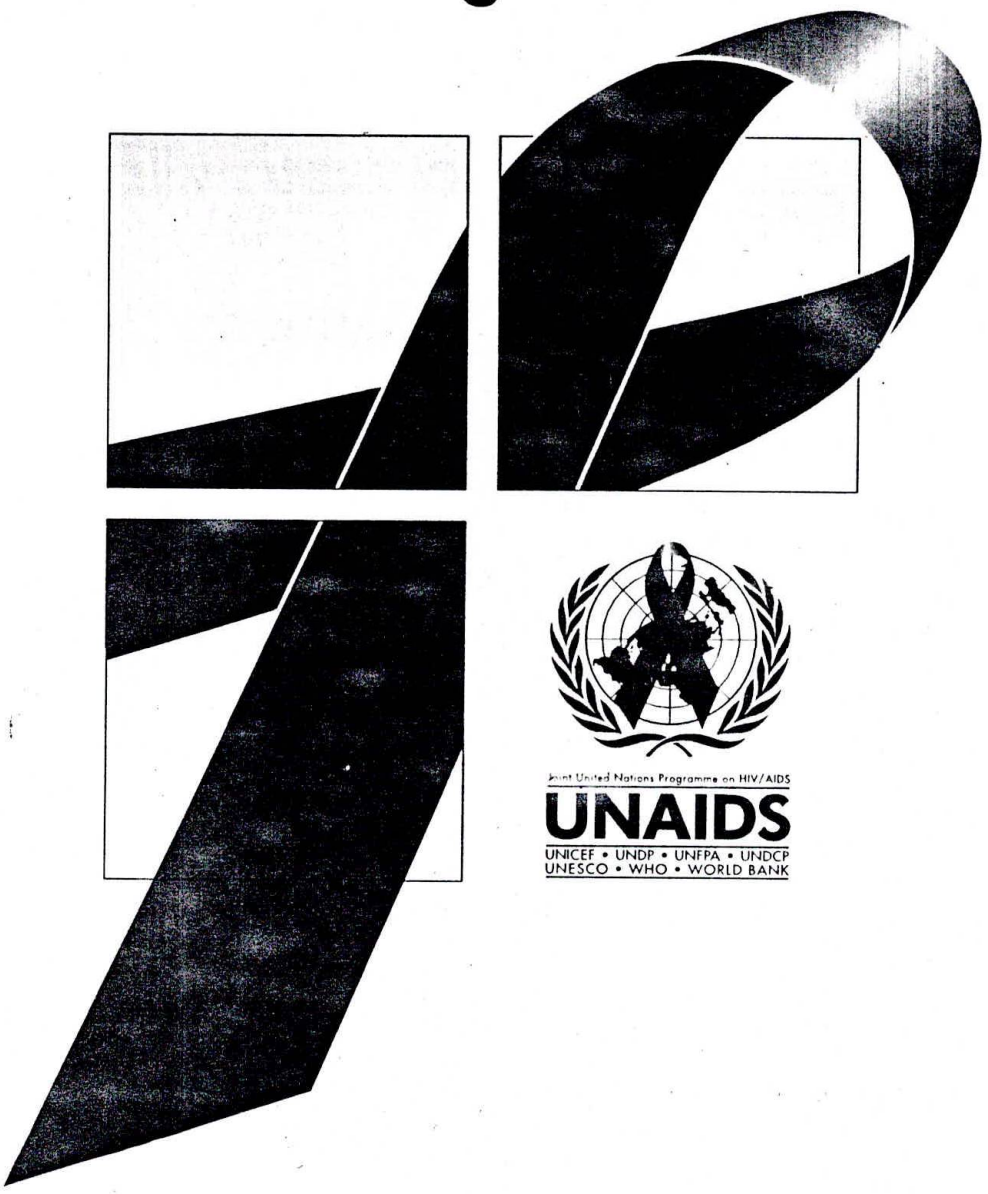
Tools for evaluating HIV voluntary counselling and testing



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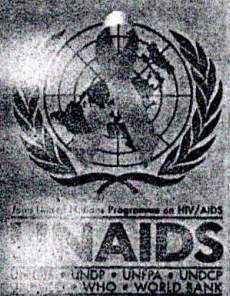
BEST PRACTICE COLLECTION

