts are required to prevent the epidemic from spreading from high risk groups such as migrant workers, transport workers, intravenous drug users, sex workers and their clients, into the general population.

Voluntary Counseling and Testing (VCT) is a crucial component of the national strategy to fight HIV/AIDS. VCT refers to the process of giving people professional counseling before and after an HIV test. The process helps people prepare for and understand their test results. Those who test negative can learn ways to avoid becoming infected, and those who are positive can learn how to live longer, healthier lives and prevent transmission to others. VCT was used initially to support people diagnosed with HIV/ AIDS in clinical settings and has developed over the years to become a main entry point to wider prevention, care, prophylaxis and treatment of HIV related illness, psycho-emotional and legal support for people tested positive and negative.

The Ministry of Health and Population, National Center for AIDS and STD Control, recognizes the need and importance of VCT for both prevention and care, and plans to establish and expand Voluntary Counseling and Testing and Referral services in a phased manner to cover all districts with at least two VCT by 2011. National guidelines for VCT developed in 2003 and updated in 2007 help to regulate HIV counseling and testing services and to standardize protocols and procedures for VCTs operations in public and private settings. The demand for VCT is growing, especially among vulnerable populations, such as injecting drug users, sex workers and their clients, migrant workers and men who have sex with men. In addition, simple and cheaper HIV testing methods, the reduced cost and increased availability of antiretroviral (ARV) drugs, cheap, simple and effective methods to reduce mother to child transmission, have made the provision of VCT services more feasible. VCT provides a crucial link for the increasing number of people infected with HIV to know their status and access care and treatment including free ART.

Many Nepali citizens do not know whether they are infected with HIV or not. Learning one's sero-status assisted with counseling can be a powerful prevention and care strategy. High quality testing and counseling services help people make informed decisions about whether or not to take an HIV test, and prepare them in advance for a possible positive result. VCT assists people with HIV/AIDS to prevent transmission of HIV to others. VCT helps people living with HIV/AIDS to access appropriate treatment and care services. Counseling helps PLHA and their families to reduce emotional stress, deal with problems, make important decisions and live positively with their situation. For non- infected people with risk of HIV infection, VCT assists in making changes in their lifestyle so as to reduce risk and remain HIV negative.

The expansion of VCT centers is a major priority of NCASC because VCT is an entry point to:

- Early access to medical care (including ARV therapy, treatment of opportunistic infections (OIs), preventive therapy for tuberculosis and other OI and sexually transmitted infections).
- Reducing mother to child transmission of HIV.
- Emotional care (individual, couple and family).
- Referral to social support and peer support.
- Improved coping and planning for the future (orphan care and will making).
- Normalization of HIV/AIDS in society (reduction of stigma and discrimination).
- Family planning and contraceptive services.

Nepal's National HIV/AIDS Strategy 2006-2011 emphasizes the need to establish voluntary counseling and testing centers in the public and private sectors and to build the capacity of counselors and other services to deliver comprehensive prevention, care and support services.

This document is based on the experience of the past four years and the current international best practice, adapted to suit the local Nepalese context. The guideline will be reviewed and updated in the context of any future change in the national or international policies related to HIV/AIDS in Nepal. Any comments and suggestions for improvement of future editions will be highly appreciated and can be sent to ncasc@mos.com.np.

The Ministry of Health and Population and the National Center for AIDS and STD Control sincerely hope that these guidelines will empower policy makers, decision makers and planners at all levels – National level, District AIDS Coordination Committees, DPHO, DHO, private sector, NGOs, and the VCTs – to establish and operationalize high quality HIV counseling and testing services for the benefit of all Nepali people.

List of Acronyms

AHW	Auxiliary Health Worker
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
ART	Anti retroviral treatment
CBO	Community Based Organization
DBS	Dried Blood Spot
DHO	District Health Office
DPHO	District Public Health Office
ELISA	Enzyme Linked Immunoabsorbent Assay
EQAS	External Quality Assessment Scheme
FHI	Family Health International
FP	Family planning
FPAN	Family Planning Association of Nepal
FSW	Female Sex Worker
HIV	Human Immune Deficiency Virus
GTZ	German Technical Cooperation
HCW	Health Care Worker
IDU	Intravenous Drug User
MARP	Most at risk population
MDG	Millennium Development Goals
MoHP	Ministry of Health and Population
MSM	Men Having Sex with Men
MSW	Male Sex Worker
NCASC	National Center for AIDS and STD Control
NGO	Non Governmental Organizations
NPHL	National Public Health Laboratory
OI	Opportunistic Infections
PLHA	People Living with HIV and AIDS
PMTCT	Prevention of Mother to Child Transmission
PT	Proficiency Testing
QA	Quality Assurance
STI	Sexually Transmitted Infection
TUTH	Tribhuvan University Teaching Hospital
TB	Tuberculosis
ToT	Training of Trainers
UA	Universal Access to HIV prevention, treatment and care
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCT	Voluntary HIV/AIDS Counseling and Testing
YFS	Youth Friendly Services
WHO	World Health Organization

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Glossary 00

1. Objectives of the National Guidelines for Voluntary HIV Counseling and Testing

This document presents the Government of Nepal's Guidelines for Voluntary HIV counseling and testing. The guidelines are based on current national and international best practices and on the recommendations of the Technical Working Group on VCT established by the National Center for AIDS and STD Control (NCASC), Ministry of Health and Population (MoHP).

These Guidelines are intended for policy makers and service providers in settings that offer both public and private HIV VCT and referral.

The Guidelines are intended to be used to set-up and provide VCT services and protocols for service delivery in clinical settings (such as STI clinics, private physicians' clinics) and non-traditional settings (e.g., free-standing, community-based or outreach settings).

The NCASC acknowledges VCT providers' need for flexibility in implementing the Guidelines, given their particular client base, setting, HIV prevalence level and available resources while adhering to a minimum quality standard.

The NCASC will ensure that these Guidelines are followed through the setting of standards, quality assurance, and mechanisms for reporting, monitoring and evaluation.

The guidelines aim:

- To strengthen and support the expansion and extension of HIV VCT services in the public and private sectors.
- To make quality VCT services more accessible and available to HIV infected persons, persons at increased risk of infection and the population as a whole.
- To strengthen the availability of confidential HIV testing and counseling and to ensure that HIV testing is voluntary, confidential, accompanied by counseling and informed consent.
- To highlight the importance of prevention counseling specifically risk reduction counseling for people living with HIV, people at increased risk of infections and the population as a whole.
- To highlight the importance of referral linkages with care and support services such as Sexually Transmitted Infections (STI) treatment, Prevention of Mother to Child Transmission (PMTCT), ARV and OI treatment using a multi-sectoral approach

2. Background and Introduction

The first AIDS case in Nepal was detected in 1988. By June 30, 2007, 9532 HIV positive cases including 1410 AIDS cases are reported in Nepal (NCASC, August 2007). Out of this about 30.8 percent HIV cases are from women, largely spouses of migrant workers, and so far, a total of 412 deaths from AIDS are reported. Among the adult population (15-49 years), an estimated 70,253 people were estimated to be living with HIV/AIDS in the country in 2005, indicating a prevalence of HIV of about 0.55 % in the adult population. (Source, monthly update report of NCASC and report of national estimation exercise conducted by NCASC, 2005). With consistently exceeding the prevalence of more than five percent in certain groups such as IDU, the country has remained at a critical juncture of “**concentrated epidemic**”.

Sexual transmission and risk behaviours are major factors in the evolution of the HIV epidemic in the country. HIV prevalence among female sex workers (FSW) was found to be 2% in 2003 in the Terai highway districts and 2% in 2004 in Kathmandu and Pokhara. Integrated Bio-behavioural surveys conducted in 2004 among MSM in Kathmandu showed about 3.9% HIV among MSMs and about 5% among male sex workers. Evidence from large scale surveillance surveys shows that HIV prevalence among male IDUs in Kathmandu valley increased from 2% in 1991 to 68% in 2003 and decreased slightly to 52% in 2005.

Current information on HIV/AIDS in Nepal

- Predominant mode of transmission is through sexual contact, mainly heterosexual.
- Highest rates of HIV infections identified in IDUs (up to 52%).
- Risk behaviours are widespread among FSWs, their clients, IDUs, labour migrants, MSM, and MSW.
- Most people living with HIV/AIDS do not know they are infected and many of them may be engaging in unsafe sexual practices.
- Stigma and discrimination make it difficult for PLHA and high-risk groups to practice safe sex, undergo testing, and from seeking treatment and care.

Behavioural data shows a high potential for an increasing spread of HIV from high-risk groups to the general population. It is believed that in the absence of effective interventions, even a low growth scenario, would make AIDS the leading cause of death in the 15-49 year old population in the coming years.

National Response

The Government of Nepal is committed to achieving universal access for HIV/AIDS services for its people¹, as reflected in the goals and targets of the National HIV/AIDS strategy 2006-2011.

Achievements of National HIV/AIDS strategy 2002

The prevention programme reached 35% of FSWs, 8.6% of IDUs, 5.4% of MSMs and less than 1 percent of migrant population². While these results are encouraging, the coverage of HIV/AIDS prevention, treatment, care and support services and the overall impact in changing the

¹ Universal Access Targets, Roadmaps and other details were worked out in December 2005 jointly by the Ministry of Health, National Centre for AIDS and STI Control (NCASC) and the civil society organizations including private sectors. *(Please refer to final report for further detail)*

² NCASC (2005) Status of the 2005 National Response to the UNGASS Declaration of commitment on HIV/AIDS, Nepal County Report

epidemiological scenario is still limited. The geographic distribution of services limits access for large portions of groups who are most vulnerable and most at risk of HIV infections.

From an initial focus on coverage of prevention interventions among key target groups, efforts have recently shifted on expanding treatment and care for PLHA. There has been a marked expansion of services for STI treatment, PMTCT, VCT and ART to many parts of the country. Operational guidelines and training modules were developed and substantive cadres of health workers were trained in HIV prevention and care. Care and treatment achievements:

- 100 Voluntary Counseling and Testing centers in 35 districts in collaboration with partners
- 14 ART Centers covering 901 PLHA on treatment (about 5% of the total need)
- 10 PMTCT sites

Key elements of the National HIV/AIDS strategy 2006-2011

The National HIV/AIDS strategy 2006-2011 focuses on the intensification of prevention efforts both in scale and scope. In addition, treatment care and support for PLHA are critical and essential components. Both components will complement each other and contribute to halting and reversing the spread of HIV and AIDS in the country.

Core elements of the national strategy include:

- Strong and broad partnerships (including public-private) in a multi-sect oral approach where partners have capacity for strategic planning, HIV/AIDS mainstreaming, resource management, service delivery, monitoring, evaluation and reporting
- Trained human resources available in all districts, particularly in areas where they are most needed (70% coverage)
- Expanded infrastructure and functional public and private laboratory and supply management systems

The national strategy focuses on scaling up VCT services and providing standardised quality support services for HIV infected individuals and their families with the aim of improving their quality of life. Access to VCT is a pre requisite for access to HIV treatment and care and the successful implementing antiretroviral therapy. The HIV status must be known before treatment can commence or before decisions can be taken about future prevention needs, such as in preventing mother-to-child transmission. A coverage target of addressing 80% of most-at-risk populations' needs for HIV/AIDS prevention, treatment, care and support is envisaged by 2011.

Prevention targets:

- At least two VCTs per district by 2011.
- 18 PMTCT centers by 2008

Care and treatment targets:

- More than 8,000 people receiving ART by 2011

Expanding access to Voluntary Counseling and Testing

Voluntary HIV/AIDS counseling and testing (VCT) and referral continues to be a major component of the national strategy. Knowing one's HIV status following pre-test and post-test counseling enables people to initiate or maintain behaviour to prevent the acquisition or further transmission of HIV. The HIV/AIDS Strategy emphasizes the need to 'establish a non-discriminatory, accessible, voluntary, confidential HIV testing system with pre-and post-test

counseling' and urges the MoHP ' to develop a policy and quality framework for government and private institutions including NGOs' as a basis for expansion of services over the coming years.

VCT services are an important part of an expanded National HIV/AIDS Prevention and Care Strategy in Nepal because they:

- Contribute significantly to the prevention of HIV transmission by helping HIV infected persons to change risk behavior.
- Ensure that persons at increased risk of HIV receive quality prevention counseling to reduce their risk of acquiring HIV infection.
- Ensure that persons who are offered or receive HIV testing are provided with information about ways in which HIV is transmitted and can be prevented and about the meaning of the HIV test results.
- Ensure that HIV infected persons have early knowledge of their HIV status and increase their access to appropriate medical, prevention, psychological and social services.
- Facilitate links with other services such as prevention and treatment of STIs, prevention and treatment of tuberculosis and other OIs, and prevention of mother to child transmission.
- Play an important part in support of psychosocial services offered as part of outreach, home and community care programs as well as institutional and hospice care.

In communities, VCTs can increase acceptance and normalization of HIV, decrease stigma and discrimination against people living with HIV/AIDS, if many people get VCT, talk together and develop their attitude and act on their knowledge.

Expected results of the National HIV/AIDS strategy 2006 – 2011 include:

- Increased capacity of health service providers to deliver and manage VCT services
- Upgraded infrastructure and condition of VCT service centres including management of products and supplies related to providing VCT services
- Increased availability and access to quality VCT services, especially for MARPs through different settings (YFS, ANC, etc)
- Established, systematic referral and linkages between HIV testing, care and treatment, especially for MARPs.

