THE REPUBLIC OF UGANDA

Uganda National Policy on HIV Counseling and Testing

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Uganda National Policy on HIV Counseling and Testing

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Acronyms

AIC	AIDS Information Centre
AIDS	Acquired Immuno-Deficiency Syndrome
AIM	AIDS/HIV Integrated Model District Programme
ANC	Antenatal clinic
ART	Antiretroviral therapy
CDC	The US Centers for Disease Control and Prevention, Uganda
CHCT	Couples HIV Counselling and Testing
CME	Continuing medical education
CT 17	VCT coordination team of 17 stakeholders
DBS	Dry blood spot
DDHS	Director of District Health Services
HBHCT	Home-based HIV Counselling and Testing
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HSD	Health sub-district
HSSP II	MOH Health Sector Strategic Plan
JCRC	Joint Clinical Research Centre
LMIS	Logistics Management Information System
M&E	Monitoring and Evaluation
MOH	Ministry of Health
NHRL	National Health Reference Laboratory
PEP	Post-exposure prophylaxis
PHAs	People living with HIV/AIDS
PMTCT	Prevention of mother-to-child transmission of HIV
PWDs	People with disabilities
PTCs	Post-test clubs
RTC	Routine Testing and Counselling
STI	Sexually Transmitted Infection
TASO	The AIDS Support Organisation
TB	Tuberculosis
TOT	Training of trainers
VCT	Voluntary Counselling and Testing
UHSBS	Uganda HIV/AIDS Sero-Behavioural Survey
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNCRC	UN Convention on the Rights of the Child
UNICEF	United Nations Children's Fund
USAID	US Agency for International Development
WHO	The World Health Organization

Foreword

Human Immunodeficiency Virus (HIV) counselling and testing (HCT) remains a pivotal service in the management HIV/Acquired Immuno-Deficiency Syndrome (AIDS) and a vital entry point to HIV/AIDS prevention and care services.

In Uganda, HCT began in 1990 with Voluntary Counselling and Testing (VCT) as the main model of implementation. In 2002 the Ministry of Health developed the first VCT policy which aimed to put high-quality VCT services within the reach of every Ugandan. This vision is well underway, and as of now about three million Ugandans have received HCT services. However, with the advent of affordable treatment options, there is urgent need to increase access to HCT in order to reach those who need treatment, care and support.

To help meet this need, the Government of Uganda, in keeping with its reputation for pioneering HIV/AIDS initiatives, has taken a bold stand to adopt new approaches to delivery of HCT. These include routine testing in clinical settings, home and family-based counselling and testing. These approaches are designed to remove some of the barriers to testing imposed by the VCT approach itself.

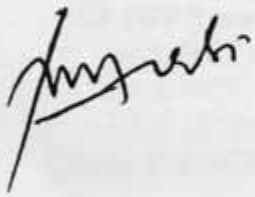
The revised policy also provides improved guidance on HCT for children and People with disabilities (PWDs), which were developed with support from the United Nations Children's Fund (UNICEF). The Government of Uganda is committed to increasing access to HCT services while also assuring that HCT services protect human rights.

Revisions to the policy are evidence-based and were guided by international scientific and programmatic advances in HIV counselling and testing, as well as findings of studies conducted in the country. The review process was conducted with technical and financial support from the Centers for Diseases Control and Prevention (CDC) Uganda, UNICEF and the US Agency for International Development (USAID) and based on the review of many global, regional and national policies.

The Government of Uganda has followed an open and participatory approach to the development of this policy. The process was highly consultative involving participation of stakeholders in six regional meetings country wide. The academic and medical communities have also reviewed and approved the policy revisions at various levels.

I am therefore convinced that these guidelines are based on cutting-edge research data, vast experience in delivering services and address community concerns.

It is my sincere hope that the guidelines provide a framework for reaching many with high-quality and ethical HCT services. I therefore take this opportunity to express the gratitude of the Ministry of Health to all the people and institutions listed in the acknowledgement for the selfless work they did to review these excellent guidelines.