Tools for evaluating HIV voluntary counselling and testing



Geneva, Switzerland
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Acronyms

ARV	antiretroviral
FGD	focus group discussion
IDU	injecting drug user
MSM	men who have sex with men
MCH	maternal and child health
MTCT	mother-to-child transmission
NGO	non-governmental organization
STI	sexually transmitted infection
TB	tuberculosis
TBPT	tuberculosis preventive therapy
TOP	termination of pregnancy
VCT	voluntary counselling and testing
ZDV	zidovudine (also known as AZT)

Contents

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 the 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 non-governmental organizations (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 have 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 seropositive[5] and adverse consequences, particularly for women, following testing[6]. The development of 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

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 Department of Mental Health HIV/AIDS counselling: participant information and 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, 10th International Conference on AIDS and STDs in Africa, Abidjan, December 1997.
6 Temmerman M et al. The right not to know HIV-test results, *Lancet*, 1996, **345**:696-7.
7 Mwingwa A, Hosp M, Godfrey-Faussett P. Twice weekly tuberculosis preventive therapy in HIV infection in Zambia, *AIDS*, 1998, **12**:2447-2457.
8 WHO/UNAIDS. *Policy statement on preventive therapy against tuberculosis in people living with HIV*, document WHO/TB/98.255 UNAIDS/98.34, 1998.

prophylaxis[9]) and relatively cheap and feasible methods to prevent MTCT[10] 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 are also now recognized[11].

HIV testing methods have also become simpler and cheaper, making testing a more feasible option in many developing countries[12]. The ease of HIV testing has also increased the role of the private sector in VCT in many developing as well as industrialized 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, injecting drug users (IDUs) and refugees. These services need particularly careful monitoring to ensure such groups are not further marginalized 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 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.

9 Sassan-Morokro M et al. *Significant reduction in mortality attributed to cotrimoxazole prophylaxis among HIV infected tuberculosis patients in Abidjan, Côte d'Ivoire.* Abstract 12461, presented at the 12th World AIDS Conference, Geneva, Switzerland, 1998.

10 Centers for Disease Control and Prevention. Administration of zidovudine during late pregnancy to prevent perinatal HIV transmission – Thailand 1996-1998, *MMWR*, 1998, **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, presented at the 12th World AIDS Conference, Geneva, Switzerland, 1998.

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

13 Coates T, Collins C. Preventing HIV infection. *Scientific American*, July 1998, pages 96-97.

14 Sangiwa G et al. *Voluntary HIV counselling and testing (VCT) reduces risk behaviour in developing countries: results from the multisite voluntary counselling and testing efficacy study.* Abstract 33269 presented at the 12th World AIDS Conference, Geneva, Switzerland, 1998.

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

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 that even when further counselling sessions are offered or referral to specialized counselling services is available, many people do not want further counselling, at least not in the immediate future[16]. Some people do, however, require ongoing counselling and some will attend for further counselling in the 1-5 years following VCT. This often coincides 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 organizations providing this service. They should also be able to refer people to community organizations and spiritual/church groups when appropriate.

VCT sites

VCT is being carried out in various settings in developing and industrialized 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. sexually transmitted infections (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)
- Workplace 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 (MSM)
  - children, orphans and street kids

16 Baggaley R et al. *Kara coping study – interim report*, Geneva, UNAIDS/WHO, 1998.

- Self testing/home testing
- Attached to research project/pilot project
  - associated with antenatal services and interventions
  - associated with tuberculosis (TB) services and TB preventive therapy
- Blood transfusion services

Different models of VCT are available in many different settings in developing and industrialized 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 cooperation 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. The Appendix gives an example of how the tools could be modified when evaluating VCT services associated with MTCT interventions.

The tools are presented in a format so they can be photocopied if required. These tools are also available via the UNAIDS website, and may be downloaded and adapted for local circumstances.

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 4.1, 4.2, 4.3 and 4.4 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 cooperation 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 will 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 is unwilling or feels uncomfortable about having someone observe the counselling session, this must be respected.