Key actions include:

- Integration of VCT services in existing health facilities (i.e. hospitals, existing health service system (ANC, TB, STI), private clinics, prison clinics etc.) and non-traditional health service centres (i.e. youth friendly service, community based health centres)
- Establishment of a functional referral mechanism at all VCT sites linking to different health services (especially care, support and treatment services) in a multi-sect oral approach
- Development and expansion of VCT services for hard to reach populations, MARPs through non-traditional methods (i.e. mobile VCT centres for street children, SWs, prison population etc.)
- Establishing and ensuring quality control mechanisms at all VCT centres

3. National HIV Testing and Counseling Policy

The national HIV testing and counseling policy stipulates that all HIV testing of individuals in Nepal should always be in the best interest of the individual must be based on counseling, the informed consent and the voluntary decision of the person being tested.

Core elements of HIV Counseling (details in section 6 and appendix 1)

The underlying principles of HIV Counseling and testing are the '3 Cs'. All HIV testing of individuals must be:

- **confidential**
- accompanied by pre and post test **counseling**
- conducted with informed **consent**, meaning that it is both informed and voluntary.

Core elements of HIV Testing in VCT (details in section 7)

- HIV testing of individuals in VCTs should follow the serial HIV testing strategy
- Only NPHL approved HIV test kits should be used for HIV testing in VCT settings
- HIV test for diagnosis in VCT must be based on whole blood, plasma or serum. In VCTs, HIV tests based on urine and oral fluids are not allowed.
- Provision of rapid HIV tests to the general public through pharmacies and other consumer outlets for use as 'home test kits 'or' self testing kits is not allowed.

HIV testing **may NOT be** done for the following purposes:

1. Mandatory HIV testing of individuals

The government of Nepal does not support mandatory HIV testing of individuals on public health grounds. Mandatory testing is testing conducted without a person's knowledge or consent and any option for refusal. Mandatory HIV testing violates the person's basic right and is detrimental to long-term HIV prevention efforts.

2. Routine HIV testing of individuals

Routine testing of a person for HIV infection in health care settings for the purpose of "infection control", pre operative screening or protecting a health worker from infection is not allowed regardless of consent. Instead, standard procedures for universal precautions and occupational exposure should be followed for all clients regardless of their HIV status. An HIV test results must never be used to deny surgery or clinical services that are otherwise indicated.

3. Compulsory HIV testing of individuals

Compulsory testing refers to testing which is required in order to access a particular benefit or service (e.g. visa, employment, medical care, armed forces, police, etc.) but where the individual has the option of rejecting the service or benefit and thus avoiding the test. Compulsory testing for HIV is prohibited, unless required by law, e.g. army recruits, police.

4. Home testing

Rapid HIV test kits should not be made available to individuals. Companies should not market rapid HIV tests as 'home test kits' or 'self testing kits' to the public. The **use and availability of home test kits is not allowed for** reasons of low literacy and awareness levels, incorrect test application, lack of counseling support, etc.

HIV testing **may be done** in the following circumstances:

1. Client-initiated Voluntary Counseling and Testing (VCT)

Individuals actively seek HIV testing and counseling at a VCT. Client-initiated HIV testing and counseling is conducted in public or private settings including health facilities, stand-alone facilities outside health institutions, through mobile services, or in community-based settings. Client-initiated HIV testing and counseling usually emphasizes individual risk assessment and management by counsellors, addressing issues such as the desirability and implications of taking an HIV test and the development of individual risk reduction strategies (see Appendix 1). The main target groups for client initiated VCT are:

- General population
- Adolescents
- Most at risk populations (MARPs)

2. Provider initiated Voluntary Counseling and Testing (VCT) for diagnostic purposes in public and private health care facilities and in services for MARPs.

Health service providers recommend HIV testing and counseling to persons attending health care facilities **with symptoms or signs of medical conditions that could indicate HIV infection**. It enables 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. This facilitates a client's access to needed HIV prevention, treatment, care and support services. Health care providers should recommend HIV testing and counseling and routinely refer the following groups to VCT:

- Symptomatic patients including patients with TB and HIV-exposed children
- STI patients
- Antenatal women in ANC, childbirth and postpartum services
- MARPs in health / outreach services for most-at-risk populations

HIV testing for diagnostic purposes should only be carried out where confirmation of the client's HIV status **would clearly benefit the client for determining the best course of treatment and with informed consent**. The overriding principle for counselors should always be to do what is in the best interests of the individual client (see details in section

5).

3. Surveillance

HIV testing of blood samples during surveillance by the NCASC's Surveillance Program such as ANC, IBBS, HSS or by partners authorized to do so (unlinked, anonymous testing of blood samples for epidemiological purposes without consent).

4. Blood donations

HIV testing of blood samples from blood donations as part of HIV and other infection screening of blood samples.

5. HIV testing for research purposes

All anonymous unlinked testing conducted for research or surveillance purposes must be in accordance with Nepal Health Research Council approvals.

All public and private institutions, NGOs and Community Based Organizations (CBOs) which conduct HIV testing of individuals **must adhere to these Policy and Guidelines for HIV testing and to minimum standards** of performance, training and reporting. Monthly reports must be submitted to the District Health Office (DHO), District Public Health Office (DPHO), and forwarded to NCASC and Regional Health Services Directorate (Appendix 14).

4. What is Voluntary HIV/AIDS Counseling and Testing?

A VCT center refers to any setting where a qualified and trained counselor provides confidential HIV pre- and post-test counseling according to standard counseling protocols (see section 6 and appendix 1) and where a qualified and trained laboratory person provides HIV testing according to standard laboratory protocols (see sections 7).

VCT offers an important entry point to prevention, care and support and is an essential component of comprehensive HIV/AIDS programming. VCT is the process of providing people with professional counseling before and after an HIV test. The process helps people prepare for and understand their HIV test results. Effective counseling also helps people reflect on issues of sexual behaviour, drug use, and behaviour change to prevent HIV, STIs or unintended pregnancy. VCT is a powerful strategy that can equip people with knowledge and skills for sustainable healthy behaviour. People who test HIV negative can learn ways to avoid becoming infected, and people who test HIV positive can learn how to live longer, healthier lives and prevent transmission to others.

A. Goals of Voluntary HIV/AIDS Counseling and Testing

The goal of VCT is:

To ensure that HIV-infected persons and persons at increased risk of HIV infection:

- Have access to HIV testing to promote early knowledge of their HIV status.
- Receive high-quality HIV prevention counseling to reduce their risk for transmitting or acquiring HIV, and have access to appropriate medical, preventive and psychosocial support services.
- Ensure that all clients receiving HIV testing are provided information regarding transmission, prevention, and the meaning of HIV test results.
- Ensure that all PLHA can access appropriate treatment and care including ART.

To ensure that HIV-negative persons:

- Have access to the knowledge and skills to prevent HIV infection and remain HIV negative.

B. Who benefits from accessing HIV counseling and testing?

- People with signs and clinical symptoms of HIV infection, such as OIs including TB (based on WHO clinical staging: Appendix 5)
- People with STIs
- Populations with high risk behaviour such as CSW, MSM, IDU, migrants,
- Pregnant women
- People who perceive themselves at risk of HIV infection through unsafe practices
 - frequent or unprotected sex
 - injecting drug use
- People who had a potential exposure to HIV:
 - through unsafe blood supplies or contaminated equipment
 - victims of rape
 - Children of HIV positive mothers
- Couples planning to commence a sexual relationship or marry and/or have children
- Sexual or needle sharing partners of PLHA
- General population

C. The VCT Process

Community understanding and acceptance of VCT services and their objectives are important for a successful implementation

Social mobilization, awareness raising, IEC campaigns, and community outreach workers motivate populations most at risk, vulnerable groups and the general population to access VCT and to 'know their HIV status'.

HIV Pre-test counseling: facilitates the client's decision to undergo an HIV test and understand the implications of a positive or negative HIV test result. The aim of pre-test counseling is to obtain informed consent from the client.

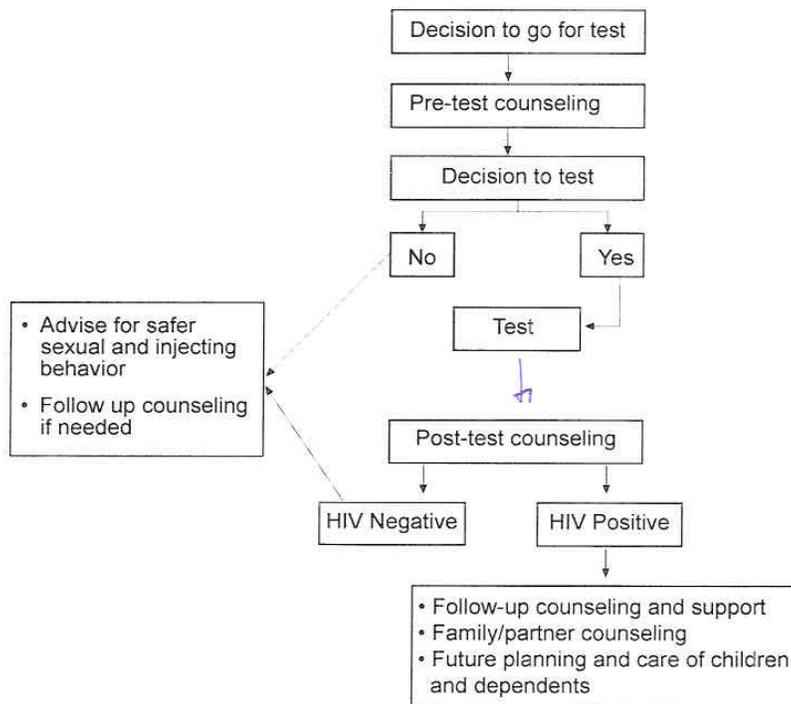
HIV Post-test counseling: facilitates the understanding of the test result, supports mechanisms for the client to cope with the result.

1. In case of a negative test result, counseling supports the client to adopt behavior that reduces the client's risk of getting infected with HIV in the future.
2. In case of a positive test result, counseling supports understanding the implications of the positive test result and supports coping with the result. This includes facilitating access to PMTCT for pregnant positive mothers, and access to treatment and care. It also includes supporting disclosure of the HIV status to partners.

Follow-up counseling includes emphasize on adoption of safe behavior to prevent HIV infection of self or others. It also includes linkages and referrals for follow up for care and support services including ART, nutrition, home based care, legal support.

The VCT Process

Development of community awareness



D. Where can VCT services be provided?

VCT can be located in different settings: (1) free-standing VCT services, (2) integrated into health services. Global best practices have shown that integrated VCT services in multiple-service delivery settings yield better outcomes than standalone VCT centres.

- Outreach programs and health services for vulnerable groups: IDUs, migrants/refugees, men who have sex with men (MSM), street children, sex workers
- Hospital services (public or private)
- Part of the continuum of care/home care
- Linked to blood banks
- NGO
- Integrated into general medical services as part of specialist care: STI, antenatal clinics (PMTCT), family planning clinics, tuberculosis
- Correctional facilities
- Drug prevention and treatment programs
- Community centers
- Private sector settings
- Workplace clinics
- Youth and school health services

E. How should VCT services be provided?

Many factors affect how clients seek, accept, and understand VCT services and service providers should consider these when establishing and implementing VCTs. VCT services should remove barriers to accessing services to increase access and acceptance of VCT services. VCT services should be:

- Easily available
- Affordable
- Accessible
- Acceptable
- Appropriate to the client's culture, age, language, sex, orientation and development level.
- Responsive to client and community needs and priorities

To increase accessibility and acceptability:

- Welcoming and friendly environment,
- Privacy and confidentiality are respected
- Hours of operation are conducive for target population
- Waiting time and delays are minimized
- Test results are provided immediately
- Blood collection is made less painful and invasive (e.g., finger-stick blood).
- Counseling provided for specific groups,
- Services are offered in non traditional settings (i.e. community or outreach settings)
- Services tailored for vulnerable groups.

5. Principles for Effective Voluntary HIV/AIDS Counseling and Testing Services

A. Human rights principles in VCTs

The following human rights principles should guide provision of HIV counseling and testing services:

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

Quality VCT can contribute to the physical and mental health of those who wish to know their HIV status. VCT is an entry point for access to supportive medical care and collaboration between client and provider.

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

Discrimination by VCT staff will deny clients' access knowing their HIV status, miss an opportunity for behaviour change and is not in the interest of public health. Staff has to protect clients from discrimination in case of a positive HIV test result by maintaining confidentiality.

3. The right to informed consent before a medical procedure:

It is a standard of medical practice that there should be informed consent before any medical procedure. The risks and benefits of the procedure should be explained to the client to facilitate an understanding and informed choice. HIV testing is a medical procedure.

4. The right participation:

Clients including young people have a right to be involved in all decisions related to their health. This means counsellors have to involve clients and make sure clients understand details of HIV and HIV testing.

5. The right to marry and have children:

Mandatory premarital testing is discouraged. Coerced abortions and sterilization of HIV positive women is a violation of their basic right. PLHAs have a right to marry and have children.

Standard operating procedures and codes of conduct

Providing highest quality services and protecting the rights of VCT clients can be promoted through the implementation of standard processes and procedures. This includes:

1. Written protocols and procedures for HIV counseling, HIV testing and VCT operations including quality assurance and evaluations.
2. An "Ethical Code of Conduct" for all staff providing VCT services. A code of conduct includes a commitment to: competence, consent, confidentiality, and respect for people's rights, professional conduct, and integrity towards their clients. (see Appendix 2)
3. Methods of redress for clients whose rights are infringed. Consideration should be given to the appointment of an independent ombudsman to whom breaches of HIV testing and counseling protocols and codes of conduct can be reported.

Quality HIV testing, counseling and referral services are based on the following principles:

1. An option of anonymous HIV testing and maintenance of confidentiality of HIV test results
2. Provision of quality counseling according to standard procedures
3. Informed consent before HIV testing.
4. Provision of high quality HIV testing according to standard procedures
5. Provision of written HIV results timely and confidentially.
6. Provision of referrals
7. Provision of tools for prevention including information and condoms

B. Ethical Principles

Voluntary and Informed Consent

Why is VCT voluntary?

