



TOOLS FOR EVALUATING HIV VOLUNTARY COUNSELLING AND TESTING

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Tools for evaluating HIV voluntary counselling and testing

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Abbreviations/ acronyms

ARV	antiretroviral
"burnout"	emotional and mental exhaustion caused by chronic work stress.
FGD	focus group discussion
IDU	injecting drug users
MSM	men who have sex with men
MTCT	mother-to-child transmission
NGO	non-governmental organisation
PLHA	person living with HIV/AIDS
TBPT	Tuberculosis preventive therapy
VCT	voluntary counselling and testing

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Introduction

It is only recently that Voluntary Counselling and Testing (VCT) services have been considered important as an entry point for prevention and care interventions for HIV/AIDS. Access to VCT services, however, remains limited and demand is often low. In many high prevalence countries VCT is not widely available and people are often afraid of knowing their serostatus because there is little care and support available following testing. Furthermore, the quality and benefits of VCT, in particular with regard to confidentiality, counselling and access to clinical and social support, vary enormously.

Setting up VCT and ensuring a quality that will create demand is thus a considerable challenge. Building in self-assessments, monitoring and regular evaluation is an important tool to enhance quality of VCT.

This document provides guidance on monitoring and evaluation of the various aspects of planning and implementing VCT. It provides tools for the evaluation of VCT as part of a national programme, as well as VCT services at specific institutions, independent sites and services for special groups, including community based NGOs. It includes monitoring and evaluation of VCT services associated with the prevention of mother to child transmission of HIV (MTCT) and tuberculosis preventive therapy (TBPT). This document revises and adapts previous draft guidelines^{1,2,3,4} and incorporates relevant operational research findings.

The context of evaluating VCT

The scope and challenges of VCT has changed over the past decade. At the outset VCT was primarily used to make a diagnosis of infection in symptomatic people to help medical management, and testing was often accompanied by minimal counselling. It was also promoted, in a piecemeal way, as a component of HIV prevention. There were reports of barriers to HIV testing because of the perceived stigma associated with a diagnosis, the lack of services and interventions available to those who tested seropositive⁵ and adverse consequences, particularly for women, following testing⁶. The development of

¹ WHO draft report (Alfred Chingono), Protocol for setting and monitoring locally acceptable standards of counselling in relation to HIV diagnosis. (1994)

² WHO draft report, Guidelines for implementing HIV/AIDS counselling (1993)

³ NACO, India draft report, Counselling policy and related aspects: National AIDS prevention and control policy (1998)

⁴ Miller D., Casey K., Thailand dept of health application for counselling: participant information & casework audit form (1998)

⁵ Baggaley R., Fear of knowing: why 9 in 10 couples refused HIV tests in Lusaka Zambia, abstract number E.1266, Xth International conference on AIDS and STDs in Africa, Abidjan Dec. 1997

⁶ Temmerman M., Ndinya-Achola J., Ambani J., Piot P., (1996), The right not to know HIV-test results, *Lancet* **345** 696-7

antiretroviral (ARV) treatment for people with HIV, less costly interventions to reduce the incidence of HIV-associated infections (such as tuberculosis preventive therapy^{7,8} and cotrimoxazole prophylaxis⁹) and relatively cheap and feasible methods to prevent MTCT¹⁰, have made the need to promote VCT for people with asymptomatic disease more compelling. VCT services for young people are also being developed and services linked with family planning are becoming more widely available. The importance and cost effectiveness of VCT in reducing HIV transmission is also now recognised¹¹.

HIV testing methods have also become simpler and cheaper, making it a more feasible option in many developing countries¹². The ease of HIV testing has also increased the role of the private sector in VCT in many developing as well as industrialised countries. The monitoring and evaluation of VCT services in the private sector brings additional challenges. VCT services have also been set up for vulnerable groups such as sex workers, prison populations, intravenous drug users and refugees. These services need particularly careful monitoring to ensure such groups are not further marginalised and services are truly voluntary and confidential.

Studies evaluating VCT have concentrated on attempting to prove that VCT reduces incidence of HIV infection and thus contributes to prevention. This is because in planning and funding of VCT services it has been important to demonstrate that VCT “works”. Studies on the efficacy of VCT have largely concentrated on the role of VCT in risk reduction and changing sexual behaviour^{13,14,15}. Monitoring of VCT has depended on reporting attendance, coverage and return rates. This document aims to provide guidelines to evaluate

⁷Mwingwa A., Hosp M., Godfrey-Faussett P., (1998), Twice weekly tuberculosis preventive therapy in HIV infection in Zambia, *AIDS* 12 2447-2457

⁸ WHO/UNAIDS Policy statement on preventive therapy against tuberculosis in people living with HIV, WHO/TB/98.255 UNAIDS/98.34 (1998)

⁹ Sassan-Morokro M., Wiktor S., Abouya L., Ackah A., Akaki A., Lobognon R., Diarrassouba M., Djormand G., Grant A., Coulibaly D., Tossou O., Maurice C., Roels T.H., Lackritz E, Karon J., Coulibaly IM, Greenberg AE. (1998). Significant reduction in mortality attributed to cotrimoxazole prophylaxis among HIV infected tuberculosis patients in Abidjan, Côte d’Ivoire. Abstract 12461, presented at the 12th International Conference on HIV/AIDS, Geneva, Switzerland

¹⁰Centres for Disease Control and Prevention. (1998), Administration of zidovudine during late pregnancy to prevent perinatal HIV transmission -- Thailand 1996-1998, *MMWR* 47 151-153

¹¹ Sweat M., Sangiwa G., Balmer D., HIV counselling and testing in Tanzania and Kenya is cost effective: Results for the voluntary counselling and testing study Abstract no. 33277 12th World AIDS Conference, Geneva

¹² The importance of simple and rapid tests in HIV diagnostics: WHO recommendations, *Weekly Epidemiological Record* 73 (42) 321-328 October 1998

¹³ Coates T., Collins C., Preventing HIV infection, *Scientific American*, July 96-7, 1998

¹⁴ Sangiwa G., Balmer D., Furlonge C., et al. (1998). Voluntary HIV counselling and testing (VCT) reduces risk behavior in developing countries: results from the multisite voluntary counselling and testing efficacy study. Abstract 33269 presented at the 12th International Conference on HIV/AIDS, Geneva, Switzerland.

¹⁵ Allen S., Serufilira A., Bogaerts J. et al (1992), Confidential HIV testing and condom promotion in Africa. *JAMA* 8 3338-3343 & Allen S., Serufilira A., Gruber V. (1993) ,Pregnancy and contraceptive use among urban Rwandan women after HIV counselling and testing, *Am J Public Health* 83:705-10

not only the implementation and effectiveness of VCT in HIV prevention, but also ways of assessing the acceptability and quality of services. It also aims to assess the effectiveness of VCT in enabling people with HIV to better accept and cope with their infection and access appropriate services.

Counselling without testing

Despite reductions in the costs of HIV testing kits, VCT as a service will not be available, in the near future, for the majority of people in high prevalence, developing countries, especially for those living outside the capital cities. Sometimes testing services will be offered intermittently when test kits are available. However, even where testing is unavailable, there are often well developed counselling services for people with symptomatic HIV and their families, and services providing HIV prevention counselling (such as counselling about safer sex in family planning clinics). This document, although primarily aimed at evaluating VCT services, will also include counselling services where testing is not available, as in many settings this is a much more common option.

Testing without counselling

As HIV testing becomes simpler to perform it is increasingly available, often without counselling or without adequate counselling or follow up. Furthermore there are reports of coercion to test and testing which is not truly voluntary. Home testing and testing in the private sector pose particular challenges.

Follow up counselling

The majority of people attending VCT, whether they test positive or negative, will attend one or at the most, two post-test counselling sessions. Studies have shown even when further counselling sessions are offered or referral to specialised counselling services is available, many people do not want further counselling, at least not in the immediate future¹⁶. Some people do, however, require ongoing counselling and some will attend for further counselling in the 1-5 years following VCT. This often coincided with a crisis or change in personal circumstances. Following VCT, many people find other informal services or resources in the community to help them with their emotional needs. Church groups, family members, friends and traditional medical workers often provide emotional support. VCT services should therefore be flexible and either able to provide ongoing counselling or have close links with organisations providing this service. They should also be able to refer people to community organisation and spiritual/church groups when appropriate.

¹⁶ Baggaley R., Weinreich S., Mulongo W., Phiri G., Phiri M., Kelly M., (1998) Kara coping study - interim report UNAIDS/WHO

VCT sites

VCT is being carried out in various settings in industrialised and developing countries, depending on demands and resources

- Free standing VCT sites
- Hospital services
 - NGO within the hospital
 - integrated into general medical outpatient services in public hospitals
 - as part of specialist medical care e.g. STI clinic, dermatology clinic, chest clinic, antenatal and family planning services
- VCT as entry into the continuum of care/ home based care (including palliative care services)
- Health centre - urban or rural
- Private sector (clinics and hospitals)
- Work place clinics
- Referral sites for legal requirements, pre-employment, pre-travel, pre-marital
- Youth health services and school health services
- Health services for vulnerable groups
 - Sex workers
 - Prison populations
 - Refugees
 - IDUs
 - Men who have sex with men
 - Children, orphans and street kids
- Self testing/home testing
- Attached to research project/pilot project
 - associated with antenatal services and interventions
 - associated with tuberculosis service and TB preventive therapy
- Blood transfusion services

Different models of VCT are available in many different settings in developing and industrialised countries. There is no single preferred model and the choice of VCT service will depend on the needs of the community, HIV seroprevalence, maturity of the epidemic, attitudes towards HIV, political and community commitment to VCT, available financing and existing VCT resources.

Cautions, difficulties and limitations with the VCT evaluation tools

This document consists of a series of tools to evaluate VCT, in order to improve and develop services. The tools should be used with the co-operation and collaboration of counsellors, clients and service managers. They should be used in a flexible manner and should be adapted and modified according to the needs of the services. Some services may only want to use a single tool to evaluate a specific aspect of their service.