When using Tool 7, 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 during field-testing of this document 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 of the observer soon after the session started. Counsellors said once they had been reassured that the purpose of the observations was to help them 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 during 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 sessions, 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 cannot, 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 intrusive 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, the counsellors are warned that this evaluation method has been chosen, 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 supervisor and other counsellors observe the role play. One VCT centre has used the four parts of Tool 4 (counselling evaluation) in training sessions for new counsellors where participants took it in turn to be clients.

V Video recording of counselling sessions

Video-recorded counselling sessions have 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, the 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 with 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" ones. Observers stated that they found it easy

to identify good aspects in the counselling sessions as well as areas that could be improved.

(iii) Who should 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 minimized 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 emphasized 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 in 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 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.

SECTION 1

National preparedness for and commitment to 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, 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 those 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 them 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 views in the community are that "HIV=AIDS=death", that "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 unfavourable, interest in VCT will be low. If, however, the community has received education and information on the benefits of VCT for individuals and their families, people are more likely to accept it. VCT services need to be built on the fact that HIV is a discussible disease and that 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 may not be "ready" for VCT, although promoting VCT will help achieve community openness.

For the benefits of VCT to be understood and hence used, services must be endorsed by and included in 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 people living with HIV or AIDS are not well developed and resources are very limited, or when the infrastructure is not sufficiently developed to support VCT services.

However, even if political commitment to VCT does not exist, NGOs can advocate the concept and set up 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 six months later by a policy to set up VCT sites in every province of Thailand.

TOOL 1

For evaluation of the national preparedness for VCT implementation

How to use

respondents = programme planners

This group would include National AIDS Programme (NAP) managers, counselling service coordinators, and NGO coordinators 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 settings ❑

Not a priority ❑

Have VCT services been developed in your country?

Comprehensive country-wide service ❑

Limited service (capital and selected large cities) ❑

Limited service provided by NGOs ❑

Other ❑

Please describe the VCT services in detail

_____

_____

Please describe any obstacles to implementation

_____

_____

_____

_____

Tool 1

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 state whether 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 services	Yes ❑	Being considered ❑	No ❑
Services for young people	Yes ❑	Being considered ❑	No ❑

Services for special groups

MSM	Yes ❑	Being considered ❑	No ❑
Sex workers	Yes ❑	Being considered ❑	No ❑
IDUs	Yes ❑	Being considered ❑	No ❑
Refugees	Yes ❑	Being considered ❑	No ❑
Prisoners	Yes ❑	Being considered ❑	No ❑
Others (please specify below)	Yes ❑	Being considered ❑	No ❑

Tool 1

Are related services available for people living with HIV or AIDS?

Ongoing medical care[17]	Yes ❑	In preparation ❑	No ❑
Ongoing social support	Yes ❑	In preparation ❑	No ❑
Support group for people living with HIV or AIDS	Yes ❑	In preparation ❑	No ❑
Ongoing counselling support	Yes ❑	In preparation ❑	No ❑
Liaison with NGOs	Yes ❑	In preparation ❑	No ❑
Family planning	Yes ❑	In preparation ❑	No ❑
MTCT interventions	Yes ❑	In preparation ❑	No ❑
TBPT	Yes ❑	In preparation ❑	No ❑
ARV interventions	Yes ❑	In preparation ❑	No ❑
Other preventive therapies[18] (please specify)	Yes ❑	In preparation ❑	No ❑

Are HIV preventive services available?

Condom supplies	Yes, country-wide programme ❑	Yes, some sites ❑	No ❑
Services for IDUs	Yes, country-wide programme ❑	Yes, some sites ❑	No ❑
Ongoing counselling	Yes, country-wide programme ❑	Yes, some sites ❑	No ❑
Other (please specify)	Yes, country-wide 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 ❑
- People living with HIV or AIDS ❑
- Others (please specify) ❑

17 Describe what services are available, e.g. CD4, viral load monitoring. Are these services available for all people living with HIV or AIDS or only available for a minority of people who can pay?
18 For example cotrimoxazole prophylaxis, specify intervention.

Tool 1

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 offered[19]

_____

_____

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

_____

_____

Are statistical data about the counselling service regularly compiled? Yes ❑ No ❑

If YES, by whom _____

19 For example, give an indication of the teaching methods, course content, curriculum (if available), etc.
20 For example, are counsellors subject to regular supervision?