Being diagnosed as HIV positive or suspecting the possibility of being HIV positive have profound emotional, social, behavioural and medical consequences on any individual. The personal and social adjustments required in the context of HIV infection have implications on family life, sexual and social relations, work and education, spiritual needs, legal needs and other aspects of life. Adjustment to HIV infection is a life changing event that requires adjustments on the individual, their families and the communities in which they live. Although there are clear benefits to knowing one's HIV status, a positive HIV status often has severe negative consequences for PLHAs. Given the possibility of stigma and discrimination, ostracism and personal persecution that a PLHA may face, it is important that VCTs adhere to basic ethical and rights principles.

What is informed consent?

Informed consent is a deliberate and autonomous permission given by a client to a counselor to proceed with the proposed HIV test procedure. This permission is based on an adequate understanding of the advantages, risks, potential consequences and implications of an HIV test result. This permission is voluntary and entirely the choice of the client and can never be implied or presumed (see Appendix 1).

Obtaining informed consent through the process of counseling involves educating, discussing advantages and disadvantages of HIV testing, listening, answering questions and seeking permission to proceed through each step of counseling and testing. Clients who decide to take an HIV test provide informed consent to ensure that all persons being tested have voluntarily and freely agreed to being tested.

Verbal informed consent for HIV testing is generally sufficient. If required and appropriate, written informed consent can be obtained. Verbal informed consent means that the client has indicated to the counsellor that he/she agrees to HIV testing for example by nodding the head or speaking out. Silence cannot be taken as verbal informed consent.

Self referred clients (Client Initiated VCT) consent to HIV testing by **actively opting for** HIV testing by saying 'yes, nodding or any other visual sign of consent' (opt-in). Opt in consent can be either verbal or written, i.e the client signs a consent form.

Provider referred clients (provider initiated VCT) are usually clients with signs or symptoms of HIV infection or with high risk behaviour. At the end of pre-test counseling, the client has **to actively disagree** to HIV testing and say "no" or leave the room (opt-out). It is assumed that HIV testing is beneficial for ongoing medical care and treatment. Opt out consent is usually verbal.

To obtain informed consent for HIV testing:

1. The client must be found competent by the counselor.
2. The client must understand the purposes, risks, harms and benefits of being tested, as well as those of not being tested.
3. The client's consent must be voluntary.

If the client is not found competent, such as in case of clients suffering from **mental illness or**

unconscious clients, a legal guardian such as a close family member (parent or spouse) has to provide consent on behalf of the client. In emergency situations, where no guardian is available, the attending doctor can recommend HIV testing. In all cases, HIV testing and knowledge of HIV status has to be clearly beneficial to the client (best interest).

Informed decision not to undergo HIV testing

Although most clients are likely to consent to testing for HIV, some clients may refuse even after repeated counseling. Ultimately, a person's refusal to be tested should be respected and the person can be requested to return for HIV counseling and testing at a later stage.

There are many reasons that may motivate a client to refuse HIV testing, including:

- False or inaccurate information.
- Insufficient psychological or emotional preparation.
- Lack of social support.
- Fear of breach of confidentiality.
- Fear of testing procedures.
- Fear of losing employment, housing, insurance or other economic support.
- Fear of losing friends, partners or child.
- Past or current history of physical or sexual abuse, or both
- Personal and cultural values or beliefs.

Informed consent for HIV testing of minors (infants, children and adolescents)

In Nepal, the legal age of consent is 18 years. Anyone 18 years or older requesting VCT is deemed able to give full informed consent. As children (below -14 years) and minors (Under 16 years) cannot legally provide consent.

Under the following circumstances, HIV testing may be of benefit to minors:

- Children born to HIV positive mothers (HIV exposed children)
- Children and adolescents with clinical indicators of HIV/AIDS.
- Vulnerable children and adolescents at increased risk of HIV infection (e.g. street children)
- Children and adolescents who engage in high risk behaviour such as sex work or injecting drug use
- Children and adolescents who have been sexually abused.
- Adolescents who are sexually active or are married

In these circumstances, the counselor or clinician will need to explore with the minor and/or their parent/guardian:

- Whether it is in the best interest of the minor to be tested for HIV.
- Whether the minor and/or parent/guardian would benefit from counselling and testing.
- Who will provide consent?
- Whether, when and how the minor will be informed of the HIV test result (disclosure to children)

1. Consent for HIV testing of children

Children below 16 years may be given preventive counseling if requested. When children are brought to the VCT center by their parents or guardians, the counselor determines the reasons for HIV testing. As with all other clients, the counsellor determines that HIV testing and counseling **promotes the best interests and optimal health outcomes for the child** and that there is no potential for neglect or abuse of an HIV positive child. In case these conditions are met, voluntary

informed consent from parents or legal guardian is required.

Children have the right to be involved in all decisions affecting their lives and to make their views known. Every attempt should be made to inform the child on the process and reasons of testing and to obtain the child's assent.

2. Consent for HIV testing of adolescents (young people under the age of 18)

All young people under the age of 18 accessing VCTs should have access to preventive counseling regardless of their marital status and whether or not parents or guardians consent. Counseling should include information on sexual and reproductive health and family planning. HIV testing may be undertaken without parental consent on a case-by-case basis, if the counselor determines that the minor has sufficient maturity to understand the testing procedures and results. Adolescents can be designated as 'mature' or 'emancipated' minors if they are married, pregnant, and sexually active or are already parents.

In special situations, where no legal guardian is available such as in the case of street children, orphans, etc. the VCT can provide HIV counseling and testing of the minor. In this case, a second health worker such as the doctor can act as surrogate guardian. Each case will need to be assessed by the counselor and a decision reached on the basis of what is **ultimately in the best interest of the minor**.

Confidentiality

Confidentiality is defined as the state of being 'private'. Confidentiality of information exists when personal information shared by the client such name, address, high risk practices, sexual orientation, is not shared with others unless the clients have given their permission.

Why is VCT confidential?

Keeping client information confidential is crucial for building trust in the counsellor and the VCT services and will encourage people to access VCT services. Trust is a very important factors in the counselor – client relationship and improves the outcome of counseling. Great harm may result from a breach of a client's trust.

Many people are afraid to seek HIV services because they fear stigma and discrimination from their families and community. During pre-test counseling, clients should be informed about how information is recorded, stored and how the VCT maintains confidentiality. VCTs should offer confidentiality because:

1. Confidentiality builds trust and encourages a relationship where clients can reveal to the counselor sensitive information and feelings normally kept to themselves.
2. Confidentiality helps clients discuss high-risk behaviours (unprotected sex, using drug and alcohol).
3. Confidentiality permits clients to remain in control and reveal their HIV sero-status to selected individuals, especially sexual partners and family members in their own way.

Confidentiality procedures

VCTs, especially those located within hospitals and health centers, should ensure that clients accessing services are not readily identifiable by the public or by other patients. VCT should also ensure confidentiality of client's information and all VCT staff should understand the importance of confidentiality and be encouraged to respect it. Confidentiality can be achieved by:

1. Keeping client information / client files in a closed cabinet

2. Using coding numbers (PID number) to the client to protect his name and address
3. Providing anonymous HIV testing, (see above)
4. Implementing VCT confidentiality procedures and policies that outline how confidentiality of client information is maintained and staff responsibilities.
5. Providing the HIV test (during post test counseling) by the counsellor to the person whose blood was tested or the legal guardian in case of children. A client's preference whether family members or confidants can be present must be respected.
6. Sensitizing all staff to confidentiality procedures
7. Advising clients on the safe-keeping of client-held records, such as HIV test results, antenatal care (ANC) cards and child health cards.

If confidentiality is wilfully breached, the client may take legal action against the organization or institution.

Types of confidentiality:

1. Shared confidentiality

Shared confidentiality is encouraged in health care settings (medical disclosure). Medical or counseling records, including HIV test results, can be shared with health care professionals who have a **direct role** in the ongoing management of the client and where sharing the information is beneficial to the client's further treatment and care. This applies to verbal and written information. The client should be informed about why information is shared, with whom it is shared and the client's consent should be sought.

2. Pediatric confidentiality

No person except the child's parents, other guardians and the treating physician has a need to know the child's HIV status. The family has no obligation to inform school authorities. If the family chooses to inform school authorities, the child's right to privacy must be assured.

3. Option of anonymous HIV testing

Anonymous testing (i.e. consented voluntary testing conducted without a client's identifying information being linked to testing or medical records, including the request for testing or test results) has been used widely and effectively to the benefit of public health.

Disclosure

Disclosure refers to the act of informing (by any means such as telephone, fax, email, etc.) an individual or organisation (such as health authority, employer or a school) of the HIV sero status of an HIV positive person. HIV positive clients should be encouraged to disclose their HIV status to their doctors, partners, spouses etc. in order to access appropriate prevention and care services and to prevent further HIV transmission. Disclosure of HIV/AIDS status should therefore be 'beneficial' and therefore should:

- be voluntary;
- respect the autonomy and dignity of the affected individuals;
- maintain confidentiality as appropriate;
- lead to beneficial results for the individual, his/her sexual or drug injecting partners, and family and maximise good for both the un-infected and the infected.

There are several options for disclosing the HIV status or other information:

1. Self disclosure by client
2. Client brings partner to VCT and self discloses in the presence of the counsellor

3. Client brings partner to VCT and counsellor discloses in the presence of the client
4. Client authorizes counsellor to disclose in the absence of the client
5. Client discloses to a key trusted family or community member who discloses to partner

1. Medical disclosure of patient's HIV status (shared confidentiality)

For patients in health care settings (In patients), disclosure of HIV status to staff that is directly involved in treatment or care of the patient such as the attending nurse or the operating physician is encouraged. Disclosure of HIV status must be medically beneficial for the treatment of the patient or should be done to avoid a threat to the life of the infected person for example, to a psychologist/psychiatrist in case of suicidal ideation.

Medical disclosure can be done by the counselor **after explaining the advantages of disclosure and seeking the consent of the client**. Medical disclosure protects both the rights of the client to confidentiality and the rights of the hospital staff to a safe work environment. The disclosed information must be kept confidential by the hospital staff.

2. Partner disclosure and partner notification

Counselors should encourage (through counseling) disclosure of HIV status by the client to the client's spouse, sexual or needle-sharing partner(s) and to bring the spouse or partner for counseling to the VCT. Counselors must support disclosure by practicing the disclosure process with the clients (e.g. through role plays). This process of helping the client sharing the test result might take more than one counseling session.

In case the client does not agree to disclose, the VCTs are vested with discretion to decide on the basis of each individual case, to **notify** the HIV positive person's sexual or needle-sharing partner of the HIV status of their client when there is **a significant risk of HIV transmission**.

Partner notification

In case the client does not agree to voluntarily disclose the HIV positive status to the spouse or partner the following protocol for partner notification should be adhered to:

1. The HIV positive person has been thoroughly counseled as to the need for partner disclosure partner and encouraged to voluntarily inform the partner or bring the partner to the VCT for joint counseling.
2. The HIV positive person has refused to notify or consent to the disclosure of his or her partners.
3. An imminent risk of transmission to the partner exists.
4. The HIV positive person is given advance notice of the intention to notify.
5. The identity of the source client from where the client acquired HIV is concealed from the partner if that is possible in practice.
6. Post-notification follow-up counseling, information and support is provided to the partner and the HIV positive person to prevent violence, family disruption, etc.

3. Couple counseling and disclosure

Couples who come together for VCT should be given their results together, unless they express a preference to receive the results separately. In case of one partner testing HIV positive, the partner should be encouraged to disclose the HIV test result to the other partner, however, a client's status should not be disclosed to his/her partner without his/her consent. There is a need to be client and understanding to the partner who is HIV positive and may be reluctant to disclose to the partner. Most people, if supported and helped to weigh the costs and benefits of

disclosure to their partner, usually disclose in the end (see partner disclosure).

4. Disclosure of HIV status to children:

In cases, where parents or guardians have provided informed consent for HIV testing of the child, parents or guardians should receive the HIV test report on behalf of the child. In case of a positive HIV report, parents or guardians need to be counselled on the necessity and process of appropriate disclosure of HIV status to the child, based on the child's age and development status. It is important to disclose the HIV status to children as knowledge of HIV status by the child facilitates healthy living, treatment adherence and safe behaviours in case of older children.

When disclosing HIV status to a children below 18 years:

- Use language and concepts appropriate to the child's age and development stage
- Use pictures, drawings and role plays to explain concepts
- Use pictures and drawings for the child to express feelings or concerns
- Be aware that children may share with other children and may be subjected to discrimination
- Do partial disclosure for young children (speak about an infection in the body without mentioning HIV)

6. Guidelines for HIV Counseling

A. Definition of HIV/AIDS counseling

A confidential dialogue between a person and a care provider (counsellor) aimed at enabling the person to cope with stress and make personal decisions related to HIV/AIDS. HIV Counseling is **issue-centered** and **goal-oriented**, helps to provide options, enables identification of alternatives and motivates decision-making. The counseling process includes an evaluation of personal risk of HIV transmission, facilitation of preventive behaviors and an informed decision regarding an HIV test.