How to use these tools

- **Adaptation of the tools to reflect needs of the service**

These tools provide suggestions of content areas within counselling services to be evaluated. The tools are not intended to be prescriptive. It is expected that managers of counselling services will assess and adapt the generic tools contained in this document to reflect specific needs and local circumstances. Some of the sample questionnaires, which have been designed as comprehensive evaluation tools, are long and complicated to administer. Items which are less relevant to the VCT services under consideration may be reduced or discarded. Appendix I gives an example of how the tools could be used to modified when evaluating VCT services associated with MTCT interventions.

The tools are presented in a loose-leaf format so may be photocopied if required. They are also presented on the enclosed disc and can therefore easily be modified. These tools are also available via the UNAIDS website.

- **Selection of tool/s**

There are eight areas in VCT service development and provision for which monitoring and evaluation tools have been designed. Depending on needs and priorities of particular VCT services, only some of these eight areas will require monitoring and evaluation. For example when setting up VCT services, Tool 2 for *VCT site evaluation: logistic considerations and coverage*, can be used to help look at the suitability of sites. Tools 4a, 4b and 4c for *Evaluation of counselling skills*, *Evaluation of counselling content*, *pre-test*, *post-test*, and *around the HIV diagnosis*, respectively, could be used in training or for periodic assessment of counsellors.

- **Participatory nature of monitoring and evaluation**

The tools are intended to be used by service providers so that they can modify and improve practices and procedures in the services where they work. Providers need to have a sense of ownership of the monitoring and evaluation process so that it is clear that the tools are for their own use and benefit. The co-operation and collaboration of both providers and clients is essential to the evaluation process. Before using the tools it is important to explain their purpose to those participating in the evaluation. The results should be seen as a way of providing constructive feedback. Participants should be given an opportunity to discuss the assessment and provide additional comments and suggestions. It is hoped that the tools would be used repeatedly over time - for example when assessing counselling quality and content - so that counsellors have the opportunity to respond to previous assessments and so that quality of counselling can be maintained. The counselling assessment is seen as a way of providing continuous appraisal of and feedback for, counsellors and could be built into training and supervision programmes for counsellors.

- **Reporting and feedback mechanisms**

Before considering using any of the tools, methods for data collection and analysis, reporting and feedback should be planned. Group discussion of the information needs for provision of services is important in this process. When

evaluating individual counsellors/counselling sessions, immediate feedback following the counselling session (to the counsellor who is being evaluated) is recommended.

- **Client consent and maintaining client confidentiality**

Some of the tools require observation of counselling sessions by the assessor. In these situations it is important to explain to the client the purpose of the observation (which is to help with training and development of the counsellor), reassure her/him that confidentiality will be maintained, and gain her/his permission. If a client feels unwilling or uncomfortable about having someone observe the counselling session this must be respected.

When using “Tool 7” (*Tool for evaluation of client satisfaction*) a sample of clients can be interviewed following a counselling session, or at a later date. Clients should be told at the earliest possible time, for example when they make the appointment, that they may be asked to help with an assessment of the counselling service. If a client declines to take part this should be respected. If he or she wishes to be seen at a later time either at the centre or at home this should be arranged. When this method was used in Zambia there were very few refusals and the majority of clients said that they had found the experience of speaking with the researcher useful. No adverse consequences were reported.

- **Specific difficulties with observational assessments.**

- (i) ***Worries about acceptability of observation***

In pilot settings where observational assessments have been used they have had a much higher acceptance by clients, than was anticipated. Both clients and counsellors report that the observations were much less intrusive than they feared, and many counsellors and clients said that they were unaware about the observer soon after the session started. Counsellors said once they had been reassured that the purpose of the observations were to help them to improve their counselling skills and that it was not a test, they felt more comfortable and could understand the benefit of the process.

Some counsellors and counselling trainers stated that they thought clients would find it difficult to have an observer sitting in a counselling session. They were worried that clients would be unable to discuss sensitive issues in front of a third person. However, in pilot studies it was found that the majority of clients did not experience any difficulties with having an observer sitting in. A small number of clients said before the counselling session that they would prefer not to have an observer and this was respected.

As with all the tools described it is important to explain their purpose (to the counsellor and/or the client), to ensure confidentiality and to allow them to defer or refuse to take part.

In some countries counsellors have stated that it would not be acceptable to have counselling sessions observed by an assessor/counsellor. Alternative methods of assessing counselling session, which would be possible ways of overcoming this problem, include:

I. Audio recording of counselling sessions

This has been successfully used in some settings and has been acceptable to both counsellor and client. Non-verbal communication can not however be observed.

II. One-way mirrors

Using a mirrored glass window through which a session can be observed by the supervisor has been used to assess counselling sessions. Although clients and counsellors may find this less obtrusive than having the observer in the same room it is an expensive option. It is therefore unlikely to be practical to use on a large scale.

III. Dummy patients

“Dummy patients” are volunteers trained to present to the counsellor with a particular problem. They can then report on the content and quality of the counselling sessions, but if the check list tools are to be used they will have to fill these in after the counselling session. It is important that if dummy patients are used that the counsellors are warned that this evaluation method is going to take place, otherwise counsellors may perceive a breach in trust between themselves and the supervisor.

IV. Role-play sessions

Role-play sessions can be very useful and have been used extensively in training of counsellors. Trainee counsellors or volunteers can present various case scenarios to the counsellor while the supervision and other counsellors observe the role-play. One VCT centre has used the *tool 4 (parts i-iv) (counselling evaluation)* in training sessions for new counsellors where participants took it in turn to be clients.

V. Video recording of counselling sessions

The use of video recorded counselling sessions has been used in some countries to assess counselling sessions. It is, however, appropriate only in very limited settings because of problems with ensuring confidentiality and expense. If video recordings are used explicit consent of the client and counsellor must be given with the assurance that the counselling session will only be viewed by the counsellor and supervisor/assessor. Furthermore a fail-safe method of ensuring that the video recording be erased following the assessment must be in place. Video recording of role-play sessions or dummy patients can however be useful and does not have problems around ensuring confidentiality.

(ii) Observation will bias the session

Having an observer sitting in a counselling session may alter the dynamics of the counselling session and it could be considered that the counsellor will have an “improved performance” if he/she is being observed. However, the aim of the observations is to help counsellors improve their counselling skills, rather than to test them. In field testing counsellors reported that although they initially felt nervous the observed sessions were not substantially different from “normal” sessions. Observers stated that they were found it easy to identify good aspects in the counselling sessions as well as areas that could be improved.

(iii) Who to carry out the observation?

The counselling observations can be carried out by:

A senior counsellor/supervising counsellor

The advantage of this is that there is no need to employ extra people. Logistic complications are minimised and it is easy to follow up on identified problems and provide continuous assessment of trainees. Furthermore the counsellor may feel less intimidated if he/she knows the person sitting in on the session.

However there are some drawbacks. It could be construed that it is in the best interests of the supervisor to demonstrate that his/her counsellors are all competent, because this could be seen to reflect on his/her ability to train and supervise. However, it should be emphasised that the evaluation is not a pass/fail test of competence, but a way of enhancing performance and highlighting strengths and weaknesses in the service with a view to improving them.

There is also the potential for personal dynamics to interfere in the evaluation of a counsellor by a supervisor. For example if a counsellor likes or dislikes a particular counsellor.

Fellow/peer counsellors

There are some advantages of using peer counsellors observations. They can benefit from the experience of other counsellors and if this is a reciprocal practice it is likely to be unthreatening. The senior counsellor/supervisor must however have a role in reviewing the process with the counsellors. This method has been used successfully in the pilot testing.

Independent/external assessor

An independent assessor may provide a more objective assessment and can make comparative observations across sites. Providing and training an independent assessor may be expensive, especially if a service is to be evaluated as part of its regular activities.

VCT monitoring and evaluation

Section 1.

National preparedness in VCT implementation

Introduction and background

Whether VCT is seen as a priority for the health system will depend on the HIV seroprevalence in the community and the resources available for HIV prevention and care and the perceptions of politicians, service planners and managers and health care workers. In lower prevalence low and middle income countries, such as countries in North Africa, Eastern Europe and some countries in Asia, it may be appropriate to target services at more affected groups, but in so doing it will be important to guard against increasing stigma and blame.

In high prevalence areas it will be more appropriate to develop services for the general population. It is important not to provide VCT services in isolation, but develop in conjunction with support services for those who test seropositive and HIV prevention services.

VCT should not only be developed in conjunction with adequate support services, there should also be a link between the type and quality of HIV education in the community and offering VCT. If the predominant view in the community is that 'HIV=AIDS=death', that of fatalism ('you can do nothing about it') and that HIV is a disease of 'promiscuous' people, interest in VCT will be low. People base their decision on having an HIV test on the balance of advantages and disadvantages of knowing their status. If community attitudes are unfavorable, interest in VCT will be low. If, however, the community has received education and information on the benefits of VCT for individuals and their family, people are more likely to accept VCT. VCT services need to be built on the fact that HIV is a discussible disease and HIV risk is discussible too. This is the case in Uganda, and this has been achieved by the long-term commitment of its leaders to openness about AIDS. A community that feels helpless against HIV and defends itself by stigma and science may not be 'ready' for VCT, although promoting VCT will help achieve this openness.

For the benefits of VCT to be understood and hence used, services must be endorsed by and included into the National AIDS programme plan. The success of VCT in Uganda, (compared with other countries in sub-Saharan Africa), is thought to be in part due to the political commitment to VCT as part of the overall HIV prevention and care programme. Some low income, high prevalence countries will continue to consider VCT a low priority, and others may consider developing VCT in a phased manner. This will be particularly appropriate if support services for PLHA are not well developed and resources are very limited or when the infrastructure is not sufficiently developed to support services.

However, even if political commitment to VCT does not exist, NGOs can advocate the concept and set up VCT projects to demonstrate the need for and benefits of VCT. The Thai Red Cross set up the 'Anonymous Clinic' VCT service in Bangkok in July 1991 when HIV was a notifiable disease and mandatory HIV testing was widely practised. The success of the Anonymous clinics succeeded in persuading the government to change the law on mandatory reporting. This was followed by a policy to set up VCT sites in every province of Thailand 6 months later.