SECTION 2

Evaluation of operational aspects of the sites and services

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 supervised space where children can play 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 stigmatizing 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 pseudonym[21], and anonymous testing is commonly available in many industrialized 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, support groups for people living with HIV or AIDS, 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 to be able to make appropriate referrals. Counsellors must also be aware of the

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

special medical needs of people living with HIV or AIDS. 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 people living with HIV or AIDS have been shown to be important in many countries[22], 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 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 strategies[23] 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, large 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 services[24].

It is also important to have a medium-term plan for the service. If a service has to be shut, or scaled down after an initial period, confidence 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 Africa[25] showing that VCT services must be carried out sensitively.

22 WHO. *TASO Uganda, the inside story: Participatory evaluation of the HIV/AIDS counselling, medical and social services.* Geneva, World Health Organization, 1995.

23 UNAIDS/WHO. Recommendations for the selection and usage of HIV antibody tests. *Weekly Epidemiological Record,* 1997, **72**:81-83.

24 *Knowlege is power: voluntary HIV counselling and testing in Uganda.* UNAIDS Best Practice Collection Case Study, Geneva, UNAIDS, 1999.

25 Wilson D. Provisional rapid assessment guidelines for prostitute interventions in sub-Saharan Africa and 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* NARESA Monograph No. 2, 1994.

TOOL 2

For VCT site evaluation: logistic considerations and coverage

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-test counselling are undertaken, do carefully defined procedures exist? Yes ❑ No ❑

Please describe these[26]

Opening hours

Are you open at any of the following times?

- Early evening (after 17:00) No ❑ Yes ❑ (specify how many evenings) ____
- Lunch hour No ❑ Yes ❑
- Weekends No ❑ Yes ❑ (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,
  - private office ❑ cubicle ❑
  - curtained-off area ❑ other (describe) ❑

---

26 For example, do written policies, checklists, data management systems, etc., exist?

Tool 2

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 confidentiality[27]

_____

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 (e.g. 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 (e.g. 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)	_____		

27 For example, are files kept in a locked filing cabinet, is a system in place to protect confidential computerized information?

Tool 2

Describe how the 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 laboratory ❑

All testing carried out in other laboratory ❑

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

_____

Describe the HIV testing schedule employed[28]

_____

_____

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? _____

Are any inducements given to people attending the site?

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

If YES, specify _____

28 For example, schedule for confirmation of test results, policy about testing in the window period.

Tool 2

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 ❑
IDUs	Yes ❑	No ❑

Level of service provision and utilization

In the last 3 months:

How many people have presented at the site? _____

What % of people have had pre-test counselling? _____

What % of people have been tested for HIV? _____

What % of people have returned for their result?[29] _____

What % of people have been given post-test counselling? _____

What % of people have received ongoing counselling? _____

What % of speople 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

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? _____

29 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 used 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 minds.

SECTION 3

Counsellors' requirements and satisfaction

Introduction and background

Counsellor selection

Reports of counsellor selection have indicated that this process is often inadequate[30]. 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 counsellors[31]. 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 counsellors, people living with HIV or AIDS and people from other professions, such as teachers[32], 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. 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-judgemental 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, and possible and available interventions, as well as the role and processes of pre-test, 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-scale[33]. Some centres offer longer, more in-depth training. The need for refresher courses and ongoing training and support is widely recognized.

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 recognized by

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

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

32 Baggaley R et al. HIV stress in the classroom and at home as identified by primary school teachers in Lusaka, Zambia. *International Journal of Public Health*, 1999, 77(3):284-288.

33 Regional AIDS Training Network, Nairobi, Kenya, 1999.

their colleagues as being important. Furthermore, other routine activities often take precedence 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 recognized 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[34,35]. In order to minimize "burnout", and avoid losing valuable and experienced staff, regular support 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 communities[36]. The questions on burnout have been adapted from previous studies[37]. Counsellors may be able to function more effectively if they alternate their counselling with other activities. It must also be recognized 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 surface[38]. Counsellors who are themselves living with HIV or AIDS report particular need for support as, when they give seropositive results, they may relive their own experiences and empathize too closely with their clients who test seropositive. These counsellors also reported the benefits of alternating counselling with other activities. In some countries counsellors have formed groups to provide mutual support and to 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.