Important features for counseling:

- Time
- Acceptance and respect
- Accessibility
- Consistency and accuracy
- Honesty
- Tactfulness
- Confidentiality

Counseling skills include:

Active listening	nodding, reflecting
Encouraging	<i>"yes, please continue..."</i>
Recognizing	<i>"that must be very difficult to accept.."</i>
Acknowledging	<i>"I understand this is not easy for you..."</i>
Effective questioning	<i>"Please tell me exactly what you know... "</i>
Empathizing	<i>"I can see you're feeling very anxious ... "</i>
Respecting	paying attention while the client talks
Paraphrasing	<i>"So you're saying that..."</i>
Challenging	<i>"Is this what you really want to do ... "</i>
Repeating	<i>"You felt happy to have a girlfriend... "</i>
Emphasizing	<i>"Can I just emphasize the following points ... "</i>
Structuring	<i>"There are three main issues we are facing ... "</i>
Summarizing	<i>"To summarize then, these are the issues..."</i>

HIV Counseling is not:

- Giving advice
- Making decisions on behalf of clients
- Judging clients
- Interrogating clients
- Blaming clients
- Preaching or lecturing to clients
- Making promises that cannot be kept
- Imposing own beliefs on clients
- Arguing with the client

B. Counseling in VCT

Counseling is a means to initiate prevention and ensure access to continuing care. The decision to be tested should always be made by the client himself/herself. More than one pre-test counseling session may be required for clients who refuse testing or are unprepared for testing. During post test counseling clients who test negative can learn ways to avoid becoming infected, and clients who test positive can learn how to live longer, healthier lives and prevent transmission to others. Follow-up counseling deals with issues of disclosure, partner testing and positive living. The detailed counseling content and process is described in Appendix 1

The purpose of counseling in VCT is to:

1. Ensure an understanding of HIV transmission and the risks
2. Ensure an understanding of the benefits and risks of HIV testing
3. Facilitate a decision whether to undergo an HIV test
4. Ensure that HIV positive persons have access to prevention, care, support and treatment
5. Ensure that HIV negative persons have access to the means of prevention and to remain HIV negative

Counseling settings

Depending on local conditions and client load, pre-test counseling and information can be provided in the form of individual counseling (one to one), in couple counseling or in group health information talks. Informed consent should always be given individually, in private, in the presence of a counselor.

1. One to one counseling consists of a counsellor and a client. It is used during pre test counseling, when obtaining consent, during risk reduction counseling and when giving the HIV test result. One to one pre test counseling can take 30-45 minutes.

2. Group counseling or information is usually offered in settings with large client numbers such as to pregnant women registering at the ANC clinic, STI patients, TB patients. In a group information / counseling session the health worker provides HIV information, the reason for initiating the HIV test, the benefits of HIV testing and potential outcomes, the follow up services that are available and the right of the client to decline the test. Following group pre test counseling, clients should provide individual informed consent.

3. Couple counseling consists of the counsellor and a married or unmarried couple or couples who are planning to get married. Couple counseling for HIV testing is beneficial in PMTCT settings and involves both the ANC mother and her spouse. Early involvement of the male partner is important for the acceptance of the HIV testing process and outcome. Couple counseling can be undertaken during pre- or post-test counseling with the consent of both partners. Couples should not be forced into being counseled together but should make an informed decision.

Counselors should ensure that both members of the couple have come voluntarily. If the counselor is concerned that one member of the couple has been coerced, the counselor should encourage the couple to return when they are both ready for VCT. Couples should be encouraged and supported to take the responsibility of discussing the implications of the HIV test result with each other.

The content of counseling focuses on sexual and reproductive health, risk assessment, safe behaviour, family planning and the benefits of HIV testing for the couple and or the unborn. The couple should be supported to explore the implications of the HIV test on their relationship, marriage,

childbearing, family planning and sex life. The couple should be given equal opportunities to talk and ask questions. Couples should also explore together the practicability of any changes in their sexual practice such as abstinence, condom use or non-penetrative sex.

- Before beginning, the counsellor should assure that each individual has given consent for counseling and testing and that each individual is aware that he/she is expected to disclose the test result to the partner
- The counsellor should first meet each partner individually to ascertain if there are any issues between the partners e.g. history of violence that may make disclosure difficult or if there is any coercion with regard to testing
- When counseling couples, the counselor should not take sides and should be respectful and understanding when conflicts or arguments arise during the session.
- Pre-test counseling may be conducted with the couple together or individually.
- Couples have an opportunity for individual counseling sessions for example during risk assessment as some may find it threatening to explore their risk behaviour in the presence of the partner.
- The counsellor should provide the HIV test results individually. The counsellor then assists one partner to disclose the result to the other partner.
- After disclosure, post test counseling may proceed with both partners present.
- Individuals who are reluctant to disclose their test result to their partner should be counseled and encouraged to disclose with the assistance of the counsellor
- The counsellor must not disclose an individual test result without the client's permission

C. Pre-test counseling and informed consent

For self-referred VCT clients (direct walk in or **client-initiated VCT**), counselors conduct an education session and a risk assessment, with a primary focus on prevention counseling for clients both prior to and after receiving their test results. For clients referred from health care providers (**provider initiated VCT**) based on signs or symptoms of HIV or for clients from MAPRs, pre-test counseling can be simplified. In both situations, verbal informed consent is sufficient but written consent can be taken.

Minimum Pre test counseling content for clients referred from providers

When recommending HIV testing and counseling to a client based on signs and symptoms of HIV or based on high risk behaviour, the counselor should provide the client with the following minimum information:

1. The reasons why HIV testing and counseling is being recommended
2. The clinical and prevention benefits of testing and the potential risks, such as discrimination, abandonment or violence
3. The services that are available in the case of either an HIV-negative or an HIV-positive test result, including whether antiretroviral treatment is available
4. The fact that the test result will be treated confidentially and will not be shared with anyone other than health care providers directly involved in providing services to the client
5. The fact that the client has the right to decline the test.
6. The fact that declining an HIV test will not affect the client's access to services that do not depend upon knowledge of HIV status
7. In the event of an HIV-positive test result, encouragement of disclosure to other persons who may be at risk of exposure to HIV
8. An opportunity to ask the counselor questions.

Populations Most at-risk of HIV transmission and women may be more susceptible to coercion to be tested. In such cases, the counselor may need to particularly emphasize the voluntary nature of the test and the client's right to decline it. Additional discussion of the risks and benefits of HIV testing and disclosure of HIV status, and providing further information about the social support that is available to the client, may also be appropriate.

Minimum Pre test counseling content for self referred clients

The counsellor will discuss

1. Basics of HIV/AIDS and the client understanding and motivation for HIV testing
2. Identification of the clients HIV risk and risk assessment
3. Risk reduction plan if required
4. The HIV testing process and outcomes of HIV testing
5. Client's coping mechanisms
6. Advantages of HIV testing and potential risks , such as discrimination, abandonment or violence
7. (continue with 3-8 from above)

D. Post-test counseling and provision of HIV test result

All individuals undergoing HIV testing should receive post-test counseling when providing the HIV test result, regardless of the test result. Given that many inpatient and outpatient facilities are crowded, care should be taken to discuss results and follow-up care in a confidential manner. HIV test reports should be given to the client in person and in writing during post-test counseling, ideally by the same counselor who conducted pre-test counseling. HIV test results should not be given by laboratory technicians or in group settings.

It is not acceptable practice to test clients and subsequently withhold or fail to convey test results. Although patients can refuse to receive or accept results of any test or investigation, VCT staff should make every reasonable attempt to ensure that clients receive and understand their test results in a confidential and empathetic manner.

Content of Post-test counseling for HIV-negative clients

Counseling for clients with an HIV-negative test result should include the following:

1. An explanation of the test result, including information about the **window period** for the appearance of HIV-antibodies and a recommendation to re-test in case of a recent exposure
2. Basic information on methods to prevent HIV transmission, including risk assessment and development of a risk reduction plan if required
3. Provision of male and female condoms and guidance on their use

The counsellor and the client should jointly assess the client's referral needs to more extensive post-test counseling or additional prevention support, for example, through community-based services.

Content of Post-test counseling for HIV-positive clients

The focus of post-test counseling for clients with an HIV-positive test results is on psychosocial support to cope with the emotional impact of the test result, to facilitate access to treatment, care and prevention services, prevention of transmission and on disclosure to sexual and injecting partners. Counselors should:

1. Inform the client of the result simply and clearly, and give the client time to consider it
2. Ensure that the client understands the result
3. Allow the client to ask questions
4. Help the client to cope with emotions arising from the test result

5. Discuss any immediate concerns and assist the client to determine who in her/his social network may be available and acceptable to offer immediate support
6. Describe follow-up services that are available in the health facility and in the community, with special attention to the available treatment, PMTCT and care and support services
7. Provide information on how to prevent transmission of HIV, including provision of male and female condoms and guidance on their use
8. Provide information on other relevant preventive health measures such as good nutrition, use of co-trimoxazole and, in malaria endemic areas, insecticide-treated bed nets
9. Discuss possible disclosure of the result, when and how this may happen and to whom
10. Assess the risk of violence or suicide and discuss possible steps to ensure the physical safety of clients, particularly women
11. Encourage and offer referral for testing and counseling of partners and children.
12. Arrange a specific date and time for follow-up visits or referrals for treatment, care, counseling, support and other services as appropriate (e.g. tuberculosis screening and treatment, prophylaxis for opportunistic infections, STI treatment, partner reduction, family planning, antenatal care, opioid substitution therapy, drug counseling, harm reduction).

E. Counseling Quality Assurance

All VCTs must ensure that the counseling provided to clients is of high quality. The VCT center in charge is responsible for quality assurance of VCTs. Several tools to assess the quality of VCT counseling services are available which include counsellor reflection tools (Appendix 18), client exit interviews, client satisfaction surveys (Appendix 19) and checklists for supervisory visits (Appendix 20). These tools can be used by DOH, DOPH, DACC, and VCT in charge, to assess and monitor the quality of VCT services. The following strategies help to ensure quality:

1. All counseling staff should receive foundation training, refresher training and training updates
2. Regular supervision and support for counseling staff by VCT in charge, district officer, NCASC staff. Supervision may include case presentations, observation of counseling sessions (with client consent), taped counseling sessions (with client consent) and application of quality assurance tools
3. Client satisfaction, client exit interviews,
4. Establishment of counsellor peer support as required.

7. Guidelines for HIV Testing

A. HIV test assays

The standard diagnosis of HIV is made by detecting antibodies against HIV infection in the blood. Diagnostic tests that detect the virus in the blood are more expensive and only used in specific situations such as for testing of newborns. A wide range of HIV antibody tests are available including rapid test and ELISA tests based on different principles. Currently available HIV rapid and ELISA tests are very reliable and Western Blots should no longer be used. Rapid tests are less expensive, do not require as high a level of technical expertise to perform and interpret, and produce fewer indeterminate results.

Operational Characteristics of ELISA and Rapid Tests:

Characteristic	ELISAs	Rapid tests
Detection (sample type / specimen)	HIV antibodies in plasma/ serum	Several can detect HIV antibodies in whole blood (finger-prick samples) as well as in serum / plasma.
Accuracy (sensitivity, specificity)	Varies with the test; ELISAs and rapid tests give similar diagnostic performances	
Laboratory equipment	Micropipette, washer, incubator, spectrophotometer	None to minimal (micropipette)
Laboratory personnel	Skilled laboratory technician	Any health care worker who has been adequately trained, including counsellors.
Ease of performance*	Level 4	Level 1–3, depending on test type
Time to perform	>2 hours	Mostly 10–30 minutes
Shelf life	Usually 12 months	Usually 12 months
Storage conditions	2–8 °C	Some 2–8 °C; most 2–30 °C.
Cost per test**	US\$ 0.40–1.20	US\$ 0.47–2.0
Volume of tests	Mostly suitable for medium volume to large-volume testing, i.e. > 40–90 samples per testing tray per day	Most kits are suitable for small- volume and large-volume testing, i.e. 1–100 samples per day.

* Level 1: little or no laboratory experience required, Level 2: reagent preparation required; procedure has multiple steps, Level 3: specific skills required, i.e. making dilution series or interpretation of agglutination patterns, Level 4: trained laboratory technician and complex laboratory equipment required.

** Based on WHO bulk purchase price in 2004, excluding freight and other charges.

Rapid (Simple) HIV tests

Interest in the development of HIV antibody tests that provide same-day results and do not require reagents or equipment not contained in the kit led to the currently available HIV rapid tests. Rapid tests are useful for VCT sites and small laboratories that routinely perform fewer than 100 HIV tests per day. The advantage of rapid tests:

- Allow single tests to be performed at a time
- Give quick results in less than 20 min.
- Can be carried out by staff with minimal laboratory training (health staff).
- May be stored at room temperature.
- Diagnostic performance is comparable with ELISA.

Rapid HIV tests enable providers to provide definitive (negative and positive) test results to clients immediately, in a single visit. Rapid HIV tests are easy to perform and interpret compared to the technically more difficult ELISA tests.

Rapid HIV tests are especially useful in settings where ELISAs are not feasible or practical and in geographic areas with limited laboratory infrastructure or with limited electricity or equipment. Rapid HIV tests are particularly appropriate for VCT for hard-to-reach populations, populations most at risk such as IDUs, FSWs or geographically remote populations. In these populations, opportunities for provision of HIV test results are often limited and test results should be provided on the same day. Therefore, HIV testing must be performed on site and on the same day as specimen collection using rapid HIV tests.

Rapid HIV tests also facilitate fast post exposure prophylaxis in health workers following occupational exposure to blood and body fluids.

The cost of rapid HIV tests is around US Dollars 1 which is slightly higher than an ELISA test. However, rapid HIV tests may be more cost-effective if additional costs of conducting ELISAs are considered such as equipment, laboratory infrastructure, technician training.

Evidence further indicates that clients and counselors have high levels of satisfaction with a VCT service that provides same hour/day results.

ELISA testing

ELISAs are best performed at a regional or national public health laboratory since they require well-trained and skilled laboratory technicians, technologically advanced equipment (incubators, washers, and spectrophotometers) that requires maintenance, and a constant source of electricity. ELISAs are most efficient for laboratories that process a large number of specimens (100 or more) daily. Because of test design, ELISAs are not suitable or cost-effective for a small number of specimens. Because laboratories often batch specimens and run them at one time, the time before results are available may be from days to weeks after collection. ELISAs have limited application in rural settings where the laboratory infrastructure and equipment may be insufficient.