Tool 1: Tool for evaluation of the National preparedness for VCT implementation

How to use

respondents = programme planners

This group would include National AIDS (NAP) Programme managers, counselling service co-ordinators, NGO co-ordinators involved in VCT activities. It may be appropriate to interview other policy makers in, for example, associated ministries such as education. As these will be few in number an effort should be made to interview them all. Sampling will therefore not be necessary. The interviews should be conducted individually and the respondents encouraged to elaborate on any of the items, qualify statements and provide additional comments where appropriate.

Country background

Per capita GNP _____

Per capita spending on health _____

HIV sentinel survey figures

 urban antenatal _____

 rural antenatal _____

 other available seroprevalence data, please specify _____

How is VCT seen by the NAP?

 Major priority

 Priority in some setting

 Not a priority

Have VCT services been developed in your country?

 A comprehensive county-wide service

 A limited service (capital and selected large cities)

 A limited service provided by NGOs

 Other

Please describe the VCT services in detail

Please describe any obstacles to implementation

Does a national policy on VCT exist?

 Yes

 In preparation

 No

Have national guidelines for implementing HIV counselling been developed?

 Yes

 In preparation

No

Please describe how these were developed and if there have been any difficulties in their implementation.

Is VCT promoted as part of HIV prevention and care services?

Yes

In preparation

No

Is HIV testing a **legal requirement** under any circumstances?

Pre-marital

Migrant workers

Other (specify)

Is HIV testing frequently performed in:

Pre-operative screening

Pre-employment

General antenatal care

As part of MTCT intervention

Prisons

Military recruitment

IDU treatment

STI clinic

TB clinic

Are VCT services available?

General service	Yes	Being considered	No
Service for young people	Yes	Being considered	No
Service for special groups			
MSM	Yes	Being considered	No
Sex workers	Yes	Being considered	No
IDU	Yes	Being considered	No
Refugees	Yes	Being considered	No
Prisoners	Yes	Being considered	No
Others	Yes	Being considered	No

Are services available for PLHA?

Ongoing medical care ¹⁷	Yes	In preparation	No
Ongoing social support	Yes	In preparation	No
PLHA support group	Yes	In preparation	No
Ongoing counselling support	Yes	In preparation	No
Liaison with NGOs	Yes	In preparation	No

¹⁷ Describe what services are available e.g. CD4, viral load monitoring. Are these services available for all PLHA or only available for a minority of people who can pay?

Family planning	Yes	In preparation	No
MTCT interventions	Yes	In preparation	No
TBPT	Yes	In preparation	No
Other preventive therapies ¹⁸	Yes	In preparation	No
ARV interventions	Yes	In preparation	No

Are HIV preventive services available?

Condom supplies	Yes, countrywide programme	Yes, some sites	No
Services for IDU	Yes, countrywide programme	Yes, some sites	No
Ongoing counselling	Yes, countrywide programme	Yes, some sites	No
Other	Yes, countrywide programme	Yes, some sites	No

Are HIV counselling training courses being run?

Yes No

If yes, at what level

- National
- Provincial
- District
- Testing site

How many counsellors have been trained? _____

What are the backgrounds of the people being trained as counsellors?

- Nurses
- Clinical officers
- Social workers
- PLHA
- Others

What training is offered?

basic counselling training	Yes	In preparation	No
advanced training	Yes	In preparation	No
follow-up supervision	Yes	In preparation	No
follow-up assessment of counsellors	Yes, countrywide programme	Yes, some sites	No

Number of training courses held _____

How long is the training? _____

Please describe in detail the training offered¹⁹

¹⁸ For example cotrimoxazole prophylaxis, specify intervention

¹⁹ For example, give an indication of the teaching methods, course content, curriculum (if available) etc.

If counsellors are assessed for the quality of their counselling how this is achieved?²⁰

Is statistical data about the counselling service regularly compiled? Yes No

If yes, by whom _____

²⁰ For example, are counsellors subject to regular supervision?

Section 2:

Evaluation of operational aspects of the service

Introduction and background

(i) Site

Accessibility and convenience

VCT services need to be accessible for the population they are serving. Opening hours need to take into account the needs of the clients. To allow easy access for working people, lunchtime, early evening and weekend services should be considered.

In services used by women, or families, providing a space where children can play supervised would enable less interrupted counselling.

Privacy

For VCT to be carried out correctly and effectively, privacy must be ensured. Discussion of risk factors and sexual relationships is part of VCT for HIV infection, and key information essential to the process will not be elicited unless people can discuss these issues in private. Private space will be required.

Waiting area

In addition, a well-ventilated waiting area is important. TB infection is commonly associated with HIV and people with reduced immunity are particularly vulnerable to nosocomial tuberculosis infection.

(ii) Confidentiality

For VCT services to be acceptable, confidentiality must be guaranteed. HIV remains a stigmatising condition in most countries and uptake of services will be low if it is not known that confidentiality will be respected. Therefore a system must be in place to avoid breaches of confidentiality at all stages in the VCT process. In some settings it has been shown that people feel more comfortable about attending VCT services if they can give a pseudonym²¹, and anonymous testing is commonly available in many industrialised countries.

(iii) Linkages

VCT has been shown to be more effective when it is developed in conjunction with support services (medical, social and emotional, family planning services, STI services, antenatal services, home based care services and palliative care services), spiritual services and traditional healers, PLHA support groups, community groups and NGOs.

In high prevalence areas a wide range of care and support activities may already be in place in the community. It will be important for counsellors to be aware of these resources and be able to make appropriate referrals. Counsellors must also be aware of the special medical needs of PLHA. The package of TB care (including TB screening and TB preventive therapy) may be available; in some countries ARV therapy is available, though often only for a minority. The spiritual needs of PLHA have been shown to be important in many countries^{22, 23}, and counsellors should be aware of these for referral.

(iv) HIV testing methods (including quality control)

Although HIV testing methods have become much more sensitive and specific (especially for sera from Africa), evaluations have shown that without rigorous quality control high numbers of false

²¹ Baggaley R., Kelly M., Weinreich S., Kayawe I., Phiri G., Mulongo W., M.Phiri M., (1998) HIV counselling and testing in Zambia: The Kara counselling experience SAFAIDS 6(2) 1-9

²² TASO/WHO TASO Uganda the inside story, WHO/GPA/HCS/95.1 1995

²³ Mildmay mission hospital, London. Personal communication 1999

positive and negative results are common. Not only can this be extremely damaging for individuals, but it can undermine the credibility of the service. If the WHO/UNAIDS testing strategies²⁴ are carried out for all tests, whatever method is used, laboratory errors can be reduced to a minimum. It is particularly important when setting up an HIV testing service, or when changing an HIV testing method, that tests are cross-checked at a reference centre. Even when these are used, high numbers of clerical errors are often reported. Therefore a cross-checking system for results is important.

(v) Cost and sustainability

Many developing countries are undergoing health reforms that include a degree of cost-sharing of medical services. However, for services to be affordable for the majority of people, they will usually have to be provided at low cost. In some countries the services are provided free to a limited number of people, or “free days” are built into the system to ensure that people who cannot afford to pay, even a small amount, are not excluded from the services²⁵.

It is also important to have a medium term plan for the service. If a service has to be shut down, or scaled down after an initial period, confidence in the services will be lost and the community will feel let down after expectations have been raised.

(vi) Services for special and vulnerable groups

VCT services may be considered for groups of people particularly affected by HIV. For example there is experience from working with sex workers in southern Africa²⁶ showing that VCT services must be carried out sensitively.

²⁴ UNAIDS/WHO Recommendations for the selection and usage of HIV antibody tests. Weekly epidemiological record No72, 1997 pp. 81-83

²⁵ AIC Uganda

²⁶ Wilson D., Provisional rapid assessment guidelines for prostitute interventions in sub Saharan Africa & Plummer F., Ngugi E., Moses S., The Pumwani experience: Evolution of a partnership in disease control. Published in Focusing interventions among vulnerable groups for HIV infection: experiences from Eastern and Southern Africa (1994) NARESA Mongraph No.2

Tool 2: Tool for VCT site evaluation (logistic considerations)

How to do

respondents = VCT managers

In some countries several VCT sites exist. Where a small number exist an effort should be made to interview managers from all sites. Where there are numerous sites a representative sample of managers from the various categories of VCT sites should be made. (For example one each from a blood transfusion site, free-standing VCT site, hospital clinical setting, private sector, research site, etc.) The sample should also contain examples of both rural and urban sites where appropriate.

Which services do you offer

- pre-test counselling
- post-test counselling
- ongoing counselling
- HIV testing
- HIV diagnostic counselling
(without testing)

If pre-and post counselling are undertaken, do carefully defined procedures exist?

Yes No

Describe these²⁷

Opening hours

Are you open at any of the following times?

- | | | | |
|-----------------------------|-----|----|------------------------------------|
| early evening (after 17:00) | Yes | No | (specify how many evenings) _____ |
| lunch hour | Yes | No | |
| weekends | Yes | No | (specify Sat or Sun or both) _____ |

Do you have an appointment system?

Yes No

If yes, what happens if someone comes without an appointment?

- | | | |
|---|-----|----|
| they are asked to make a future appointment | Yes | No |
| they will always be seen the same day | Yes | No |
| they will usually be seen the same day | Yes | No |

Privacy

Do you have adequate space to ensure counselling sessions can be private?

Yes, there is adequate space

There is some private space, but not enough

No

Specify,

²⁷ For example, do written policies, check lists, data management systems etc. exist?

- private office
- cubicle
- curtained off area
- other (describe)

Waiting area

Describe the waiting area

Confidentiality

Does the site have a written policy on confidentiality? Yes No

Describe the steps that have been taken to ensure confidentiality²⁸

Have any of the following staff received specific guidance about the role of counselling and confidentiality?

counsellors	Yes	No
laboratory staff	Yes	No
non-counselling medical staff	Yes	No
ward attendants	Yes	No
receptionists	Yes	No
ancillary staff (e.g. cleaners)	Yes	No
others (specify) _____		

Linkages

Do you receive referrals from any of the following?

Medical services (eg clinics/hospital)	Yes	Occasionally	No
Social services	Yes	Occasionally	No
Other counselling services	Yes	Occasionally	No
NGOs	Yes	Occasionally	No
Family planning services	Yes	Occasionally	No
MCH services	Yes	Occasionally	No
TB/chest clinic	Yes	Occasionally	No
STI services	Yes	Occasionally	No
Traditional healers	Yes	Occasionally	No
Spiritual/religious groups	Yes	Occasionally	No
Others (specify) _____			

Do you refer to any of the following?