34 Baggaley R et al. HIV counsellors' knowledge and attitudes and vulnerabilities to HIV. *AIDS Care,* 1996, **8**:155-166.

35 Kalibala S. 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, 1995.

36 van Dis H, van Dongen E. *Burnout in HIV/AIDS health care and support,* Amsterdam University Press, 1993.

37 Questions adapted from Miller D. *Dying to care? Work, stress and burnout in HIV/AIDS. Social aspects of AIDS,* London, Routledge, 2000; Bennett, Kelaher & Ross, AIDS impact scale, 1992; Maslach & Jackson, Maslach Burnout Inventor, 1982.

38 WHO. *TASO Uganda, the inside story: Participatory evaluation of the HIV/AIDS counselling, medical and social services.* Geneva, World Health Organization, 1995.

TOOL 3

For evaluation of counsellor selection, training and support

How to use

This tool is not designed to evaluate the individual counsellor's counselling skills and counsellor competence, which will be covered in the section on counselling evaluation. Rather 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-judgemental and allow the interviewee to express his/her anxieties. Additional points and comments may be recorded where appropriate.

What is your background?

- Nurse ❑
- Clinical officer ❑
- Social worker ❑
- Person living with HIV or AIDS ❑
- Other (specify) _____

Selection

How were you selected to be a counsellor?

- Proposed by senior colleague ❑
- Self-motivated (expand)[39] ❑

_____

_____

Do you feel that you have been pressurized into doing counselling? (explain)[40]

_____

_____

Training

Describe the counselling training have you received?[41]

_____

_____

How would you rate your counselling training?

very good ❑ good ❑ adequate ❑ inadequate ❑

39 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.

40 For example, is counselling something you feel comfortable doing, or do you feel it is a strain, or that you have to do it as part of your job?

41 For example, number of courses and duration of courses attended.

Tool 3

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

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? Yes ❑ No ❑
If YES, 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? Yes ❑ No ❑
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 _____

Tool 3

"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

_____

_____

_____

Tool 3

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 _____ hours
Counselling about other issues _____ hours
Other work (specify) _____ hours

How many days per week do you do counselling?

_____

_____

How many clients do you 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[42]?

_____

_____

42 For example, "...will go on with my counselling job for the foreseeable future", "...find counselling too stressful/difficult and want to find a new job".

SECTION 5

Counselling for special interventions

5a Counselling for TBPT

Introduction and background

Tuberculosis (TB) is the leading cause of death in people with HIV in many countries. In countries where TB is common many people will have been infected, sub-clinically, during childhood and adolescence. If they then become infected with HIV a reactivation of this latent TB infection can occur causing clinical disease. It has been shown that by giving tuberculosis preventive therapy (TBPT), usually isoniazid 300 mg daily for 6 months, the incidence of clinical TB in people with HIV can be halved[43]. It is, however important to screen people for active TB before TBPT is given. It has been proposed that TBI could be offered to seropositive people following VCT[44]. Specific information needs to be discussed with clients during the post-test counselling session. In addition, the following areas would have to be covered during the post-test counselling session.

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

44 WHO/UNAIDS *Policy statement on preventive therapy against tuberculosis in people living with HIV,* document WHO/TB/98.255 UNAIDS/98.34, 1998.

TOOL 5.1

For evaluation of counselling content for TBPT

How to do

respondents = observers of counselling sessions

This section should be completed by an external assessor, counselling supervisor or counsellors who have 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 three to five sessions need to be observed at each counselling site. Where there are many counsellors, a random sample (three to five), 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 one or two counsellors exist, three to five 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 there are irreconcilable concerns about observations by supervisors, alternative evaluation methods include using peer counsellors as observers, role play or audio-taped consultations (see **Introduction**).

During the session have the following occurred?

Have specific questions about TB and TB treatment been covered?