Western Blot testing

Should only be used in very rare circumstances

B. Which test should be used?

Recommended HIV test for HIV diagnosis in VCT should be whole blood, plasma or serum. Tests based on urine and oral fluids are not allowed. The MoHP, NPHL and NCASC regularly update the list of HIV test tested and approved for use in Nepal. All VCT sites must use HIV tests kits endorsed by the MoHP or pre qualified by WHO.

Comparative evaluation of HIV test kits can be found in the following documents / web sites:

1. **RAPID HIV TESTS:** Guidelines for use in HIV testing and counseling services in resource constraint settings, World Health Organization 2004
<http://www.who.int/hiv/pub/vct/en/rapidhivtestsen.pdf>
2. **HIV ASSAYS:** Operational Characteristics (Phase 1) Report 14, Simple/Rapid Tests, World Health Organization 2004

http://www.who.int/diagnostics_laboratory/publications/en/hiv_assays_rep_14.pdf

3. **Logistical Fact Sheets:** HIV Test Kits, USAID, 2006

http://portalprd1.jsi.com/pls/portal/docs/PAGE/DEL_CONTENT_PGG/DEL_PUBLICATION_PG1/DEL_FACT_SHEET_PG1/HIVTEST_FS_COMPLETE.PDF

Rapid HIV Tests kits recommended by National Public Health Laboratory, MoHP

(August 2007)

Rapid HIV Tests:

Rapid Test Kit	Sensitivity Percent	Specificity Percent	Antigen	Principle of Testing
Determine HIV-1/2*, Abbott Laboratories, USA	100 (95.5-100.0)	99.4 (96.7-100.0)	rGP41, sGP41, rGP120, sGP36	Immunochromatography (Lateral flow)
Capillus HIV-1/2*, Trinity Biotech, USA	100 (95.5-100.0)	100.0 (97.9-100.0)	rGP41, rGP120, sGP36	Latex agglutination
UniGold HIV*, Trinity Biotech, USA	100 (95.5-100.0)	100.0 (97.9-100.0)	rGP41, rGP120, sGP36	Immunochromatography (Lateral flow)
SD Bioline HIV 1/2 3.0**, Standard Diagnostics, Korea	100 (97.7-100.0)	99.3 (97.6-99.9)	HIV1 (rGP41, rP24), HIV2 (rGP36)	Immunochromatography (Lateral flow)
Tridot Biotech Inc, India Cold Chain required	100	100	Recombinant proteins	Immunofiltration

Source: WHO 2002. HIV Assays: Operational Characteristics Report 12: Simple/Rapid Tests
WHO 2004. HIV Assays: Operational Characteristics Report 14/ Simple/Rapid Tests

Dried Blood Spot (DBS)

Dried Blood spot is whole blood collected by venipuncture or a finger prick or ear lobe stick on filter paper and air dried for at least 3 hours at room temperature. The DBS are collected at the time of client testing (e.g. finger prick) on filter paper and commonly sent for EQAS to a NPHL as reference laboratory. For procedures for finger prick and preparing a dried blood spot (Appendix 7 and 8). Dried blood spots allow:

- For storage at room temperature for 30 days, at 2-8°C for 90 days or at -70°C for more than 90 days
- For easy transport, for example by mail to a National Public Health Laboratory.
- NPHL to perform quality assurance of the local laboratory.

The use of dried blood spots (DBS) is one method that is currently being evaluated by NPHL as EQA for whole blood tests in sites where it may be impractical to refer specimens for additional testing or where there is limited or no access to serum PT specimens for monitoring test performance. Further development of DBS protocols is necessary in order to assist with the expansion of rapid testing for testing and counseling services, especially at remote sites.

C. Collecting, processing, and storing blood specimens

Whole Blood, Serum, and Plasma

Blood needed for an HIV test can be collected either by venipuncture (whole blood, serum, plasma) or by finger stick (whole blood).

a) Processing Blood Collected by Venipuncture

Collecting blood by venipuncture, follow local clinical or laboratory procedures.

b) Blood collected by Finger stick

Blood collected by finger stick or ear-lobe stick can be used to perform rapid tests as well as DBS. The specimen is placed directly on the rapid test apparatus or DBS. As most occupational exposure occurs during venipuncture, the risk of such exposure is substantially reduced with finger-prick blood collection.

D. National HIV testing strategy - Serial HIV testing

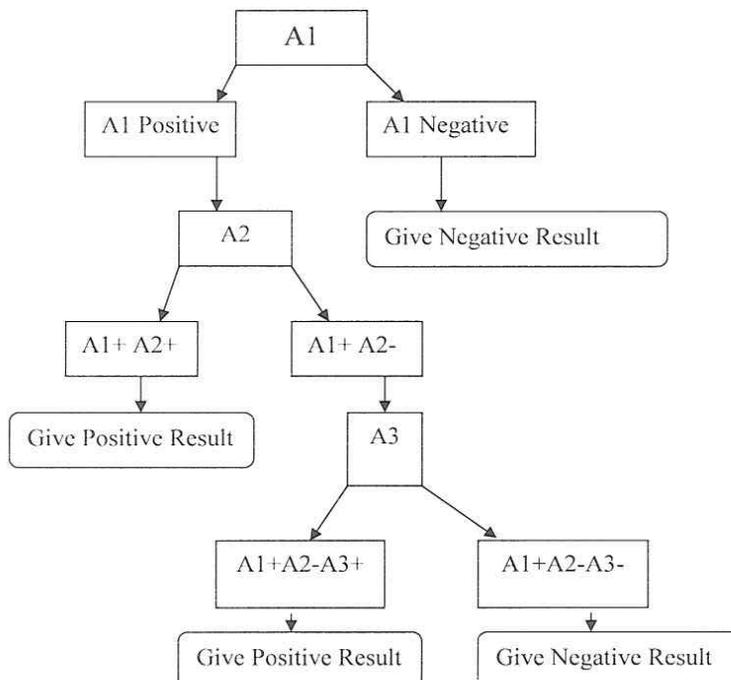
The standard national strategy for HIV testing is based on the serial HIV testing strategy using three different HIV test kits (based on different antigen principles). The first test (screening test) should be highly sensitive to provide reliable detection of antibodies in a blood sample. The second test (confirmatory test) should be highly specific to confirm that all truly negative blood samples as negative. **The strategy has to be followed at all levels of health care delivery system (hospitals, health centers, clinics, etc.) in government, private and NGO settings.**

Sensitivity is the capacity of a test to correctly identify a true positive specimen. A highly sensitive test will give very few false negative results.

Specificity is the capacity of a test to correctly identify a true negative specimen. A highly specific test will give very few false positive results.

If the first test result is positive a second HIV test using a different antigen principle has to be used. Samples that test positive in the first test and negative in the second test will undergo a third test (tie breaker) using a third test with different antigen principle (or an ELISA).

Serial HIV testing algorithm: Interpretation of HIV test results: (A refers to Assay (HIV test))



Description

1. All serum/plasma is first tested with first rapid test, which is highly sensitive (A1).
2. Serum that is non-reactive on the first test is considered HIV antibody negative (A1-). A negative HIV test report is issued.
3. Serum that is reactive on the first test is retested with a second highly specific rapid test based on a different antigen and/or different test principle.
4. Serum that is reactive on both tests is considered HIV antibody positive (A1+ A2+). A positive HIV test report is issued.
5. Any serum that is reactive on the first test but non-reactive on the second test is retested with a third different rapid test / tiebreaker test or ELISA. (The tiebreaker test kits will be needed in around 1% of cases).
6. If the third test result is reactive, the serum is considered HIV antibody positive (A1+.A2-A3+). A positive HIV test report is issued. The reactive result at the first test was probably a laboratory error.
7. Any serum that is non reactive on the third test will be reported as negative (A 1+ A2-A3-). A negative HIV test report is issued.

Possible rapid HIV test combinations for use in VCT laboratory:

	1. Option	2. Option	3. Option	4. Option	5. Option
1. Test	Determine	Determine	Tridot	SD Bioline	SD Bioline
2. Test	Unigold	Unigold	Capillus	Unigold	Unigold
3. Test	Capillus	SD Bioline	Unigold	Capillus	Tridot

E. Informing clients of HIV test results

VCTs should ensure that clients tested for HIV infection receive their test results in a timely manner (preferably same day) to reduce loss to follow up and improve return rates. The HIV test result using the client code number should be sent from the laboratory to the counselor who provides **the written HIV test report to the client during post-test counseling**. Strict confidentiality of the HIV test result must be maintained.

HIV Positive test result

An HIV test should be considered positive only after screening and confirmatory tests are reactive. A confirmed positive test result indicates that a person has been infected with HIV. False-positive results when both screening and confirmatory tests are reactive are rare. However, the possibility of a mislabelled sample or laboratory error must be considered, especially for a client with no identifiable risk for HIV infection.

HIV Negative test result

Because a negative test result likely indicates absence of HIV infection. A negative test need not be repeated in clients with no new exposure in settings with low HIV prevalence.

Window period

For HIV negative clients with a recent history of exposure to HIV who are tested before they could

develop detectable antibodies, the possibility of HIV infection cannot be excluded without follow-up testing. It usually takes at least 3 months, for antibodies to develop, so the client should be advised to return for testing after the window period.

F. Quality Assurance of Rapid HIV Testing

Quality assurance is an ongoing process of monitoring a system for reliability and reproducibility of results. Monitoring includes corrective action when established criteria are not met.

The NPHL has the overall responsibility to ensure quality for all HIV testing services in the public and private sector.

VCT sites are the first line of testing and counseling using mostly rapid tests from the recommended list. Regional laboratories will be developed to undertake EQAS with ELISA or rapid tests. The NPHL is the third line testing center and responsible for quality assurance.

Adequate monitoring and reporting mechanisms will be established by the Ministry of Health and Population, NPHL and regional laboratories will provide regular monitoring, supervision and evaluation according to set standards.

National HIV Testing Monitoring and Supervision System

VCT Sites

Rapid tests from approved list, DBS

Regional / District Laboratories

ELISA / Rapid tests, DBS

Regular monitoring / supervision

National Public Health Laboratory, Kathmandu

Rapid / ELISA / Western Blot

National Quality Assurance

The NCASC, MoHP requires that laboratories at all levels (e.g., HIV laboratories in hospitals, blood transfusion services, and private HIV laboratories and VCT sites) participate in a national external quality assessment of their performance. The National Public Health Laboratory, in collaboration with the NCASC, will monitor the effectiveness of the participating laboratories' quality systems to identify any laboratory that might require further training or other action.

1. Proficiency Testing

Proficiency testing (PT) is the most common form of EQA and involves development of specimen panels by the NPHL for distributing to VCT sites. Every 6 months, the NPHL will send to all participating VCT laboratories a proficiency panel of approximately six specimens to identify as HIV positive or HIV negative and report back on their local results.

The limitations of PT are that it usually involves only a few specimens and the test results may not represent the routine test performance. This may be due in part to the greater care in handling PT specimens.

2. EQAS

The MoHP requires all private and public laboratories performing HIV test to participate in External Quality Assessment Scheme (EQAS). Public and Private laboratories are required to

send quarterly the following serum samples following standard shipment procedures for biological materials:

1. VCTs in high HIV prevalence settings such as for populations most at risk: 10% of all samples randomly selected
2. VCTs in low prevalence and general hospital settings: All positive samples and 10% of negative samples

Alternatively, to avoid shipment of serum samples, VCTs and other participatory laboratories can prepare DBS and send them to NPHL for EQAS. This system is currently being established.

Laboratory Procedures

Internal Quality Assurance

Laboratories at all levels (national, regional, and local) that conduct HIV testing must have a functioning internal quality assurance program. This includes following standard operating procedures (refer to National Laboratory Guidelines) and following procedures laid out by the HIV test manufacturers. Each laboratory conducting HIV testing should routinely monitor and assess the quality in the pre-analytical, analytical, and post-analytical phases of the testing process. Laboratory errors often occur in the pre-analytic (i.e., specimen collection, labelling, transporting, processing, and storing) and post-analytic steps of testing (i.e. results validation and reporting) rather than during the test itself.

- Check the expiry of the test kit: it should be used within its expiry date.
- Store the test kits at the temperature specified by manufacturer, if the test kits require cold chain. The temperature of the refrigerator compartments should be monitored regularly.
- Place the procedural flow chart of the testing in visible area and follow the instruction strictly while doing the tests.
- Use correct amount of reagents as specified by the manufacturer, reagent for one-test kit should not be used for another
- Test the kits without in build control bands, with the specific control everyday before carrying out the actual testing.
- Assess the presence or absence of the control band in a test kit which has In-built control during the testing. If the control band appears within the device, the test is considered valid and if the control band does not appear the test result is invalid and should not be reported.
- Interpret result of each test kit used properly.
- Completely follow the whole algorithm before declaring the final test result
- Record the result with the correct identifier code.
- Maintain records and the forms appropriately.

The minimal requirement for approval to perform HIV testing in a VCT is basic training as a Laboratory Technicians / Laboratory Assistant and a 4 day NPHL approved training in HIV testing. (see also section 8 qualification of VCT laboratory technicians)

Providers must ensure the quality of HIV testing by:

1. Assessing the efficiency of the laboratory staff.
2. Adhering to standard laboratory procedures including universal precautions.
3. Assessing record keeping procedures and procedures for maintaining confidentiality.
4. Ensuring good networking with care and support organizations.