Medical services (eg clinics/hospital)	Yes	Occasionally	No
Social services	Yes	Occasionally	No
Other counselling services	Yes	Occasionally	No
NGOs	Yes	Occasionally	No

²⁸ for example, are files kept in a locked filing cabinet, is a system in place to protect confidential computerised information?

Family planning services	Yes	Occasionally	No
MCH services	Yes	Occasionally	No
TB/chest clinic	Yes	Occasionally	No
STI services	Yes	Occasionally	No
Traditional healers	Yes	Occasionally	No
Spiritual/religious groups	Yes	Occasionally	No
Others (specify) _____			

Describe how referral systems work and any problems and successes

Do you feel there are adequate referral services available, particularly for the needs of people who test positive?

HIV testing methods

Where do you carry out HIV tests?

All testing done on site

Preliminary tests done on site, confirmations sent to other lab

All testing carried out in other lab

What is the time interval between taking blood and results being available?

Describe HIV testing schedule employed²⁹

Do you have external quality control for HIV testing? Yes No

If yes, describe

Cost and sustainability

Do you charge for services?

Counselling only No Yes amount _____

Testing No Yes amount _____

Ongoing counselling No Yes amount _____

If yes:

Are there any people who do not pay? Yes No % who do not pay _____

How is the service funded? _____

How long is the funding of the services ensured? _____

²⁹ for example, schedule for confirmation of test results, policy about testing in the window period

Are any inducements given to people attending the site?

(e.g. transport costs, refreshments etc.) Yes No

If yes, specify _____

Services for special and vulnerable groups

Do you have special services for any of the following groups?

Pregnant women	Yes	No
Young people	Yes	No
Children and families	Yes	No
Sex workers	Yes	No
Refugees	Yes	No
MSM	Yes	No
IDU	Yes	No

Level of services provision and utilisation

In the last 3 months

How many people have presented at the site? _____

How many (%) people have had pre-test counselling? _____

How many (%) people have been tested for HIV? _____

How many (%) people have returned for their result?³⁰ _____

How many (%) people have been given post-test counselling? _____

How many (%) people have received ongoing counselling? _____

How many (%) people have been referred to other services? _____

List the services to which most referrals have been made _____

Describe any problems and successes you have observed in people returning for test results

Outreach counselling (counselling in non-clinical settings)

Is outreach counselling carried out? Yes No

If yes,

How many people, on average, per group? _____

How many outreach sessions in the past 3 months? _____

Where are outreach sessions held? _____

Advertising and promotion of the VCT service

Do you advertise or promote your service in any way? Yes No

If yes, describe _____

Group counselling

³⁰ It is important to note here that “return rates” to collect HIV test results may be very dependent on the HIV testing method used. Where simple/rapid testing strategies are use it may be virtually impossible for clients not to get their test results as they are available shortly after the sample is taken and the client may be asked to remain in the clinic to receive the test result. If, however ELISA testing is used and blood samples are sent to a central laboratory a delay of 2-3 weeks is common between taking the blood test and the results being available to the client. This may result in fewer clients receiving their test result for logistic reasons or due to people changing their mind.

Is group pre-test counselling carried out?	Yes	No
If yes,		
How many people, on average, per group?	_____	
How many group counselling sessions in the past 3 months?	_____	
How long, on average is each session?	_____	

Section 3.

Counsellors' requirements and satisfaction

Introduction and background

Counsellor selection

Reports of counsellor selection have indicated that this process is often inadequate³¹. Counsellors are often selected by managers who have little understanding of the needs and responsibilities of counsellors. It has, however, been shown that health care workers who are motivated to counsel are more likely to be empathetic and proficient counsellors³². Therefore counselling training should not be a mandatory part of work, but rather assigned to health care workers who feel committed to counselling. In order to avoid over commitment or the imposition of the counsellor's own personal agenda, regular supervision of counsellors is important. Counsellors may not necessarily have a health background, and lay counsellors³³, people living with HIV/AIDS (PLHA) and people from other professions, such as teachers³⁴, have been trained as counsellors in many developing countries.

Counsellor attitudes

Counsellors will often have clients from different backgrounds and with different health and social beliefs from themselves. If they are dealing with groups such as sex workers, drug users, or young people, they may require training in special communication skills. Welcoming, friendly, sensitive and non-judgmental attitudes from counsellors are essential.

Counsellor training (including counsellor training materials)

Counsellors in VCT services will need training which should consist of basic information on HIV, transmission routes, risk factors, possible and available interventions, as well as the role and processes of pre, post-test and ongoing counselling. For the latter they will often need to acquire new skills. There are several models of counselling training. A short course (usually 1-2 weeks) followed by practical work, then a further 1-2 weeks is a common time scale³⁵. Some centres offer longer, more in-depth training. The need for refresher courses and ongoing training and support is widely recognised.

Counsellor recognition

Many people in high HIV prevalence areas have received training in HIV counselling, but are often unable to use their skills because counselling is not recognised by their colleagues as being important. Furthermore, other routine activities often take precedent over counselling or counselling-trained staff are transferred to other posts where they cannot carry out their duties. If counsellors are trained and given additional duties in HIV counselling, this role must be recognised and appreciated, and they must be allowed sufficient time to carry out these duties.

Counsellor support and follow up

Many counsellors experience considerable stress as a result of full time counselling for HIV^{36, 37}. In order to minimise "burnout", and avoid losing valuable and experienced staff, regular support

³¹ Miller D., Casey K., draft report on a consultancy on strategic counselling development in Thailand, Chang Mai, UNAIDS, July 1997

³² Lie G., Biswalo P., (1994) Perception of appropriate HIV/AIDS counsellors in Arusha and Kilimanjaro regions of Tanzania: Implications for hospital counselling *AIDS Care* 6 (2) 139-151

³³ MacIntyre Lay counsellors in Baragwanath

³⁴ Baggaley R., Sulwe J., Chilala M., Mashambe C., (1999) HIV Stress in the classroom and at home as identified by primary school teachers in Lusaka, Zambia. *Bulletin of the World Health Organisation. The international Journal of Public Health* 77 (3) 284-8

³⁵ Regional AIDS Training Network, Nairobi, Kenya (1999)

³⁶ Baggaley R., Sulwe S., Ndovi-Macmillan M., Godfrey-Faussett P. (1996). HIV counsellors' knowledge and attitudes and vulnerabilities to HIV. *AIDS Care* 8, 155-166

and supervision should be planned and provided. This has been shown to be effective and feasible, even in busy hospitals providing care in high HIV prevalence communities³⁸. The questions on burnout have been adapted from previous studies³⁹. Counsellors may be able to function more effectively if they alternate their counselling with other activities. It must also be recognised that many health care workers, even those working in high prevalence areas, may have had little formal training in HIV and may have similar prejudices to those held by others in the community. These prejudices may have to be challenged during training. Furthermore, some of the issues they will be expected to discuss (such as condom use, or safer sex practices for young girls) may go against their own religious beliefs, or what they have been advising previously. It has also been reported that when health care workers start to discuss HIV issues with their patients, their own anxieties and vulnerabilities to HIV may surface²². PLHA counsellors report particular need for support as when they give seropositive results they may relive their own experiences⁴⁰ and empathise too closely with their clients who test seropositive. PLHA counsellors also reported the benefits of alternating counselling with other activities. In some countries counsellors have formed groups to provide mutual support and where they can discuss complex cases. Counsellors, many of whom may have limited training or work in isolated situations, need a structure for supervision and referral of difficult cases.

³⁷ Kalibala S., (1995) Research , interventions and current issues in burnout and response in Health Workers and AIDS, Ed. Bennett L., Miller D., Ross M., Hardwood Academic Publishers, Switzerland

³⁸ van Dis H., & van Dongen E., (1993) Burnout in HIV/AIDS health care and support, Amsterdam University Press.

³⁹ Questions adapted from D.Miller, (2000) Dying to Care? Work, Stress and Burnout in HIV /AIDS. Social aspects of AIDS London: Routledge; 2000 ; Bennett, Kelaher & Ross (1992) AIDS impact scale; Maslach & Jackson (1982) Maslach Burnout Inventory.

⁴⁰ Zulu W. Positive and Living Squad (PALS), Lusaka, Zambia. personal communication

Tool 3: for counsellor evaluation

How to use

This tool is not designed to evaluate individual counsellor's counselling skills and counsellor competence which will be covered in section on counselling evaluation but it is to highlight the counsellor's perceived adequacy of his/her selection, training support and work satisfaction.

Respondents = counsellors

This tool is a semi-structured interview that should be carried out individually by a trained researcher. As it will require some time to perform a small random sample of counsellors should be used. The interviewee must be assured of his/her anonymity. The interviewer should be trained to be non-judgmental and allow the interviewee to express his/her anxieties. Additional points and comments may be recorded where appropriate.

What is your background?

Nurses

Clinical officers

Social workers

PLHA

Other (specify) _____

Selection

How were you selected to be a counsellor?

Proposed by senior colleague

Self-motivated (expand)⁴¹

Do you feel that you have been pressurised into doing counselling? (explain)⁴²

Training

Describe the counselling training have you received?⁴³

How would you rate your counselling training?

very good good adequate inadequate

What were the good things and poor things in your training?

⁴¹ for example, give reasons why you decided to train as a counsellor e.g. "concerned about the impact of HIV in the community", "following personal experience" - e.g. have friend, relative with HIV etc.

⁴² for example, is counselling you feel comfortable doing or do you feel it is a strain or that you have to do it as part of your job

⁴³ for example, number of courses and duration of courses attended

Are there any areas in which you feel you need more training?

Have you had follow up or ongoing training? Yes No

If yes, describe it.

If no, do you think ongoing training would be a good idea? Describe how it might, or might not, help.

Support and supervision

How many hours a week do you spend in counselling activities?

What proportion of your working life is spent counselling?

Do you attend a counsellor support group? Yes No

If yes, in what way is the group helpful or not helpful?

If no, in what ways do you think you would benefit (or not benefit) from a support group?