Questions for TB screening (symptoms explored)

Cough	Yes ❑	No ❑
Productive	Yes ❑	No ❑
Fever	Yes ❑	No ❑
Weight loss	Yes ❑	No ❑
Family contact with TB	Yes ❑	No ❑

Contraindications and cautions to TBPT discussed

Drug reactions	Yes ❑	No ❑
Other medicines being taken	Yes ❑	No ❑
Pregnancy	Yes ❑	No ❑
Past history of TB	Yes ❑	No ❑
Past history of TB medication	Yes ❑	No ❑

Explanation of TBPT adequately given including

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

5b Counselling for MTCT interventions

Introduction and background

The risk of HIV transmission from 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 by avoiding breastfeeding. Preliminary results from trials of single-dose intrapartum and postpartum (to the infant) Nevirapine have also shown significant reductions in MTCT[45]. To be able to make informed decisions about infant feeding and access to antiretroviral (ARV) therapy, where this is available, a pregnant woman 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 to take ARVs, both of 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 areas of high HIV prevalence 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 babies due to the high viral load associated with acute infection[46].

Studies have indicated that, for women testing in the antenatal setting, there is great benefit for women of being tested together with their partners[47 48]. 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 pilot projects on MTCT prevention it is usual for this to occur, and disclosure to partners may only happen in a minority of cases. Where interventions to prevent MTCT are available, antenatal testing should always be offered to couples. Testing women individually should be the exception (at the woman's request) and not the rule.

45 Guay L, Musoke P, Fleming T, et al. Intrapartum and neonatal single-dose nevirapine compared with zidovudine for prevention of mother-to-child transmission of HIV-1 in Kampala, Uganda: HIVNET 012 randomised trial, *Lancet*, 1999, **354**:795-802.

46 UNICEF/UNAIDS/WHO. *A review of HIV transmission through breast-feeding in HIV and Infant feeding*, 1999, CHD/98.3

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

48 Allen S, Tice J, Van der Perre P. Effect of serotesting with counselling on condom use and seroconversion among HIV discordant couples in Africa, *BMJ*, 1992, **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 three to five sessions need to be observed at each counselling site. Where there are many counsellors, a random sample (three to five) 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 one or two counsellors exist, three to five 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 there are irreconcilable concerns about observations by supervisors, alternative evaluation 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 HIV-positive result for her baby	Yes ❑ No ❑
Implications of a HIV-positive result for future children	Yes ❑ No ❑
Implications of a HIV-positive result for decisions about infant feeding	Yes ❑ No ❑
Implications of a HIV-positive 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 HIV-positive 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 termination of pregnancy (TOP) (if available legally and safely)	Yes ❑ No ❑

Tool 5.2

Post-test counselling for HIV-positive 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 regimen 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 HIV-negative 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 maximize 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[49]. 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-judgemental and inclusive of different beliefs (religious, cultural, medical, etc.) of group members
- refraining from "lecturing" the group – allowing the group to learn from each other's experiences.

There are many examples of post-test groups where people gain mutual support from people who have been through VCT[50]. 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.

49 Allen S et al. Confidential HIV testing and condom promotion in Africa. *JAMA*, 1992, **8**:3338-3343.
50 WHO. *TASO Uganda, the inside story: Participatory evaluation of the HIV/AIDS counselling, medical and social services*. Geneva, World Health Organization, 1995.

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 fewer than 20.

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 group work

How to do

respondents = observers 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 three to five 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	_____
Ensuring 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	_____
	Summarizes main issues discussed	3 2 1	_____
Giving information	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	_____
	Summarizes main issues	3 2 1	_____
Handling special circumstances	Accommodates language difficulty/ differences in the group	3 2 1	_____
	Talks about sensitive issues plainly and appropriately for the culture/group composition	3 2 1	_____
	Prioritizes issues to cope with limited time	3 2 1	_____
	Manages participants' 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 in order 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[51 52]. In attempts to evaluate these matters, generic tools have been developed to be administered by research workers to clients after counselling sessions. One has been used in several developing and middle-income developed countries and was modified for use in Zambia where it has been most extensively used. The modified questionnaire included many open-ended questions to explore people's attitudes, feelings and behaviour in depth following VCT: 377 people were interviewed on three occasions during the two 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[51 54 55].

Areas covered in the Zambian VCT 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
- Terminal care

51 Temmerman M et al. The right not to know HIV-test results. *Lancet*, 1994, **345**:696-697.
52 McGreal C. This is worse than apartheid. *The Guardian*, London, 16 March 1999.
53 Kayawe I et al. *Client's views on HIV counselling and testing. Is it helpful?* Abstract 33265, 12th World AIDS Conference, Geneva, Switzerland, June 1998.
54 Baggaley R, Kelly M, Mulongo W. *To tell or not to tell: sharing HIV results with sexual partners*, SANASO Conference in Mbabane Swaziland, October 1997.
55 Baggaley R et al. HIV counselling and testing in Zambia: The Kara counselling experience, *SAfAIDS News*, 1998, **6**(2):1-9.