Dr. Sam Zaramba

Ag. Director General of Health

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The development of these policy guidelines was made possible by the input of e individuals, who participated in the consultations and stakeholders' meetings that led to the formulation of these guidelines. The following, listed by organisation/ institutions, are acknowledged for their time, dedication and contribution.

Centers for Disease Control and Prevention (CDC) Uganda.

USAID

UNICEF

World Health Organization (WHO) Uganda

Ministry of Health STD/ACP

Ministry of Health – Disability Project

AIDS/HIV Integrated Model District(AIM)

Uganda Programme for Human and Holistic Developpment (UPHOLD)

JAP/CDC Project

The Strengthening HIV Counselor Training Project (SCOT)

Research Triangle International(RTI)

CRD

Population Services International

UgandaDELIVER - MOH

DANIDA

AHA

Hospice Africa

The AIDS Support Organization (TASO)

AIDS Information Center (AIC)
Joint Clinical Research Centre (JCRC)

PWDs

FPAU
All Regional Hospitals

All district Hospitals
Nsambya Home Care

Regional Centre Quality Health Care

The Mildmay International Study Centre Uganda

Uganda AIDS Commission

Uganda Business Coalition

Uganda Cares, AIDS Health Care Foundation

Health and Law

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Dr. Alex Opio, Assistant Commissioner, National Disease Control and Dr. Elizabeth Madraa, STD/AIDS Control Programme Manager who facilitated and supported the development of these guidelines.

1. Introduction

This document replaces the 2003 document "Uganda National Policy Guidelines for HIV Voluntary Counselling and Testing". The revision was prompted by scientific and programmatic advances in HIV Counselling and Testing as well as advances in prevention, treatment and care of HIV-infected persons. These advances include increased access to effective treatment for HIV infection and opportunistic infections and new testing approaches and technologies. Since these new guidelines incorporate VCT among a broader range of testing approaches, the title has changed to "Uganda National Policy Guidelines for HIV Counselling and Testing".

There are two related national policy documents regarding HCT services in Uganda: "Uganda National Policy Guidelines for HIV Counselling and Testing" and "Uganda National Policy Implementation Guidelines for HIV Voluntary Counselling and Testing". This document, the "Policy Guidelines" states what should and what should not be done regarding HCT in Uganda. Policy-makers and planners of HIV/AIDS programmes are the main target audience for the policy guidelines.

The related document is the Uganda National Policy Implementation Guidelines for HIV Counselling and Testing Services, which restates the national policy on HCT and goes further to spell out how the policy should be implemented. The "Implementation Guidelines" are intended for HIV/AIDS programme managers and service providers but also serve as a useful resource for policy-makers and planners.

The objectives of HCT policy are:

- To provide a framework for providing HCT services in Uganda.
- To empower HCT service providers to deliver HCT services appropriately to all people.
- To make HCT services part of the wider health care system to help bring about positive behaviour change for prevention of HIV transmission.

1.1. Process of development of the policy guidelines

These guidelines were developed through a highly consultative process and following the principles of consensus building. The process began with presentations of the evidence - based information from researchers in Mulago National Referral Hospital and Mbarara University Teaching Hospital as well as studies conducted by CDC Uganda and AIDS Information Center (AIC) Uganda. Study findings were presented at national level stakeholder meetings and in six regional workshops. Input from young people and persons with disabilities was specifically sought and incorporated.

The writing process was supported by USAID, the AIDS/HIV Integrated Model Programme (AIM) and CDC with extensive consultation and review by partners and stakeholders. The fully reviewed and revised draft was submitted to the HCT Coordination Team of 17 stakeholders (CT 17) and the Ministry of Health (MOH) senior management team for final approval.

2. Background

2.1. Uganda's Response to the HIV/AIDS Pandemic

Uganda's national response to the HIV/AIDS pandemic has been recognized worldwide. Its success in reducing HIV prevalence is considered unique in Africa and is rooted in the participation of all sectors of society under the guidance of strong and committed leadership.