Information on Universal Precautions and Waste Management can be found in Appendix 6 and in the 'National Guidelines on Universal Precautions and Waste Management'

8. Guidelines for Establishment and Operations of VCT services

The NCASC acknowledges VCT providers need to flexibility in implementing VCTs, given their client base, setting, HIV prevalence and available resources. Nationally agreed goal is to establish at least two VCTs per district by 2011. The VCT setting should be based on the needs, HIV prevalence, resources, and client base. Preferably one VCT could be established in a government health center either in the STI clinic, or the TB DOTS center, or in the general OPD.

Districts should coordinate and prioritize the establishment of VCTs considering available epidemiological information of the predominant mode of HIV transmission and the most affected groups in the district.

A. Location of VCT:

VCTs should be located in settings where they are easily accessible and easy to locate by clients, non stigmatizing with appropriate opening hours.

In a hospital setting, the VCT should be located either near the general OPD, or in the ART center, STI department, Antenatal clinic, DOTS center, depending on client load and HIV prevalence. If large numbers of STI patients are found to be HIV positive, the VCT may be located in the STI department.

In NGO settings, the VCT should be located close to the target population. VCT services could be established in the NGO centers or as mobile VCTs.

B. Set up and basic infrastructure

1. Counseling site:

Minimum requirement:

- counseling room / area, providing privacy
- 1 table or desk
- 2 chairs
- Counseling tools (flipcharts, flyers)
- Counseling registers and forms
- Referral directory
- Penis model,
- Condoms,
- VCT guidelines
- Access to lockable filing cabinet
- Water jug and steel cup

2. HIV blood collection and testing site:

Minimum requirement:

- Working counter / table
- Desk and chair
- Place for elbow rest (blood draw)
- Sink and running water
- Disposable needles and syringes
- Vials and blood sample tubes
- Color coded waste disposal containers
- Sharps disposal container
- Gloves
- Laboratory coat
- Test tube rack
- Cotton swabs
- Bleach solution
- Cleaning materials (spirits or antiseptic lotion)
- Rapid HIV test kits
- Micropipettes
- Disposable plastic tips
- Refrigerator with lock
- Centrifuge
- Laboratory register and forms
- National Laboratory Guidelines
- PEP kit

Desirable / Additional:

- Needle destroyer

Desirable / Additional:**3. Waiting area (Optional):**

The waiting area should provide space for people to sit comfortably and should provide some privacy.

- IEC materials (general health materials, HIV, TB, Malaria, immunization, etc.)
- TV and video
- Chairs
- Waste basket
- Client suggestion box

C. Staff qualification and roles:

The staff in a VCT should include a responsible VCT in charge, a counsellor and a laboratory technician.

HIV Counseling should be provided by the staff nurse, health worker, health assistant, auxiliary health worker, ANM after completion of the 7 or 10 days National HIV Counseling Training

HIV testing can be conducted by the laboratory technician or in cases where laboratory technicians are not available by the laboratory assistant after completing a 4 day HIV testing training.

VCT in charge

The VCT in charge is responsible the VCT. The role is to supervise the overall functioning of the VCT and its staff, supervise administration and accounts, establish linkages and referral directory, prepare operating procedures for VCT, sign HIV test reports, order HIV test kits, coordinate with the DPHO and send monthly report to the DHO, DPHO, RHSD and NCASC, conduct staff appraisals, conduct periodic VCT assessments and client satisfaction surveys.

VCT in charge Qualifications

The VCT in charge should be a nursing supervisor, Public Health Inspector or senior health assistant. In NGO settings, the VCT in charge can be the project coordinator or project manager. The VCT in charge should have administrative knowledge and received orientation to VCT and counseling.

VCT Counsellor

The counsellor's role is to provide quality HIV counseling to the clients according to national guidelines and protocols, to complete the counseling records and prepare the monthly report for the VCT in charge. Counselors should also develop linkages with health centers, NGOs and others and prepare a referral directory of additional services available to VCT clients in the district.

The counsellor should not perform HIV testing unless s/he has undergone laboratory training in rapid HIV testing. VCT Counselors can provide ART or PMTCT counseling if they have undergone the required training.

Counselor Qualifications

VCT Counselors will be recruited amongst graduates including those in the fields of health or social work, psychology, nursing/paramedical, and amongst laboratory technicians (for sites where the technician will undertake a dual role). In sites where counsellors with these qualifications are not available, persons with SLC / intermediate pass can be recruited.

Selection criteria should include personal attributes conducive to HIV counseling including: capacity to be non judgmental; understanding; patience; comfortable speaking explicitly about sensitive issues such as sexual practices, sexual orientation, drug use, and sex work; comfortable demonstrating and discussing condom use; empathic; warm; and mature. PLHA with the required qualification and training can be given preference as VCT counsellors (peer counsellors).

All recruited staff is required to undergo a VCT counseling skills training program based on the standardized national training curriculum of 7 or 10 days duration, as per NCASC standards.

VCT Laboratory Technician

The laboratory technician's role is to conduct HIV tests according to standard laboratory procedures, plan HIV test kit requirements, issue HIV test reports for signature by VCT in charge,

The laboratory technician should not perform HIV counseling unless s/he has undergone the 7-10 day counsellor training

Qualification of the VCT laboratory technician

The preferred qualification of the VCT laboratory technician is certificate level (SLC + 3 years course). In places where certified laboratory technicians are not available, laboratory assistants (SLC + 1.5 years course) can be selected. In both case, the VCT laboratory technician should have undergone the 4 day training in HIV testing.

The minimal requirement for approval to perform HIV testing in a VCT is basic training as a Laboratory Assistant / Laboratory Technician and a 4 day NPHL approved training in HIV testing

In some sites it may not possible to recruit a laboratory technologist. In this case, health care staff such as doctors, nurses, laboratory technicians and other professional staff can perform rapid HIV testing after undergoing a standardized training course on HIV testing procedures approved by the NPHL / MoHP.

Community health worker, Outreach worker, Lay Counselor

Community health worker's roles is to raise awareness about HIV prevention and promote and create demand for voluntary counseling and testing (VCT), and prevention of mother to child transmission (PMTCT) services. Outreach workers with some counseling aptitude or training can function as lay counsellors.

The role of DACC

DACC should coordinate the VCT progress in the district. DACC should be actively involved in the establishment, strengthening and monitoring and supervision of VCT services in the district and conduct review meetings.

The role of the DHO/DPHO

The district health office / district public health office in collaboration with the DACC must be involved in planning and deciding where VCTs should be established. DHO/DPHO should

- provide technical advice, supervise VCT functioning, undertake periodic monitoring visits.
- ensure that all VCTs submit monthly reports and should check the report quality,
- collate monthly reports and forward them to NCASC and HMIS.
- in collaboration with VCTs, assess VCT HIV test kit requirement and forward projections to NCASC.

- In the future, DHO/DPHO should coordinate EQAS for VCT by collecting the specimens from all VCT sites (government & NGO) and send samples to RHL or NPHL for EQAS.

The role of NPHL

- Conduct regular induction and refresher trainings for VCT laboratory technicians
- Coordinate proficiency HIV testing
- Coordinate of EQAS,
- In collaboration with NCAS conduct regular orientation meetings for laboratory assistants, technicians about HIV/AIDS, VCT and HIV testing procedures.

The role of NCASC

- Overall responsibility for expansion and strengthening of VCT operations
- Coordination with NPHL, DHO, DPHO, DACC and civil society and NGOs
- Conducting regular planning meetings for HIV test kit requirements including buffer stock
- Conducting site assessments to prepare VCT establishments
- HIV test kit procurement and supply to VCTs,
- Report collation and provision of feedback
- Preparation of monthly national statistics,
- Dissemination of VCT programme performance
- VCT service Quality Assurance
- VCT site visits for supervision and monitoring to ensure that services are provided according to the guidelines.
- Annual VCT review meetings (counsellors and laboratory technicians (in collaboration with NPHL))
- VCT Programme Evaluation (in collaboration with partners)
- Conducting / arrange a VCT update and ToT update
- Provision of funds to NPHL, DHO/DPHO, DACC and VCT if required.
- Revision / update of guidelines, training materials, forms, posters as necessary.

D. General Client Flow in a VCT

Client's pre-test counseling (initial visit)

- Step 1** Client follows signboards, enters VCT and is seated in the waiting area
- Step 2** Counselor calls client, enters client register, assigns a code number* or PID (Personal Identification Digit) and conducts HIV pre-test counseling
- Step 3** Decision to regarding HIV test.
- a. Client does not consent: Client leaves VCT
 - b. Client agrees to undergo an HIV test and gives **verbal informed consent** (written consent can be taken if required):
 - Counselor provides return time for post-test counseling (depending on HIV test turn-around time).
 - Client is given a receipt without client's name
 - c. Client proceeds for blood collection.
- Step 4** Blood collection
- a. Blood is drawn and sent for HIV testing to laboratory technician
 - b. Client is reminded to wait in the waiting area in case of same day results OR
Client is asked to return on assigned date with Personal Identification Digit (PID) number and receipt
- Step 5** Client waits in waiting area for test result (Alternatively, client exits VCT and returns on the assigned date and time

The HIV test is being performed as per the national guidelines by the laboratory and the HIV test report is prepared and sent back to the counselor

Client's post-test counseling (follow-up visit)

- Step 6** Client returns to VCT or waits in waiting area
- Step 7** Counselor calls client for post-test counseling
- Based on the PID number provided by the client, the counselor take out the client's pre-test counseling record and the HIV test result
 - Counselor provides the written HIV test report and post-test counseling
 - Counselor provides appointment date for follow-up counseling session
 - Client is referred to medical treatment and other services including ART, if required
- Step 8** Client exits VCT

At any point in time during the VCT visit, the client has the choice to consult a medical officer if he/she wishes.

* Note: Generation of code number (PID), use first district name, then initials of institute, then running VCT number, then date of first visit e.g. Kath / NCASC-231 / 29-6-2003

9. Guidelines for VCT services in specific settings & for vulnerable and high risk groups (MARF)

A. VCT in specific settings

VCT in ANC settings for pregnant women and their spouses (see also PMTCT programme guidelines):

Rationale:

HIV among pregnant women has increased over the years to 0.2% prevalence. HIV positive pregnant women can access antiretroviral treatment and programmes to prevent the transmission of HIV to their child. In order to be able to make informed decisions about protecting her unborn child, safe infant feeding and access to antiretroviral (ARV) therapy, a pregnant woman needs to know and understand her HIV status. Infants who acquire HIV infection from their mothers do so during pregnancy, during labour and delivery and after birth through breastfeeding. The risk of infection is now thought to be 5-10 percent during pregnancy, 10-20 percent during labour and delivery and 10-20 percent during breast feeding.

To whom should the counselor offer an HIV test? All pregnant women attending the ANC and their partners. Couple counseling (see section 6) should be promoted. If women are tested alone, or their partners refuse to be involved in the VCT process, women may feel unable to disclose their status to their sexual partner and take full advantage of the benefits of VCT. They will have difficulties in making decisions about using safer sex practices, planning for their and their families' future, accessing care and support, and making infant feeding choices. Testing a woman individually should be the exception (at the woman's request) and not the rule.

HIV counseling can be provided by the gynaecologist, nurse, laboratory technician, health assistant, senior AHW, AHW, ANM. Usually, in ANC settings, group counseling is provided followed by individual counseling if requested and verbal informed consent is taken.

Content of Pre-test counseling:

In addition to the standard pre test counseling content (section 6), pre-test counseling for women who are or may become pregnant should include:

- The risks of transmitting HIV to the infant
- Measures that can be taken to reduce mother-to-child transmission, including antiretroviral prophylaxis and infant feeding counseling
- The benefits to infants of early diagnosis of HIV.
- **Reinforcing safer sex messages to all women and their partners**

Content of Post-test counseling for HIV-positive pregnant women

In addition to the standard post test counseling content (section 6), post-test counseling for HIV positive pregnant women should include:

- Child birth plans
- Use of antiretroviral drugs for the client's own health, when indicated and available, and to prevent mother-to-child transmission
- Adequate maternal nutrition, including iron and folic acid
- Infant feeding options and support to carry out the mother's infant feeding choice. It is important that even in VCT settings where ARV interventions (ART or PMTCT) are not available, HIV positive women are counseled about appropriate infant feeding options.

- HIV testing for the infant and the follow-up that will be necessary
- Disclosure to spouse and Partner testing. Sharing an HIV test result with her partner or close family members requires sensitive counseling as interventions to reduce mother to child transmission may involve decisions to change infant feeding methods and taking ARVs, which will make it difficult to conceal a seropositive status. **Sharing results during pregnancy should be encouraged only if the woman has adequate emotional support and is not at risk of harm or social ostracism/exclusion through disclosure.**

Content of Post-test counseling for HIV-negative pregnant women

The content follow the standard post test counseling content (section 6) for HIV negative people.

VCT in TB settings for TB patients:

Rationale:

HIV among TB patients has continuously increased over the years to 2.44% (2001/2002). (Source: SAARC Tuberculosis and HIV/AIDS center 2005 (update)). TB patients with HIV infection benefit from early HIV diagnosis to access antiretroviral treatment and to prevent HIV infection to others. Health providers in TB settings should therefore routinely offer an HIV test to TB infected persons with vulnerable and high risk behaviors to HIV infection or affiliation to partners with high risk behavior.

The HIV test can be either performed in the DOTS center if the DOTS center is integrated with a VCT or through referral to the nearest VCT.

VCT can be established in TB settings: (DOTS centers, microscopy centers).

Indication for offer of HIV test: People with signs and symptoms of HIV infection (WHO clinical staging: Appendix 5), non responsiveness to TB treatment, MDR TB, reported high risk behaviour (unprotected sex, multiple sexual partners, injecting drug use), reported vulnerability.