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[56,57,58]. 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 VCT in groups of people who had been tested and had received their test results compared with groups of people who were not told their test results[59].

(ii) Sharing results

To make changes in sexual behaviour to reduce HIV transmission following VCT, 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[60,61]. However, unless couples present together, or are particularly targeted, reports have often shown a low level of partner notification and subsequent partner testing[62]. 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 tested positive did not exceed 1% in West Africa and 5% in South Africa[63]. However, in Zambia, although people were often reluctant to share their test results initially, over time

56 Sangiwa G et al. *Voluntary HIV counselling and testing (VCT) reduces risk behaviour in developing countries: results from the multisite voluntary counselling and testing efficacy study,* Abstract 33269 presented at the 12th World AIDS Conference, Geneva, Switzerland, 1998.

57 Moore M et al. *Impact of HIV counselling and testing in Uganda,* Abstract WS-C16-4 presented at the 9th International Conference on AIDS, Berlin, Germany, 1993.

58 Allen S et al. Confidential HIV testing and condom promotion in Africa, *JAMA,* 1992, **8**:3338-3343.

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

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

61 Williams G. *From fear to hope. AIDS care and prevention at Chikankata Hospital, Zambia,* Strategies for Hope 1, Actionaid, 1990, ISBN 1 87250214 8.

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

63 Cartoux M et al. *Acceptability of voluntary HIV testing and interventions to reduce mother-to-child transmission of HIV in developing countries,* Ghent International Working Group/UNAIDS/EU Final report, 1999.

more people were able to discuss this with their partner and the vast majority were able to tell someone about it. 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 pressurizing 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 them 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

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.

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. one 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 interviews will be voluntary and the clients should be assured that they are anonymous and confidential.

Have you talked to your counsellor today about:

Having an HIV test	Yes ❑	No ❑
Receiving test results	Yes ❑	No ❑
Issues arising from an HIV test taken some time ago	Yes ❑	No ❑
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

_____

_____

Tool 7

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

Costs 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[64 65 66 67]. 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 start-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 woman tested
Mansergh in a sub-Saharan African developing country setting 1996: US$ 18.50
Mansergh in a sub-Saharan African developing country setting 1998: US$ 8.00
Marseille in a sub-Saharan African developing country setting 1998: US$ 4.00

The costs described in these models are based only on the cost of HIV testing, rental of premises and staff time and are less that 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:

Organization 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 supervision to ensure quality of counselling and to minimize staff burnout

64 Mansergh G et al. Cost-effectiveness of short-course zidovudine to prevent perinatal HIV type 1 infection in a sub-Saharan African developing country setting, *JAMA*, 1996, **276**(2):139-145.
65 Mansergh G et al. (1998) Cost-effectiveness of zidovudine to prevent mother to child transmission of HIV infection in a sub-Saharan African developing country setting, *JAMA*, 1998, **280**(1):30-31.
66 Marseille E, Kahn J, Saba J. Cost-effectiveness of zidovudine to prevent mother to child transmission of HIV infection in a sub-Saharan African developing country setting, *AIDS*, 1998, **12**(8):939-948.
67 Wilkinson D, Floyd K, Gilks C. Antiretroviral drugs as a public health intervention for pregnant HIV infected women in rural South Africa: an issue of cost-effectiveness and capacity, *AIDS*, 1998, **12**(13):1675-82.

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 sensitization _____

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 _____
Phlebotomists	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.