Do you have support for your counselling from other sources? (if yes, explain whom and how does it help)

Do you have access to a designated counselling supervisor to provide you with support and technical back up?

Yes No

If yes, who provides:

support _____

supervision _____

“Burnout”

How do you feel about your job?

Do you feel valued or undervalued by clients (explain in what ways)?

Do you feel valued or undervalued by other staff (explain in what ways)?

Do you feel valued or undervalued by your superiors (explain in what ways)?

Are you given adequate time in your job to carry out your counselling duties?

Please indicate how you feel about the following statements

“I feel emotionally drained by my work”

always often occasionally never

“My work is very stressful”

always often occasionally never

“My work is very rewarding”

always often occasionally never

“My work environment is very stressful”

always often occasionally never

“I learn something new in my work every day”

always often occasionally never

“I feel isolated in my work”

always often occasionally never

“I have problems communicating with my colleagues”

always often occasionally never

“I can help my clients”

always often occasionally never

“I have no confidence in my clinical skills”

always often occasionally never

Please elaborate on any of the above statements

How many years have you been counselling?

How many hours per day do you do counselling?

*If your daily schedule varies please give an **approximate** indication of the number of hours you spend, for each day of the week:*

- counselling about HIV related problems _____
- counselling about other issues _____
- other work (specify) _____

How many days per week do you do counselling?

How many clients do see per day?

If your daily schedule varies please give an approximate indication of the number of clients you see for each day of the week:

clients with HIV related problems _____

clients with other problems _____

How do you see your future in counselling?⁴⁴

⁴⁴ for example, “will go on with my counselling job for the foreseeable future” “find counselling to stressful/difficult and want to find a new job”)

Section 4. Counselling evaluation

Introduction and background

The aim of this section is to evaluate the process, content and the quality of the counselling sessions and the client-counsellor interaction. The series of tools that have been developed have been designed to evaluate counselling that takes place in various clinical and non-clinical settings. They can also be used to help in the training and assessment of individual counsellors during their training or follow-up review.

HIV-related counselling can be divided into pre-test, post-test, follow up counselling, diagnostic HIV counselling (where testing is not available or desired) and counselling associated with specific interventions such as TB preventive therapy and interventions to prevent MTCT. Counselling assessment will also have to be adapted according to the types of counselling (including, individual, couple, family and children) and may vary considerably with various groups, such as counselling for young people, gay men, drug users or sex workers.

The counselling evaluation has been divided into common elements (content and competency/counselling quality) which are important for all counselling session and additional content elements which are important when counselling in specific circumstances and when specific interventions, such as MTCT and TBPT interventions, are available. These tools may need to be adapted to correspond with VCT guidelines used in the particular setting. Although the elements included in the tools are fairly inclusive, the particular guidelines used by a particular site may differ. The counsellor may be evaluated based on the protocol he/she has been trained to follow, rather than other external tools that may or may not correspond. In field-testing, however, the tools were found to be compatible with the counselling service protocols.

Elements of counselling; content and quality

1. Competency based elements

1.1 *Interpersonal relationship*

Interpersonal interactions are influenced by gender, cultural and socio-economic factors. Other factors such as workload, resources and referral opportunities will also be important. These factors should be taken into account when setting standards.

- Sensitivity and discretion to the fact that the client may be nervous or embarrassed.
- Appropriate physical environment for comfort, privacy and confidentiality.
- Good client reception, greeting and introduction.
- Rapport, respect, interest and empathy.
- Non-judgmental attitude.
- Engagement of the client in conversation.
- Active listening (non-verbal and verbal).
- Emotional warmth and support.

Establishing good rapport by showing respect and understanding will make problem solving easier in difficult circumstances.

1.2 *Information gathering*

- The use of appropriate balance of open and closed questions
- The appropriate use of silence to allow for self-expression, dealing with impact, thinking through implications
- The clarification about client expectations; information heard to avoid premature conclusions
- Summarising main issues discussed

1.3 *Information giving*

- Acceptable knowledge about HIV by the counsellor.
- Counsellor's ability to provide simple and clear information about HIV-related issues.
- Repetition and reinforcement of important information.
- Checking for understanding/misunderstandings.
- Summarisation.

1.4 Dealing with special circumstances

- Sensitivity to and accommodation for language difficulties.
- Talking about sensitive issues, plainly and appropriate to the culture, educational level and beliefs (spiritual and traditional) of the client.
- Prioritising issues to cope with the limited time and short contacts.
- Innovations for overcoming constraints, such as time and privacy.
- Appropriate management of client's distress or emotional reactions.
- Flexibility to involve partner or significant other, when appropriate or requested.

2. Content based elements

- Pre-test
- Post-test
- In HIV diagnostic counselling
- For special services/interventions
 - TBPT
 - MTCT
- For special and vulnerable groups

It is envisaged that for each counselling session observed Tool 4.1 would be used to observe counselling quality and one of the content tools (4.2, 4.3, 4.4 etc) depending on the type of counselling session.

Tools for evaluation of counselling content and quality

How to do

respondents = observers of counselling sessions

4.1. Counselling Skills

This section should be completed by an external assessor, counselling supervisor or counsellors who have had training. It is aimed at assessing the standards of the counselling of individuals taking place in the various contexts of HIV testing care and support services. The standards assessed are based on the performance skills of the counsellors and these are best assessed through the observation of real counselling situations. Not more than 3-5 sessions need to be observed at each counselling site. Where there are many counsellors, a random sample (3-5) should be selected from among them. For each selected counsellor an observation could be made on the first counselling session conducted on the day of monitoring. When only 1-2 counsellors exist, 3-5 counselling sessions could be selected at random. Before the observer sits in, the client is informed about the observation and its purpose. Consent is sought. The observer must ensure that he/she is as unobtrusive as possible and does not disrupt the counselling session. Assurance of confidentiality must also be given. Immediate feedback to the counsellor by the trained supervisor is advised with an opportunity for the counsellor to express his/her opinions and concerns.

Occasionally counsellors feel unhappy about a supervisor observing their session. Where irreconcilable concerns about observations by supervisors occur alternative methods include using peer counsellors as observers, role-play or audio taped consultations (see introduction for a discussion of alternative methods).

Function	Skills	Score	Comments
Interpersonal relationship	• Greets clients	3 2 1*	
	• Introduces self	3 2 1	
	• Engages client in conversation	3 2 1	
	• Listens actively (both verbally and non-verbally)	3 2 1	
	• Is supportive and non-judgmental	3 2 1	
Information gathering	• Uses appropriate balance of open and closed questions	3 2 1	
	• Uses silence well to allow for self-expression	3 2 1	
	• Seeks clarification about information given	3 2 1	
	• Avoids premature conclusions	3 2 1	
	• Probes appropriately	3 2 1	
	• Summarizes main issues discussed	3 2 1	
Information giving	• Gives information in clear and simple terms	3 2 1	
	• Gives client time to absorb	3 2 1	

	<p>information and to respond</p> <ul style="list-style-type: none"> • Has up-to-date knowledge about HIV • Repeats and reinforces important information • Checks for understanding/ misunderstanding • Summarises main issues 	<p>3 2 1</p> <p>3 2 1</p> <p>3 2 1</p> <p>3 2 1</p>	
Handling special circumstances	<ul style="list-style-type: none"> • Accommodates language difficulty • Talks about sensitive issues plainly and appropriate to the culture • Prioritises issues to cope with limited time in short contacts • Uses silences well to deal with difficult emotions • Is innovative in overcoming constraints (eg space for privacy) • Manages client's distress • Flexible in involving partner or significant other 	<p>3 2 1</p> <p>3 2 1</p> <p>3 2 1</p> <p>3 2 1</p> <p>3 2 1</p> <p>3 2 1</p> <p>3 2 1</p>	

*3= best

2. Content-based assessment

This tool is designed to assess the standards of HIV counselling by monitoring the content of the counselling session. The content of the counselling session will vary, depending on its purpose and needs of the client.

For counselling in relationship to testing, and for counselling around an HIV diagnosis in clinical settings (where an HIV test may not always be possible), the dialogue needs to cover certain minimum ground.

This observation needs to be completed by an experienced and trained external assessor, counselling supervisor or counsellor colleague who can either sit in a counselling session, or review audio or video recordings of the session.

4.2. Pre-test counselling

During the session have the following occurred?

- | | | | |
|---|-----|-----|----|
| • Reason for attending discussed | Yes | No | |
| • Knowledge about HIV and modes of transmission explored | Yes | No | |
| • Misconceptions corrected | Yes | No | |
| • Assessment of personal risk profile carried out | Yes | No | |
| • Information concerning the HIV test given
(e.g. process of testing, meaning of possible test results, window period) | Yes | No | |
| • Understanding checked for | Yes | No | |
| • Discussion of meaning of +ve and -ve results
and possible implications | Yes | No | |
| • Capacity to cope with +ve result | Yes | No | |
| • Discussion of potential needs and available support | Yes | No | |
| • Discussion of a personal risk reduction plan | Yes | No | |
| • Time allowed to think through issues | Yes | No | |
| • Informed consent/dissent given freely | Yes | No | |
| • Follow-up arrangements discussed | | Yes | No |
| • Adequate time for questions and clarifications | Yes | No | |

4.3. Post-test counselling

During the session have the following occurred?

- | | | |
|--|-----|----|
| • Results given simply and clearly | Yes | No |
| • Time allowed for the result to sink in | Yes | No |
| • Checking for understanding | Yes | No |
| • Discussion of the meaning of the result for the client | Yes | No |
| • Discussion of the personal, family and social
implications including who, if any, to tell | Yes | No |
| • Discussion of a personal risk reduction plan | Yes | No |
| • Dealing with immediate emotional reactions | Yes | No |

• Checking adequate immediate support available	Yes	No	
• Discussion of follow-up care and support		Yes	No
• Options and resources identified	Yes	No	
• Immediate plans, intentions and actions reviewed		Yes	No
• Follow-up plans discussed and referrals where necessary	Yes	No	

4.4. Counselling where HIV testing is not available

During the session have the following occurred?