HIV counseling can be provided by TB doctor, nurse, health assistant, senior AHW, AHW, ANM, laboratory technician with reduced pre-test counseling content (PITC). In large settings group counseling followed by individual counseling and verbal informed consent can be implemented.

Establishing VCT in TB settings as part of collaborative TB and HIV activities should be based on epidemiological information (e.g. sentinel surveillance data) and be implemented collaboratively by the tuberculosis and HIV/AIDS Control programmes, nongovernmental organizations, community-based organizations and the private sector. The coordination lies with the district health units and the national tuberculosis and HIV/AIDS control programmes.

VCT in STI settings for patients with STIs:

Rationale:

HIV is a sexually transmitted infection (STI). People with STIs have had high risk behaviour (such as unprotected sex) and may be infected with HIV. HIV Sentinel Surveillance (HSS) among STI patients conducted in six sites from 1998 to 2001 showed that the average HIV prevalence increased from 1.3% in 1998 to 2.7% in 2001. But HIV prevalence among STI patients in Nepalgunj (one of the six sites) increased from 4.3% in 1998 to 8.3% in 2001 (NCASC, 2002). The HIV test can be either performed in the STI department (if it is also a VCT) or through referral to the nearest VCT.

To whom should the health care provider offer an HIV test? People with presence of STIs, signs and symptoms of HIV infection (see WHO HIV clinical staging: Appendix 5), presence of OIs (such as TB), reported high risk behaviour (unprotected sex, multiple sexual partners, injecting drug use), reported vulnerability.

HIV counseling can be provided by STI doctor, nurse, laboratory technician, health assistant, senior AHW, AHW, ANM, with reduced pre-test counseling. Risk reduction counseling can be performed during post test counseling

Patients diagnosed with an STI should be encouraged to propose HIV testing and counseling to their partners. Such testing can be done following counseling of the couple, or through referral of the partner to client-initiated VCT services.

B. VCT for vulnerable groups and populations most at risk (MARPs)

Vulnerable groups in Nepal include youth, IDU, MSM, CSW, FSW, MSW, Migrants and spouses, children and youth, street children, prison population, uniformed services, etc. Although vulnerable groups require the same information as other groups, there are special considerations and challenges when providing services. Some of these are outlined below.

Group	Special considerations	Challenges for VCT service
Female Sex workers	<ul style="list-style-type: none"> • Pressure to have unprotected sex • No access to female condoms • Discrimination i.e., when carrying condoms • Difficult to reach preventive Services • Low awareness of safe sex Often have undiagnosed STIs Regarded as socially unacceptable, immoral • FSWs often subject to police Harassment (prostitution is not illegal) 	<ul style="list-style-type: none"> • Target clients of FSW (including uniformed services) • Important to avoid blame and stigma • Need to offer comprehensive STI, condoms and family planning services • Access to services - inconvenient locations and opening hours. • Ongoing support for HIV positive FSW should be ensured • Different strategies are needed to address different needs of FSWs (students, housewives, bar girls) • FSWs may have multiple risk factors (drug and alcohol use, mental health, coercive unprotected sex)

Group	Special considerations	Challenges for VCT service
IDUs	<ul style="list-style-type: none"> • Very high risk • Needle sharing behaviours • Stigma • Often sex workers • High risk of hepatitis B & C • Possession of drugs is illegal (drug use not illegal) • Punitive rather than prevention approach • Mandatory testing before medical and psychosocial treatment or entry into prison. • Drug treatment 	<ul style="list-style-type: none"> • Counseling on clean sterilized needles and decreased sharing of needles • Oral substitution • Safe sex • Support groups • Peer counselors • Information Hepatitis B and C • Rehabilitation/treatment counseling • Partner counseling • Limited availability of care and support services for IDUs with HIV
Group	Special considerations	Challenges for VCT service
MSM	<ul style="list-style-type: none"> • Anal sex is particularly risky • Many bisexual men • Often stigmatized 	<ul style="list-style-type: none"> • Counseling on high risk behaviour • Safe sex practices for MSM • Support groups • Group counseling • Peer support
Group	Special considerations	Challenges for VCT service
Migrants (Internal and external)	<ul style="list-style-type: none"> • Poor social support • Difficult to provide continuity of care • Low awareness of HIV/AIDS • Higher risk due to contact with casual partners and spouse 	<ul style="list-style-type: none"> • Increase awareness of risk • Consider pre-departure, destination, border counseling • Promote support groups • Family counseling, prior to or when returning from place of employment • Emphasis on STI counseling
Group	Special Considerations	Challenges for VCT service
Children and youth	<ul style="list-style-type: none"> • Experimenting and sexually active • High risk behaviors often associated with drugs and alcohol • Peer pressure • Vulnerable period (dependent on others) • Unemployment • Broken families • Homeless street children 	<ul style="list-style-type: none"> • Disclosure (to parent, guardian, family, partners). Although there are benefits of disclosure youth may be reluctant to disclose to parents and may be unsupported • Consent (legal and ethical considerations). When is acceptable to be tested? • Adequate support for vulnerable youth (orphans, street kids, children-headed households). Many children may not have adequate social and emotional support from families/communities • Lack of support groups/services available for youth • VCT available outside formal health settings • Collaboration with Peer Educators. Young women, in particular, are vulnerable and may face difficulties when they insist on condom use or make changes in sexual behavior following VCT. VCT is often of no benefit in such cases. Sex and gender awareness in schools and in association with VCT needs to be considered

VCT in IDU settings (harm reduction, needle exchange) for IDUs:**Rationale:**

HIV prevalence in male IDUs in Kathmandu has increased from 2% in 1991 to 68% in 2001 and is 52% in 2005 HIV prevalence in male IDUs is 31.7 percent in Eastern Tarai districts, 11.7 percent in the Western Tarai districts, and 21.7 in Pokhara (New ERA/SACTS, 2005) Injecting drug use is an important risk factor for HIV infection. VCT can help IDUs to prevent HIV transmission, can 'channel' them into harm reduction programmes and drug rehabilitation / drug dependence treatment programmes and into early ART. Often IDUs act as bridge population.

VCT should therefore be offered to all IDUs routinely every 6 months. VCT should also be offered to their sexual partners

HIV counseling can be performed by the doctor, nurse, laboratory technician, health assistant, senior AHW, AHW, ANM, with reduced pre test counseling (PITC) focusing on behaviour that place client at risk and the potential benefits of HIV testing. Additional counseling content may include harm reduction and importance of spouse counseling

Mobile VCTs may be important to reach IDU populations

VCT in MSM outreach programmes for MSM:**Rationale:**

HIV prevalence in MSM in Kathmandu in 2004 was 4% and among male sex workers 5% MSM often have multiple sexual partners and may engage in unprotected sex. Access to VCT can help MSM to prevent HIV transmission, can 'channel' them into early ART.

VCT should therefore be offered to MSM and their partners routinely every 6 months

HIV counseling can be performed by the doctor, nurse, laboratory technician, health assistant, senior AHW, AHW, ANM, with reduced pre test counseling (PITC) focusing on behaviour that puts MSM at risk and the potential benefits of HIV testing.

Mobile VCTs may be important to reach MSM populations

VCT in MSW/FSW interventions:**Rationale:**

Female Sex Workers in 16 Tarai highway districts in the East, HIV infection has decreased significantly since 1999, from 3.9% to 1.5% in 2006, whereas as in Pokhara infection among FSWs has remained low and constant at 2% In Kathmandu, infection recorded in 2006 was 1.4% compared to 2% in 2004 and 15.7% among a sub group of FSW – street based in 2001³.

VCT should therefore be offered to all M/FSWs routinely every 6 months. VCT should also be offered to their spouses

HIV counseling can be performed by the doctor, nurse, laboratory technician, health assistant, senior AHW, AHW, ANM, with reduced pre test counseling (PITC) focusing on behaviour that puts SW at risk and the potential benefits of HIV testing. Additional counseling content can include the importance of spouse VCT, safe sex practices, condom use, and STI treatment

³ NCASC (2005). National Estimates of adult HIV infections, Kathmandu

10. Guidelines for Referral

Referral is an essential part of VCT services and ensures access to comprehensive HIV prevention and care (Continuum of Care). Generally, VCTs provide specific services related to HIV testing and counseling, however, many clients may have a variety of additional needs resulting from the knowledge of HIV status which the VCT cannot fulfil. Therefore the objective of referrals is to ensure that HIV positive, HIV negative persons, and persons at risk for HIV infection or transmission have access to appropriate and comprehensive prevention, treatment, care and support services including medical treatment, PMTCT, legal and psychosocial support such as faith-based services.

Referral is the process by which the client's needs are identified and clients are facilitated to access required additional services. Referral is usually a two-way process but does not include ongoing long-term support for non VCT related issues.

A. Referral needs

The VCT center staff should develop a network of referral services to ensure that VCT clients can receive continuous support. Below is a list of services from which VCT clients can benefit:

HIV-related referral services:

- **Basic prevention services** for persons diagnosed **HIV-negative**:
 - Post-test HIV prevention counseling for individuals or couples that includes information about prevention services
 - Promotion and provision of male condoms (and female condoms if available)
 - Needle and syringe access and other harm reduction interventions for injecting drug users
 - Post-exposure prophylaxis, where indicated
- **Basic prevention services** for persons diagnosed **HIV-positive**:
 - Individual post-test counseling by a trained provider that includes information about and referral to prevention, care and treatment services, as required
 - Support for disclosure to partner and couples counseling
 - HIV testing and counseling for partners and children
 - Safer sex and risk reduction counseling with promotion and provision of male and female condoms
 - Needle and syringe access and other harm reduction interventions for injecting drug users
 - Interventions to prevent mother-to-child transmission for pregnant women, including antiretroviral prophylaxis
 - Reproductive health services, family planning counseling and access to contraceptive methods
- **Basic care and support services** for persons diagnosed **HIV-positive**:
 - Education, psychosocial and peer support for management of HIV
 - Periodic clinical assessment and clinical staging (Appendix 5)
 - Management and treatment of common opportunistic infections
 - Co-trimoxazole prophylaxis
 - Tuberculosis screening and treatment when indicated; preventive therapy when appropriateⁱ
 - Malaria prevention and treatment, where appropriate

- STI case management and treatment
- Palliative care and symptom management
- Advice and support on other prevention interventions, such as safe drinking water
- Nutrition advice
- Infant feeding counseling
- Antiretroviral treatment

ART service: All HIV positive persons with AIDS defining symptoms should be referred to the nearest ART center for baseline assessment and registration in HIV care.

Detection and treatment of other STIs: The VCT center should take an active role in the detection and treatment of other sexually transmitted infections and diseases. STI screening should be offered to all VCT clients.

Tuberculosis screening and referral: All HIV+ VCT clients should receive counseling and health education about the risks of TB. TB screening should be provided in the hospital outpatient department for HIV+ VCT clients who may have TB.

PMTCT service: HIV positive pregnant women should be referred to the nearest PMTCT Center.

Family planning services: Basic family planning information should be incorporated into all VCT counseling sessions, both for HIV+ and HIV- clients. Especially for HIV+ women, the risks of mother-to-child transmission and the benefits of family planning should be explained.

Treatment and preventive therapy for opportunistic infections: For example, co-trimozazole for lungs and stomach infection and the isoniazid for TB and ARV when available.

B. Implementing and managing referrals

When referring, clients should be provided with information necessary to find and access the referral service. At a minimum referral should include providing the client with information about the name of the organization, name of contact person, where, when and how to contact, eligibility requirements, address and means of reaching there, hours of operation, telephone number. Client referral works best if the counselor makes contact in the presence of the client and schedules an appointment. Staff within the referral network need to routinely inform each other of changes in personnel or processes which could impact upon the referral. VCT staff should assess and document whether the client received the referral services and the outcome.

Referral Directory

VCT services may be the first entry point to health services for many clients. It is the responsibility of the VCT counselor to establish and maintain a network of referral services, collaborative mechanisms and a referral directory. When referral resources are not available locally, providers should identify appropriate resources available in their communities and link clients with them.

The referral directory should include accurate and current information regarding referral services.

(Appendix 16)

Referrals and release of confidential information

When referring clients to other services, basic confidentiality standards must be maintained, including the use of a code number or not sharing the client's name with the referral service if possible.

Most referrals do not require the release of the client's VCT information. However, in case client's counseling details or HIV test results are to be shared with the referral service, the client's consent needs to be obtained. Clients should always have the right to decline a referral.

In addition, the client must be motivated to share all relevant information with the referred service in order to optimize the referral outcome.

C. Ensuring high-quality referral services

Providers of referral services should know and understand the service needs of their clients and be aware of available community resources.

Education and support of staff

Providers should ensure that staff receives adequate training and continuing education to develop and maintain knowledge, skills, abilities essential to implement and manage referrals.

Authority

Staff members providing referrals must have the authority necessary to accomplish a referral. Supervisors must ensure that staff members understand referral policy and protocol and have the necessary support to provide referrals. This requires the authority of one provider to refer to another (e.g., through memoranda of agreement) or to obtain client consent for release of medical or other personal information.

Provider coordination and collaboration

Providers should develop and maintain strong working relationships with other providers and agencies that may be able to provide needed services. Such coordination and collaboration promotes a shared understanding of the specific medical and psychosocial needs of target populations, current resources available to address these needs, and gaps in resources.

Memoranda of agreement are useful in outlining provider/agency relationships and delineating roles and responsibilities of collaborating providers in managing referrals.