_____

_____

Tool 8

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 details of training, including frequency of training and numbers of staff involved and estimates of costs:

Initial training

_____

_____

Ongoing training

_____

_____

Counsellor support/supervision

_____

_____

Appendix

Modified tool for reviewing quality of VCT associated with MTCT interventions

The following checklist 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 suggested[68]*. The following checklists suggest 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% ❑

68 UNAIDS/UNICEF/WHO. *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*
1. HIV-related issues	
❑ Knowledge about HIV and transmission	❑ Assessment of personal risk of HIV exposure and how to avoid it (e.g. safer sex)
❑ Misconceptions about HIV transmission	❑ Capacity to cope with a positive result
❑ The HIV testing process	❑ Potential needs and possible support
❑ The "window period"	❑ Clarification of understanding about information given
❑ The meaning and possible implications of HIV-positive and HIV-negative results	❑ Time to think through issues and for answering questions
❑ The value of getting partner/father involved	❑ Informed consent/dissent given freely
❑ Potential needs and available support	❑ Follow-up arrangements after counselling session
2. MTCT-related issues	
❑ Full information about HIV in pregnancy and risk of transmission to the infant	❑ Implications of a positive result for the baby and for future children
❑ Possible benefits of knowing HIV status and interventions available if positive	❑ Implications of a positive result for decisions about infant feeding
❑ Testing is not mandatory and antenatal care and other services will not be denied if mother decides not to be tested	❑ Implications of a positive result for the relationship with the baby's father
❑ ARV therapy for MTCT is not a cure/ treatment for mother	❑ Desirability of getting partner/ father involved
❑ The need to attend maternity services regularly	❑ Options for termination of pregnancy (if available legally and safely)
❑ Known adverse effects and drug interactions	❑ 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. The following checklist 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 regimen

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 termination of pregnancy (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)

4. Counsellor skills

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

FUNCTION	SKILLS	
1. Interpersonal relationship	Introduces self	❑
	Listens actively and supportively	❑
	Non-judgemental	❑
2. Gathering information	Uses open questions	❑
	Seeks clarification	❑
	Summarizes appropriately	❑
3. Giving information	Clear and simple	❑
	Gives time to respond	❑
	Checks for (mis)understanding	❑
	Summarizes appropriately	❑
4. Special circumstances	Appropriate and sensitive discussion	❑
	Prioritizes 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, for example, all people receiving counselling within a specific period (e.g. one 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):

Having an HIV test	Yes ❑	No ❑
Receiving test results	Yes ❑	No ❑
Issues associated with having been tested some time ago	Yes ❑	No ❑
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?

_____

_____

_____

Further reading from UNAIDS

See also http://www.unaids.org for a full listing of UNAIDS publications

Caring for Carers: Managing stress in those who care for people with HIV and AIDS. UNAIDS Best Practice Collection Case Study, Geneva, UNAIDS, 2000 (available in English)

Comfort and hope: Six case studies on mobilizing family and community care for and by people with HIV/AIDS. UNAIDS Best Practice Collection Case Study, Geneva, UNAIDS, 1999 (available in English)

Counselling and HIV/AIDS. UNAIDS Best Practice Collection Technical Update, Geneva, UNAIDS, 1997 (available in English, French and Spanish)

Counselling and voluntary HIV testing for pregnant women in high HIV prevalence countries: Elements and issues. UNAIDS Best Practice Collection Key Material, Geneva, UNAIDS, 1999 (available in English, French and Spanish)

From principle to practice: Greater involvement of people living with or affected by HIV/AIDS (GIPA). UNAIDS Best Practice Collection Key Material, Geneva, UNAIDS, 1999 (available in English, French and Spanish)

Knowledge is power: Voluntary HIV counselling and testing in Uganda. UNAIDS Best Practice Collection Case Study, Geneva, UNAIDS, 1999 (available in English and French)

Voluntary Counselling and Testing (VCT). UNAIDS Best Practice Collection Technical Update, Geneva, UNAIDS, 2000 (available in English)

The Joint United Nations Programme on HIV/AIDS (UNAIDS) is the leading advocate for global action on HIV/AIDS. It brings together seven UN agencies in a common effort to fight the epidemic: the United Nations Children's Fund (UNICEF), the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), the United Nations International Drug Control Programme (UNDCP), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the World Health Organization (WHO) and the World Bank.

UNAIDS both mobilizes the responses to the epidemic of its seven cosponsoring organizations and supplements these efforts with special initiatives. Its purpose is to lead and assist an expansion of the international response to HIV on all fronts: medical, public health, social, economic, cultural, political and human rights. UNAIDS works with a broad range of partners – governmental and NGO, business, scientific and lay – to share knowledge, skills and best practice across boundaries.

Joint United Nations Programme on HIV/AIDS

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