• Symptoms and course of illness reviewed and discussed	Yes	No	
• Investigations and treatments reviewed and discussed	Yes	No	
• Possibility/certainty of HIV-related diagnosis based on clinical presentation	Yes	No	
• Review of knowledge about HIV including transmission and prevention	Yes	No	
• Misconceptions corrected and information given.		Yes	No
• Personal risk assessment carried out, with respect to sexual and drug injecting behaviour, and history of blood contact	Yes	No	
• Further discussion of possibility/certainty of HIV-related diagnosis combining risk profile, symptoms and clinical state		Yes	No
• Time allowed for news to sink in	Yes	No	
• Understanding checked for	Yes	No	
• Discussion of the meaning of the diagnosis for the client		Yes	No
• Discussion of a personal risk reduction plan	Yes	No	
• Discussion of the personal, family and social implications of the diagnosis for the client	Yes	No	
• Dealing with emotional reactions		Yes	No
• Discussion of strategies, options and referral for further support and care	Yes	No	

5b) Counselling for MTCT interventions

Introduction and background

The risk of HIV transmission for an infected mother to her child can be reduced by 50% by giving short course zidovudine from 36 weeks of pregnancy and during labour and avoiding breastfeeding. To be able to make informed decisions about infant feeding and access to antiretroviral (ARV) therapy, where this is available, a pregnant women needs to know and understand her HIV status.

Pregnant women will require the same information as other people in pre- and post-test counselling sessions but additional areas will need to be explored. An area which will require sensitive counselling is sharing results with the baby's father/her partner and close family members, as interventions to reduce MTCT may involve decisions to change infant feeding methods and taking ARVs, which will make it difficult to conceal a seropositive status. Furthermore there may be considerable benefits of sharing HIV results in pregnancy so that women may have adequate emotional support.

Even in high HIV prevalence areas the majority of women tested during pregnancy will be seronegative and it is important to use this opportunity to reinforce safer sex messages.

Women who become infected with HIV during pregnancy or during breastfeeding are at increased risk of transmitting HIV to their baby due to the high viral load associated with acute infection⁴⁷.

Studies have indicated that, for women testing in the antenatal setting there is great benefit for women, of being tested together with their partners^{48, 49}. If women are tested alone, or their partners refuse to be involved in the VCT process, or if they feel unable to disclose their status to their sexual partner, it is difficult for women to 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. Despite the problems of women testing alone, in PMTCT pilot projects it is usual for this to occur, and disclosure to partners may only occurs in a minority of cases. Antenatal testing where PMTCT interventions are available should always be *offered* to couples. Testing women individually should be the exception (at the women's request) and not the rule.

⁴⁷ A review of HIV transmission through breastfeeding in HIV and Infant Feeding (1999)
UNICEF/UNAIDS/WHO/FRH/NUT/CHD/98.3

⁴⁸ Meursing K. (1997) A world of silence. Living with HIV in Matabeleland, Zimbabwe. Royal Tropical Institute, The Netherlands, doctoral thesis

⁴⁹ Allen S., Tice J., Van de Perre P., (1992) Effect of serotesting with counselling on condom use and seroconversion among HIV discordant couples in Africa *BMJ* **304** 1605-9)

Tool 5.2 for evaluation of counselling content for MTCT interventions

How to do

Respondents =observers of counselling sessions

An external assessor, counselling supervisor or counsellor who has had training should complete this section. It is aimed at assessing the standards of the counselling of individuals taking place in the various contexts of HIV testing care and support services. The standards assessed are based on the performance skills of the counsellors and these are best assessed through the observation of real counselling situations. Not more than 3-5 sessions need to be observed at each counselling site. Where there are many counsellors, a random sample (3-5), should be selected from among them. For each selected counsellor an observation could be made on the first counselling session conducted on the day of monitoring. When only 1-2 counsellors exist, 3-5 counselling sessions could be selected at random. Before the observer sits in, the client is informed about the observation and its purpose. Consent is sought. The observer must ensure that he/she is as unobtrusive as possible and does not disrupt the counselling session. Assurance of confidentiality must also be given. Immediate feedback to the counsellor by the trained supervisor is advised with an opportunity for the counsellor to express his/her opinions and concerns.

Occasionally counsellors feel unhappy about a supervisor observing their session. Where irreconcilable concerns about observations by supervisors occur alternative methods include using peer counsellors as observers, role-play or audio taped consultations (see introduction).

During the session have the following occurred?

In early pregnancy.

Have the following areas been adequately covered

- | | | |
|---|-----|----|
| • Client's views on pregnancy explored | Yes | No |
| • Full information about HIV in pregnancy and the risk of transmission to the infant given | Yes | No |
| • Possible benefits of knowing her status and interventions available if the result is positive (including making it clear that ARV therapy cannot be given to women whose status is not known) | Yes | No |
| • Implications of a +ve result for her baby | Yes | No |
| • Implications of a +ve result for future children | Yes | No |
| • Implications of a +ve result for decisions about infant feeding | Yes | No |
| • Implications of a +ve result for her relationship with the baby's father | Yes | No |
| • Discussions around the benefits of testing together with her partner/ her baby's father | Yes | No |
| • Implications and benefits of sharing a +ve result with her partner/ her baby's father | Yes | No |
| • Explaining that testing is not mandatory and that she will not be denied access to antenatal care or other services if she chooses not to be tested | Yes | No |
| • Options for TOP (if available legally and safely) | Yes | No |

Post-test counselling for +ve women attending maternity services

In addition to the general issues that should be covered in post-test counselling, counselling for pregnant women who are HIV seropositive should include:

- | | | |
|--|-----|----|
| • Information on ARVs, if available | Yes | No |
| • Information on infant feeding options
and the benefits and risks of breastfeeding | Yes | No |
| • Information on family planning | Yes | No |
| • Information about treatment, care and
support services available and referral | Yes | No |
| • Discussion of potential benefits and risks of sharing information
about their HIV status with partner, family | Yes | No |
| • Information about safer sex and using condoms
to prevent transmission of HIV and STIs | Yes | No |
| • Information about care of the child (including nutritional advice
and seeking early treatment for illnesses) | Yes | No |
| • Planning for the future
(including emotional, spiritual and legal support) | Yes | No |
| • Options for referral if required | Yes | No |

Have specific questions about MTCT and ARV treatment been covered?

- | | | |
|-------------------------------------|-----|----|
| • Previous ARV use | Yes | No |
| • Not a cure | Yes | No |
| • Need to attend maternity services | Yes | No |
| • Need to take ARVs as prescribed | Yes | No |
| • Understanding checked for | Yes | No |

Contraindications and cautions to ZDV discussed

- | | | |
|-------------------------------|-----|----|
| • Drug reactions | Yes | No |
| • Other medicines being taken | Yes | No |

Explanation of ZDV therapy for prevention of MTCT adequately given including

- | | | |
|---|-----|----|
| • The regimen explained | Yes | No |
| • The need to take medicines continually according to the regime and the dangers of
taking ZDV erratically | Yes | No |
| • The possible side effects and when to seek medical help | Yes | No |
| • Understanding checked for | Yes | No |

Post-test counselling for -ve women attending maternity services

- Information about safer sex and using condoms to prevent infection

- | | | |
|---|-----|----|
| (especially during pregnancy and breastfeeding) | Yes | No |
| • Explain about discordancy | Yes | No |

Section 6.

“Group counselling”/Group education

Introduction and background

In situations with limited resources and few counsellors it has been suggested that “group counselling” can be used to maximise the number of people having access to VCT. Video information can also be used in this setting. This model has been used to provide pre-test information to women in antenatal settings and to couples and groups of young people in various settings in developing countries^{50,51}. It may be more appropriate to describe this group interaction, where people learn details about HIV transmission, risks, testing and interventions, as “group education” rather than counselling. It may be very difficult for individuals to discuss personal issues and fears in a group setting and people may feel swayed by the opinion of the group and need time to discuss their own circumstances. Although group work has been used successfully as part of pre-test preparation, it should not replace individual pre-test counselling. Everyone being tested for HIV should have the opportunity for individual pre-test counselling. Giving HIV test results and post-test counselling should always be conducted individually, unless a significant other has been invited to attend by the client or with children and minors. The counsellor who leads the group session will need similar skills to those required for individual counselling, but in addition will need to cope with the complex dynamics which may arise in a group.

- dealing with an over-assertive, dominant individual
- including quiet, shy or overwhelmed individuals, yet respecting “listeners”
- allowing all participants to speak
- coping with people who become emotionally distressed in a group
- being non-judgmental and inclusive of different beliefs (religious, cultural, medical etc.) of group members
- refraining from “lecturing” the group - allowing the group to learn from each others experiences

There are many examples of post-test groups where people gain mutual support from people who have been through VCT⁵². This, again should not replace post-test and ongoing counselling which should be available for all people following VCT.

Important characteristics of group work

- **Clear identification of participants**

Group participants should share a similar goal - for example women attending antenatal clinic seeking information on VCT for MTCT interventions.

- **Confidentiality**

As with individual counselling sessions group participants should agree that personal information disclosed in the group should remain confidential to the group.

- **Small numbers**

If individuals are to be able to participate in a group numbers need to be limited to less than 20.

⁵⁰ Allen S., Serufilira A., Bogaerts J. et al (1992) Confidential HIV testing and condom promotion in Africa. *JAMA* **8** 3338-3343

⁵¹ Gray G., personal communication

⁵² TASO Uganda, the inside story: Participatory evaluation of the HIV/AIDS counselling, medical and social services 1993-4 WHO/GPA/TCO/HCS/95.1

- **Language**

The group must agree upon a common language and the group leader should be aware of the educational background of the group participants, using clear, jargon-free language.

- **Group structure**

Ideally the group should sit in a circle with the group leader being part of the group, rather than adopting a teacher/class model.

- **Counselling back-up**

Individual counselling should always be available for group participants. If someone in the group becomes distressed and cannot be adequately helped in the group there should be the opportunity for him/her to be taken out of the group for individual support.

Tool 6: for evaluation of groups

How to do

respondents = observations of group sessions

Assessors who have counselling training and training in-group work should complete this section. It is aimed at assessing the standards of the counsellor in leading groups that take place in the various contexts of HIV testing care and support services. The standards assessed are based on the performance skills of the counsellors and these are best assessed through the observation of real groups. Not more than 3-5 sessions need to be observed at each counselling site. Before the observer sits in the group, the participants are informed about the observation and its purpose. Consent is sought. Assurance of confidentiality is also given.