11. Guidelines for Recording & Reporting

A. Recording

Recording of VCT information is an important part of VCT service delivery. Information from VCT:

- can be analyzed to provide programmatic information on the functioning of the services, determine whether the service has an impact and whether the clients needs are met
- plays an important role in quality assurance
- may be required as legal documents

VCT recording formats:

VCT in charges staff should ensure the availability of standard record keeping formats such as:

- VCT Counseling Record (Client intake form) (Appendix 9)
- Informed consent form (Appendix 10)
- HIV laboratory request form (Appendix 11)
- HIV test result format (Appendix 12)
- VCT Register (Appendix 13)
- Monthly VCT Report form, (Appendix 14)
- National HIV/AIDS case reporting form (Appendix 15)
- Referral form (Appendix 17)

A standardized coding system should be developed for assigning codes to ensure clients confidentiality yet allowing for identification. For example, first district name, then initials of institute, then running VCT number, then date of first visit e.g. Kath / NCASC-231 / 29-6-2003

1. VCT Counseling Record (Client intake form)

The counsellor can record all information related to the client in this form. The minimum VCT client information to be recorded includes:

- Client code
- Client demographics including age, gender
- Reasons for seeking VCT including referral information
- Detailed counseling information, risk behaviour or exposure
- Vulnerabilities or MARP
- Date of pre test counseling
- HIV test result
- Date of Post Test Counseling and provision of test result
- Referral and follow up provided and its outcome

2. Monthly T&C report form

The monthly forms contain the minimum required information that has to be provided to MoHP.

This form can be adapted to site specific needs if additional information is required. The standard information must be retained. The reports play a crucial role in monitoring the VCT programme and the nature of the epidemic in the country and different regions. This information along with other data can be used in tailoring programs to more adequately address prevention and care needs. **All VCTs have to submit monthly reports to NCASC, DPHO, DACCs.**

3. Additional guidelines and forms in a VCT:

- Quality Assurance Checklists (Counselors Reflection form, Client Exit Survey, Site Supervision and Monitoring form and checklist) (Appendix 18-20)
- Standard VCT operating procedures

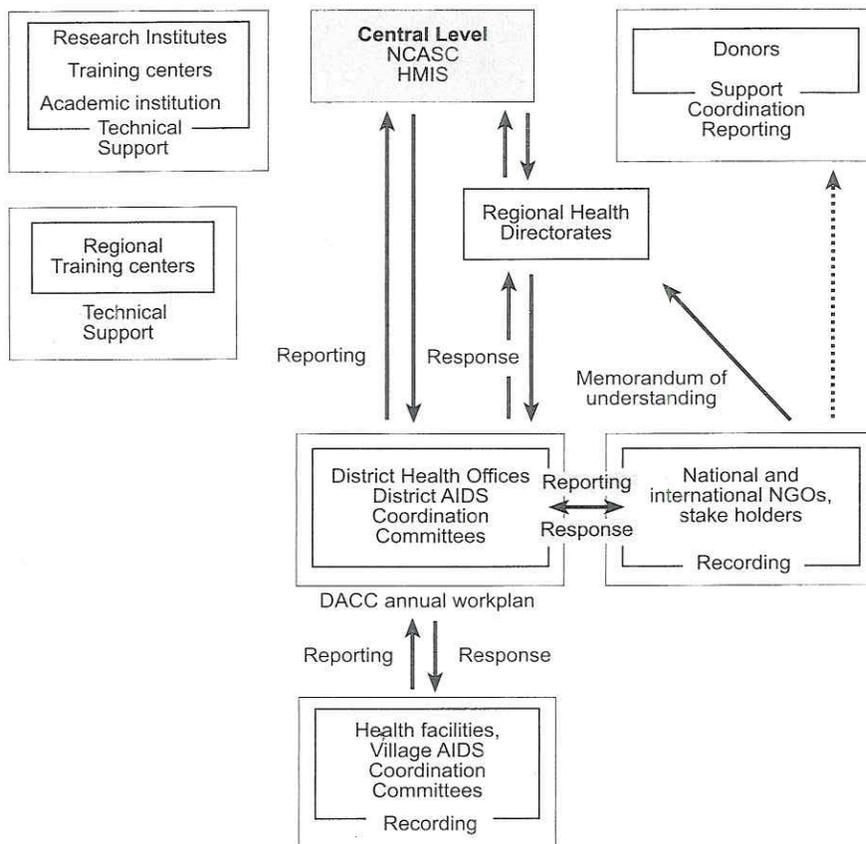
- Guidelines for EQA
- Standard Laboratory procedures (for HIV Testing)
- Confidentiality protocols
- Code of ethics
- Referral Directory (Appendix 16)

B. Reporting

All VCTs (government and NGO) will submit monthly reports by the end of the first week of the following month to DACC, DHO, DPHO who will vet the reports and forward them to NCASC. A central strategic information unit at NCASC will compile and analyse information received use the information for planning and dissemination. Copies of reports can also be faxed to NCASC at (01) 426 1406 or emailed to NCASC@mos.com.np

Information flow and links between levels and partners:

(Source: UNAIDS, Monitoring and Evaluation Guidelines for HIV/AIDS in Nepal, 2006)



C. Storing and maintaining records

Following national standards, NCASC / MoHP requires each VCT to keep client's records (counseling files, monthly reports) in a secure area (e.g. locked drawers / cabinets). Only VCT staff directly involved in treating or counseling the client (authorized staff) should have access to the client's file (shared confidentiality, Section 5). Client files and records should be filed in a way they can be easily retrieved, such as according to serial number. Files must always be accessible by authorized staff during clinic working hours.

12. Guidelines for Monitoring & Evaluation

Monitoring and evaluation are critical components for the successful implementation of VCT services. Well designed recoding mechanisms and a minimum set of agreed upon indicators are important for a strong monitoring and evaluation system. Monitoring and evaluation will help identify and correct problems on an ongoing basis and provide feedback in the process of planning, designing and implementing of programs.

Monitoring and evaluation activities should address:

- Service delivery - how well VCT is provided, for example, uptake and acceptability of VCT, quality and content of counseling, reliability of HIV testing strategy (including external quality control), uptake of interventions, stress and burnout among counselors/health care workers).
- Program effectiveness - the outcomes and long term impact that VCT may have on the populations receiving the service. For example, coping, safe sex practices, use of family planning methods/services, and morbidity and mortality.

A. Routine NCASC VCT Indicators:

Core Indicators:

1. Number of service points providing VCT
2. Number of trained counsellors providing VCT
3. Number of clients accessing VCT services (pre test), by gender and HRG
4. Number of clients receiving HIV test results and post test counseling, by gender and HRG

Other indicators

5. Number of new HIV positive cases

B. Process, Outcome and Impact Indicators:

Process and outcome indicators (service delivery, program output):

- Proportion of people in the community/vulnerable groups who know about the HIV VCT disaggregated by risk groups.
- Number of people counseled and tested at the VCT site (per month).
- Proportion of people counseled and tested for who have returned to receive their test result.
- Proportion of people testing HIV positive who have been referred to appropriate care and support services.
- Proportion of people counseled and tested, who state that they intend to inform their partners
- Proportion of people counseled and tested who have informed their partners (disclosure).

Impact indicators:

- Changes in HIV/STI-related risk behavior among VCT clients and their partners
- Changes in behavior among people stating that they know their sero status.
- Changes in STI trends in sub-populations reached by the program.
- Increased community support for people living with HIV/AIDS.

C. Monitoring your own VCT services

The following indicators can be used for internal monitoring and review of VCT services. They can be calculated every month or quarter using the client register. The indicators can be mapped in a graph and discussed with the VCT staff to identify strengths and gaps.

Quality of Counseling

- a) Number of clients accessing VCT services and receiving pre-test counseling
In a VCT with a good outreach, social mobilization and quality of services, the number of clients should increase
- b) Out of a), the number / percentage of clients consenting to HIV testing and getting tested (consent rate)
In good VCT, the consent rate (number counselled / number tested) should never be 100% or more. Ideally, the rate should be between 90 and 95%
- c) Out of b), the number / percentage of clients returning for post test counseling and receiving HIV test result (return rate)
In good VCT, the return rate (number tested / number received test result and post test counseling) should be more than 90% if same day test results are provided. The rate should be more than 80% in case of next day results.

Client Load

- d) Daily or monthly number of all counseling sessions (pre test counseling + post test counseling + follow up counseling) / the number of counselors
On average, a good counsellor can handle around 12-16 counseling sessions in an 8 hour working day

Quality of Linkages

- e) Number / percentage of clients referred from health care providers / NGOs to VCT
- f) Number / percentage of self referred clients accessing VCT
In a VCT with a good outreach, mobilization, quality of services and good linkages, the number of self referred and provider referred clients should increase
- g) Number of clients referred from VCT to TB, STI, ART, NGO services
In a well functioning VCT, increasing number of clients should be referred to other services.

Quality of Testing

- h) Number / percentage of proficiency HIV testing samples identified correctly

D. Monitoring and Supervision

A set of tools has been developed by UNAIDS, FHI and other organizations to monitor the quality and content of counseling services. These include:

- Counselor reflection form (Appendix 18)
- Client Exit Survey (client satisfaction) (Appendix 19)
- Site Supervision and Monitoring form and checklist (Appendix 20)
- Tool for evaluation of counselor selection, training and support
- Tool for evaluation of counseling skills and counseling content.

13. Demand Generation and awareness raising for VCT services

How to increase uptake of VCT?

Efforts to expand access to VCT for most-at-risk populations should include social mobilization and education initiatives to encourage people to learn their HIV status and to access services.

Partnerships with NGOs / CBOs / PLWA groups and target groups to increase community awareness and create demand for VCT and referral services should be developed. The success of VCT services depends on partnerships with target groups and among the organizations working in a community to ensure community support, public awareness and high quality, comprehensive medical support services. Providing only VCT without appropriate linkages, referrals and associated prevention and care services undermines the potential impact of VCT services for both HIV prevention and HIV care and impact mitigation.

The main objectives of VCT communication and awareness raising activities are to:

- Promote awareness among target populations of the availability of high quality VCT services;
- Encourage the target population to use VCT services;
- Promote understanding of VCT and its benefits among the target population, including information on referral services such as clinical, treatments of STI, family planning, PLWHA support groups and possibilities for economic support;
- Encourage local leaders, public and private health providers and policy-makers to endorse the use of VCT center; and
- Reduce stigma and discrimination.

Demand creation for VCT and mobilization of target groups can be done through:

- Recruitment and training of doctors and nurses from hospitals and private clinics (STI, TB);
- Recruitment and training of local NGOs which conduct HIV prevention activities in the community;
- Specially trained peer volunteers will ensure that potential clients understand the meaning of their decision to:
 - Obtain VCT
 - Assess their risk
 - Adopt positive behavior changes.
 - Become aware of care and support services within their locality.
 - Peer volunteers may accompany clients to the VCT site and referral services.

Strategies to increase access to and uptake of VCT for MARPs, include services delivered through mobile clinics in other community settings, through harm reduction programmes or through other types of outreach.

Increasing demand for VCT includes a routine referral from within a hospital of patients with clinical symptoms of HIV infection and of patients reporting high risk behaviour.

14. Guidelines for Training and Orientation

VCT Counselor

Induction Training

Duration: 7 or 10 days

Content: NCASC approved HIV counseling curriculum

Refresher training (after 6-12 months)

Duration: 3-5 days

Content: Review meeting based on the needs of counselors, case discussions, special counseling situations and advanced counseling skills such as adherence counseling, infant feeding counseling, sexual assault, etc

VCT Laboratory technician

Duration: 4 days

Content: NPHL approved curriculum

VCT in charge (orientation)

Duration: 1 day (5 hrs)

Content:

1. Basics of HIV/AIDS (1 hr.)	<ul style="list-style-type: none"> National and district scenario, Modes of transmission, Risk behaviour and risk groups (CSW, IDU, MSM, migrants, pregnant women) 	Module 1, Submodule 2
2. What is HIV Counseling? (2 hrs)	<ul style="list-style-type: none"> Counseling vs. health information Content of Pre and post test counseling, Scenarios for Individual, group, couple counseling, Issues of informed consent, confidentiality, stigma & discrimination 	Module 2, Submodule 1, 2, 3
3. Principles of Rapid HIV testing (1 hr.)	<ul style="list-style-type: none"> National Testing strategy and test reports EQA 	Module 1, Submodule 4
4. Recording and reporting (1 hr.)	<ul style="list-style-type: none"> Monthly report formats 	Module 5, Submodule 6, 7

Non VCT staff: Medical doctors, nurses, others (Sensitization)

Duration: 1 day (5 hrs)

Content:

1. Basics of HIV/AIDS (1 hr.)	<ul style="list-style-type: none"> National and district scenario, Modes of transmission, Risk behaviour and risk groups (CSW, IDU, MSM, migrants, pregnant women) 	Module 1, Submodule 2
2. What is HIV Counseling? (1.5 hrs)	<ul style="list-style-type: none"> Counseling vs. health information Content of Pre and post test counseling, Scenarios for Individual, group, couple counseling, Issues of informed consent, confidentiality, stigma & discrimination 	Module 2, Submodule 1, 2, 3
3. Principles of Rapid HIV testing (1 hr.)	<ul style="list-style-type: none"> National Testing strategy and test reports EQA 	Module 1, Submodule 4
4. UP and PEP in health care (1.5 hrs)	<ul style="list-style-type: none"> UP, PEP, Waste management 	

Outreach worker (orientation)**Duration:** 1 day**Content:**

1. Basics of HIV/AIDS:	<ul style="list-style-type: none"> • National and district scenario, • Modes of transmission, • Risk behaviour and risk groups (CSW, IDU, MSM, migrants, pregnant women) 	Module 1, Submodule 2
2. What is VCT?	<ul style="list-style-type: none"> • Objectives of VCT • Counseling vs. health information 	Module 1, Submodule 5 Module 2, Submodule 1
3. Outreach	<ul style="list-style-type: none"> • How to reach out to communities • Issues of informed consent, confidentiality, stigma & discrimination • Services required by HIV negative and positive people 	Module 5, Submodule 6, 7