Function	Skills	Score	Comments
Establishing group relationship	• Greets participants	3 2 1*	
	• Introduces self	3 2 1	
	• Facilitates group introductions	3 2 1	
Ensures group participation	• Allows all members to participate	3 2 1	
	• Seeks clarification about information given/discussed	3 2 1	
	• Directs discussion appropriately	3 2 1	
	• Summarises main issues discussed	3 2 1	
Information giving	• Gives information in clear and simple terms	3 2 1	
	• Gives participants time to absorb information and to respond	3 2 1	
	• Has up-to-date knowledge about HIV/MTCT etc**	3 2 1	
	• Repeats and reinforces important information	3 2 1	
	• Checks for understanding/misunderstanding	3 2 1	
	• Summarises main issues	3 2 1	
Handling special circumstances	• Accommodates language difficulty/differences in the group	3 2 1	
	• Talks about sensitive issues plainly and appropriate to the culture/group composition	3 2 1	
	• Prioritises issues to cope with limited time	3 2 1	
	• Manages participant's distress	3 2 1	

*3= best

**depending on the aim/requirements of the group

Section 7.

Client satisfaction

Introduction and background

Outcome measures

The aim of VCT is to enable people to know and understand their HIV status. Thus it is hoped that, for those who test seropositive, they can access care and support at an earlier stage, cope better emotionally with their infection, plan for their and their dependants' future, and prevent HIV transmission to sexual partners. For those who test seronegative, the main aim of VCT is to enable them to make decisions about their sexual (or other risk) behaviour to remain negative. Balanced against this are the possible negative consequences of HIV testing, such as depression and anxiety for the individual who tests positive, and the possible stigma, discrimination and abuse for those who share their positive status with others^{53, 54}. In an attempt to evaluate these, UNAIDS/WHO developed a protocol for "The evaluation of the supportive benefits of counselling". This generic tool was developed to be administered by a research worker to the client after counselling sessions. It has been used in several developing and middle-income countries. It was modified for use in Zambia, where it has been most extensively used. The modified questionnaire included many open-ended questions to explore in depth people's attitudes, feelings and behaviour following VCT. 377 people were interviewed on three occasions during the 2 years following their post-test counselling session. A further 50 people were interviewed who had undergone VCT, but did not return for their test results^{55, 56, 57}.

Areas covered in the UNAIDS/WHO/KARA evaluation

First interviews

- Recruitment from different sites
- HIV seropositivity
- Demographic characteristics
- Counselling sessions
- Motivation for HIV testing
- Sharing HIV test results
- Knowledge of partner's HIV status
- Coping with HIV result
- Family planning
- Marriage/relationship issues
- Safer sex practices
- Medical needs - allopathic/western; traditional; spiritual
- Psychological needs/support
- Self-help/support groups
- Government and community assistance
- Planning for the future
- Legal and discrimination issues
- Financial/work planning

⁵³ Temmerman M., Ndinya-Achola J., Ambani J., Piot P. (1994). The right not to know HIV-test results. *Lancet* **345**, 696-697

⁵⁴ McGreal C. (1999) This is worse than apartheid. *The Guardian* UK 16/3/99

⁵⁵ Client's views on HIV counselling and testing. Is it helpful? Kayawe I., Weinrech S., Chana S., Nsiska., Mulongo W., Baggaley R., abstract number 33265 12th world AIDS conference Geneva June 1998

⁵⁶ To tell or not to tell: sharing HIV results with sexual partners. Baggaley R., Kelly M., Mulongo W., 5th SANASO conference in Mbabane Swaziland, Oct. 1997

⁵⁷ HIV counselling and testing in Zambia: The Kara counselling experience. Baggaley R., Kelly M., Weinreich S., Kayawe I., Phiri G., Mulongo W., Phiri W., *SAFAIDS* 6(2) 1-9

- Terminal care

Section 2 Follow up

- Sexual behaviour and "safer sex"
- Medical care
- Self-help groups and social support
- Family planning and marriage
- Coping
 - Financially
 - Emotionally
 - The future/terminal care

Key issues

(i) Sexual behaviour

Other evaluations have concentrated on looking at reported sexual behaviour following VCT and have looked at, for example, number of sexual partners and condom use^{58, 59, 60}. It has been argued that reported information of sexual behaviour must be interpreted with caution. People may wish to please the interviewer by reporting what they perceive to be "good" sexual behaviour, or may not wish to disclose sensitive information on a questionnaire. In order to provide a direct measure of the impact of VCT on sexual behaviour a study from Rwanda looked at rates of STIs, pregnancy and the incidence of HIV following VCT⁶¹ in groups of people who had been tested and had received their test results compared with groups of people who had were not told their test results.

(ii) Sharing results

To make changes in sexual behaviour, following VCT to reduce HIV transmission, it is important to be able to share HIV results with sexual partners, and ideally to persuade partner/s to be tested as well. It has also been shown that people with HIV often gain much support if they are able share knowledge of their infection with partners, friends or family^{62, 63}. However, unless couples present together, or are particularly targeted, reports have often shown a low level of partner notification and subsequent partner testing^{64, 65}. This is particularly marked at VCT sites targeting women for MTCT interventions, where it has recently been shown that the proportion of men who accepted VCT after their spouse was tested positive did not exceed 1% in west Africa and 5% in

⁵⁸ Sangiwa G., Balmer D., Furlonge C., et al. (1998). Voluntary HIV counselling and testing (VCT) reduces risk behavior in developing countries: results from the multisite voluntary counselling and testing efficacy study. Abstract 33269 presented at the 12th International Conference on HIV/AIDS, Geneva, Switzerland.

⁵⁹ Moore M., Tukwasibwe E., Marum E., Taremwa C., O'Reilly K., Rosner L. (1993). Impact of HIV counselling and testing in Uganda. Abstract WS-C16-4 presented at the 9th International Conference on AIDS, Berlin, Germany.

⁶⁰ Allen S., Serufilira A., Bogaerts J., et al. (1992). Confidential HIV testing and condom promotion in Africa. *JAMA* **8**, 3338-3343.

⁶¹ Allen S., Serufilira A., Gruber V. (1993). Pregnancy and contraceptive use among urban Rwandan women after HIV counselling and testing. *Am J Public Health* **83**, 705-710.

⁶² Kaldjian L., Jekel J., Friedland G., (1998) End-of-life decisions in HIV-positive patients: the role of spiritual beliefs *AIDS* **12** (1) 103-107

⁶³ Williams G. (1990) From fear to hope. AIDS care and prevention at Chikankata Hospital, Zambia *Strategies for Hope 1* Actionaid ISBN 1 872502148

⁶⁴
⁶⁵Fenton K., French R., Giesecke J., (1998), An evaluation of partner notification for HIV infection in genitourinary medicine clinics in England, *AIDS* **12** (1) 95-103

South Africa⁶⁶. However, in Zambia, although people were often reluctant to share their test results initially, over time more people were able to discuss this with their partner and the vast majority were able to tell someone about their test result. The level of partner notification should not be seen as a simple indication of success, as cultural and social factors will be of importance in this issue. In some contexts it may be appropriate for women not to reveal their status, and pressurising them to do so may lead to abuse.

(iii) Follow up care and support

For people to benefit fully from VCT, it is important for people to have access to further emotional, medical and social support. An indication of the availability and uptake of these services and unmet needs is important.

(iv) Satisfaction with the service

It is important to examine how the client views the service so that any problems can be addressed. The client's view of the services covering the following areas could be looked at:

- **convenience** (site and opening hours)
- **waiting time**
 - to get appointment
 - to see counsellor
 - to get result
- **counsellor**
 - warmth/rapport/confidence
 - confidentiality
 - consistency of counsellor
- **physical environment** (privacy)
- **unresolved problems/needs**

⁶⁶ Cartoux M., Meda N., van de Perre, P., Newell M-L. , de Vincenti I., Dabis F., (Ghent International Working Group/UNAIDS/EU)(1999), Acceptability of voluntary HIV testing and interventions to reduce mother-to-child transmission of HIV in developing countries. Final report.

Tool 7: for evaluation of client satisfaction

How to do

respondents = exit interviews with people attending counselling

This tool is designed to evaluate how those attending the service felt about it, and if and how it should be.

This tool is a semi-structured interview, which should be carried out individually by a trained and experienced researcher. The interviewer should be trained to be non-judgmental and allow the interviewee to express his/her anxieties. Additional points and comments may be recorded where appropriate. As it will require some time to perform a small sample of people should be interviewed. To avoid a selection bias, a convenience sampling method can be used. All people receiving counselling within a specific period (e.g. 1 week) will be asked by their counsellor to attend a confidential and anonymous exit interview. If the number of people attending the service over this period is too great, random sampling can be adopted to space people through each day and through the week. The client interviews will be voluntary and they should be assured that they are anonymous and confidential.

Have you talked to your counsellor today about:

- a)having an HIV test Yes No
 b)receiving test results Yes No
 c)talked about issues arising from an HIV test taken some time ago Yes No
 d)other issues (specify)

How did you *first* come to the centre?

Referred (specify by whom) _____

Recommended to come (e.g. by partners/friend)(specify) _____

Just dropped in _____

Other (specify) _____

Why did you come to the centre?

How much time did you spend

getting your first appointment _____

waiting for your HIV test result _____

waiting to see your counsellor today _____

in the session with your counsellor today _____

How do you view your counsellor? Describe the good and bad things about him/her

Do you wish you had a different counsellor (different sex, older, younger)?

Were you able to see the same counsellor for discussion both before and after the test?

If a friend or relative were in a similar position to you before you came to the service, would you recommend that he/she came to the service? Yes No

Why?

Have you recommended the service to any one else? (Specify who and how many people)

Section 8. Cost of VCT

Introduction and background

When planning VCT services it will be important to estimate the additional costs that will be required to either develop an independently functioning VCT service, or to provide VCT as an integrated part of other health services. Furthermore, when promoting interventions, or deciding on their feasibility for wider application, it may be important to assess how cost effective they are. For example, "cost effectiveness" models for MTCT interventions have been described where VCT cost estimations have been included^{67, 68, 69, 70}. These models estimate the cost per case of HIV averted or cost per disability adjusted life year (DALY). If VCT projects are part of pilot projects it is also important to have realistic estimations of their set up and running costs if services are to be expanded or replicated. Underestimating costs will mean that services may be developed with inadequate funding leading to frustration and poor implementation.

VCT costs associated with MTCT interventions per women tested

Mansergh in a sub-Saharan African developing country setting 1996 --	18.5 US\$
Mansergh in a sub-Saharan African developing country setting 1998 --	8 US\$
Marseille in a sub-Saharan African developing country setting 1998 --	4 US\$

The costs described in these models are based only on the cost of HIV testing, rental of premises and staff time and are less than the actual operating costs described by VCT sites, such as AIC, Uganda and Kara, Zambia. They do not include the costs of setting up and developing a service and the costs of ongoing care and emotional support that some people will need following testing.

Some additional costs which have not been included in these models may also need to be considered:

Organisation of services

- providing appropriate or additional accommodation for confidential counselling services
- laboratory equipment for HIV testing
- transportation costs if testing is carried out at a laboratory at a distance from the VCT site
- safe disposal of clinical waste, (including sharps)
- quality assurance system for HIV testing
- development of record system to ensure confidentiality of HIV results
- support of referral services (e.g. home care, medical services, ongoing counselling services, social support)

Staff training and support

- counselling training related to VCT
- performance of laboratory tests
- ongoing counsellor support and supervisions to ensure quality of counselling and to diminish burn out of staff

⁶⁷ Mansergh G., Haddix A., Steketee R., et al (1996) Cost-effectiveness of short-course zidovudine to prevent perinatal HIV type 1 infection in a sub-Saharan African developing country setting *JAMA* **276** (2) 139-145

⁶⁸ Mansergh G., Haddix A., Steketee R., et al (1998) Cost-effectiveness of zidovudine to prevent mother to child transmission of HIV infection in a sub-Saharan Africa *JAMA* **280** (1) 30-31

⁶⁹ Marseille E., Kahn J., Saba J., (1998) Cost-effectiveness of zidovudine to prevent mother to child transmission of HIV infection in a sub-Saharan Africa *AIDS* **12** (8) 939-948

⁷⁰ Wilkinson D., et al (1998) Model for Hlabisa District, South Africa

Tool 8: for evaluation of VCT costs

How to do

respondents = VCT managers

In some countries several VCT sites exist. Where a small number exist an effort should be made to interview managers from all sites. Where there are numerous sites a representative sample of managers from the various categories of VCT sites should be made. (For example one each from a blood transfusion site, free-standing VCT site, hospital clinical setting, private sector, research site, etc.) The sample should also contain examples of both rural and urban sites where appropriate.

Set up costs

additional accommodation required

If additional accommodation has been built or adapted estimate costs _____

project development costs

When setting up the service start up costs may be incurred. These may include the following categories. Where possible make estimations of the cost of these activities.

- advertising of the service _____
- community sensitisation _____
- development of record system to ensure confidentiality of HIV results _____
- other (specify) _____

Ongoing/running costs

Estimations for running costs should be made for a specified period e.g. quarterly or annually depending on existing accounting systems

number of additional staff required*

counsellors	FT____	PT____	total salary costs_____
phlebotamists	FT____	PT____	total salary costs_____
clerical/administrative		FT____	PT____ total salary costs_____
laboratory staff	FT____	PT____	total salary costs_____
drivers		FT____	PT____ total salary costs_____
other (specify)		FT____	PT____ total salary costs_____

*some services will use existing clinic staff or redeploy existing funded staff - details of this should be included

additional accommodation required

If additional accommodation is required estimate rental

service running costs

- electricity _____
- water _____
- taxes _____
- rubbish collection, including clinical waste and sharps disposal _____
- transport _____
- laboratory supplies
 - gloves _____
 - needles & syringes _____
 - HIV test kits _____
 - reagents _____
 - equipment _____
 - maintenance _____
- quality control (external) _____

staff training and support

please give detail of training, including frequency of training and numbers of staff involved and estimates of costs

initial training

ongoing training

counsellor support/supervision

appendix i

Modified tool for reviewing quality of VCT associated with MTCT interventions

The following check list can be used where VCT is offered as part of interventions to reduce MTCT of HIV. In some of the pilot projects being developed for MTCT interventions a model of group pre-test information/discussion followed by individual or couple counselling is suggested⁷¹. The following check lists suggests minimum contents and quality of pre and post-test counselling.

Reviewing quality and content of HIV counselling associated with MTCT interventions

1. Background information respondents = VCT managers

What is the VCT setting ?

- ANC clinic
- Hospital VCT services
- Free standing VCT service
- Other

What is the **uptake** of VCT by the antenatal women attending the service?

- 100%
- 90-99%
- 70-89%
- 50-69%
- <50%

What is the **return rate** to collect HIV test results by the antenatal women attending the service?

- 100%
- 90-99%
- 70-89%
- 50-69%
- <50%

⁷¹ UNAIDS/UNICEF/WHO report on Local monitoring and evaluation of the integrated prevention of mother to child HIV transmission in low income countries Abidjan May 1999

2. Observational study of pre-test content

GROUP EDUCATION TOPICS	INDIVIDUAL COUNSELLING TOPICS
<p>1. HIV-Related Issues</p> <ul style="list-style-type: none"> • Knowledge about HIV and transmission • Misconceptions about HIV transmission • Misconceptions about HIV and transmission • The HIV testing process • The ‘window period’ • The meaning and possible implications of +ve and –ve results • The value of getting partner/father involved • Potential needs and available support <p>2. MTCT-Related Issues</p> <ul style="list-style-type: none"> • Full information about HIV in pregnancy and risk of transmission to the infant • Possible benefits of knowing HIV status and interventions available if positive • Testing is not mandatory and antenatal care and other services will not be denied if she decides not to be tested • ARV therapy for MTCT is not a cure/treatment for mother • The need to attend maternity services regularly • Known adverse effects and drug interactions 	<ul style="list-style-type: none"> • Assessment of personal risk of HIV exposure and how to avoid it (e.g., safer sex) • Capacity to cope with a positive result • Potential needs and possible support • Clarification of understanding about information given • Time to think through issues and for answering questions • Informed consent/dissent given freely • Follow-up arrangements after counselling session <ul style="list-style-type: none"> • Implications of a positive result for the baby and for future children • Implications of a positive result for decisions about infant feeding • Implications of a positive result for the relationship with the baby’s father • Desirability of getting partner/father involved • Options for TOP (if available legally and safely) • Previous ARV use • Check for understanding

Post-test counselling

As with post-test counselling in other circumstances, results should always be given individually or to couples who were tested together.⁷² The following check list suggests minimum contents of post-test counselling

3. Observational study of post-test content

INDIVIDUAL COUNSELLING TOPICS

1. Breaking the News

- Results given simply and clearly
- Time allowed for result to sink in
- Checking for understanding
- Discussion of the meaning of the result for the client
- Discussion of personal, family and social implications
- Who to tell, and how to tell them
- Managing immediate emotional reactions
- Checking for immediate follow-up support outside the clinic
- Review options and resources
- Immediate plans, intentions and actions reviewed

2. MTCT-Related Issues

- Explanation of the delivery processes (e.g., maintaining confidentiality through ARV administration in labour)
- Implications of the positive result for the baby and for future children
- Implications of the positive result for decisions about infant feeding (e.g., benefits and risks of breastfeeding) and information on feeding options
- Information on family planning
- Previous ARV use
- Explanation of the ARV regimen and the role of ARVs
- The need for medicines to be taken regularly and according to the regime

3. HIV-Related Issues

- Implications of sharing the positive result for the relationship with the baby's father, and the family
- Desirability of getting the father involved in counselling and follow-up
- Information about safer sex and using condoms to prevent transmission of HIV and STIs
- Options for TOP (if available legally and safely)
- Information about care of the child (including nutritional advice, seeking early treatment for illnesses)
- Information on support services in the community

- Check for understanding
- Next appointment made (possibly with partner)

⁷² UNAIDS/UNICEF/WHO report on Local monitoring and evaluation of the integrated prevention of mother to child HIV transmission in low income countries Abidjan May 1999

4. Counsellor skills

The following check lists suggests a minimum quality for pre and post-test counselling skills.

FUNCTION	SKILLS
1. Interpersonal Relationship	Introduces self Listens actively and supportively Non-judgmental
2. Information-gathering	Uses open questions Seeks clarification Summarizes appropriately
3. Information-giving	Clear and simple Gives time to respond Checks for (mis)understanding Summarizes appropriately
4. Special Circumstances	Appropriate and sensitive discussion Prioritises issues with the client Manages client distress sensitively and appropriately Flexible in involving partner

5. Assessing acceptance of counselling in MCH settings with exit interviews

This is a semi-structured interview. It aims to help assess client satisfaction in counselling, and should be administered by a trained researcher. It should be used on a convenience sample of, e.g., all people receiving counselling within a specific period (e.g., 1 week), who have agreed to be interviewed in this way when asked previously by their counsellor. If the numbers are too large, random sampling may be used at specific periods each day through the week.

The exit interview should be voluntary, undertaken in privacy and confidentiality assured.

Have you talked to your counsellor today about (you may answer more than one):

- | | | |
|--|-----|----|
| I. Having an HIV test | Yes | No |
| II. Receiving test results | Yes | No |
| III. Issues associated with having been tested some time ago | Yes | No |
| IV. The health of your baby | Yes | No |

Did you come specifically to discuss testing for HIV ? Yes No

Did you come specifically to discuss receiving treatment to protect your baby from HIV? Yes No

How long did you wait for your first appointment to visit the Clinic ? _____ days

How long did you wait before someone talked with you in the Clinic ? _____ mins

How much time did you spend with your counsellor today ? _____ mins

How many visits have you made to your counsellor at this Clinic ? _____ visits

Did you feel comfortable with your counsellor ? Yes No

Was there enough privacy during your counselling ? Yes No

What were the good things about your counselling ?

What were the bad things about your counselling ?

What information did you receive from the counsellor ?

Did you see the same counsellor before and after the test ? Yes No

Did you want to see a particular counsellor this time (a specific person) ? Yes No

Would you recommend using this service to a friend or family member ? Yes No

Why ? _____