The virus was first identified in Uganda in the early 1980s and prevalence peaked in 1992 at an estimated 18%. Today, according to the preliminary results of the recent Uganda HIV/AIDS Sero-Behavioural Survey (UHSBS) of 2004/5, the national prevalence of HIV is estimated at 7%. There are indications, however, that declines in prevalence have begun to stagnate over the past four years, and that massive inputs to combat the spread of HIV are not keeping pace with the evolution of the epidemic.

The country began providing VCT services in 1990 and VCT remains the main model of implementation in 2005. In 2003, AIC reported that fewer than one million people had tested for HIV in its 14 years of existence. Even today about 15% of the adult Ugandan population have had access to HCT and know their HIV status, but 70% want to test.

Faced with this enormous demand, the Government of Uganda determined to make every effort to expand the range of testing services. This revised policy reflects that determination. The government remains committed to assuring that these expanded HCT services are grounded in human rights and that, HCT clients and patients have access to HIV prevention messages, commodities and services.

2.2. Rights-Based Approach

HCT services in Uganda conform to the Joint United Nations Programme on HIV/AIDS (UNAIDS)/World Health Organization (WHO) Policy Statement on HIV Testing (June 2004) which states that HIV testing:

...must be grounded in sound public health practice and respect, protection, and fulfilment of human rights norms and standards and that consent and confidentiality in testing must remain at the heart of all HIV policies and programmes, both to comply with human rights principles and to ensure sustained public health benefits.

The Ugandan Government has adopted the UNAIDS/WHO recommendations that HCT policies incorporate the following factors:

1. *Ensuring an ethical process for conducting the testing, including defining the purpose of the test and benefits to the individuals being tested; and assurances of linkages between the site where the test is conducted and relevant treatment, care and other services, in an environment that guarantees confidentiality of all medical information;*

2. *Addressing the implications of a positive test result, including among others, human rights and access to sustainable treatment and care for people who test positive*

3. *Reducing HIV/AIDS-related stigma and discrimination at all levels, notably within health care settings;*

4. *Ensuring a supportive legal and policy framework within which the response is scaled up, including safeguarding the human rights of people seeking services;*

5. *Ensuring that the healthcare infrastructure is adequate to address the above issues, and that there are sufficient trained staff in the face of increased demand for testing, treatment, and related services.*

2.3. Policy Framework

These policy guidelines are based in, support and operationalize principles outlined in the following policy documents:

- Uganda Constitution
- The HIV/AIDS Policy for Uganda
- The Health Sector Strategic Plan II: 2005-2010
- Revised National Strategic Framework for HIV/AIDS Activities in Uganda: 2003/04-2005/06
- The National Monitoring and Evaluation Framework for HIV/AIDS in Uganda, June 2004
- The Children Statute, 1996

The MOH's Health Sector Strategic Plan (HSSP II), for instance, is the framework that guides "ALL interventions by ALL parties at ALL levels of the national health system". HCT services directly support the HSSP II strategies to reduce new HIV infection and identify persons living with HIV/AIDS.

The Revised National Strategic Framework for HIV/AIDS Activities in Uganda has three goals: 1) to reduce HIV prevalence by 25%, 2) to mitigate the effects of the epidemic on the quality of life of people infected and affected by the virus as well as on national development, and 3) to strengthen the national capacity to respond to the epidemic. These HCT Policy Guidelines are critical to achievement of goals 1 and 2, and reflect the improved capacity to respond to goal 3.

These Policy Guidelines establish systems and supports to assure that key data is available to support the goals of the National Monitoring and Evaluation Framework for HIV/AIDS. Finally, the Policy Guidelines reinforce the human rights described in the Ugandan Constitution and in the Children Statute.

3. Programme Guidelines

Programmes including the private sector offering HIV testing must conform to national standards for delivery of services. At a minimum, HCT services must have personnel, space for confidential counselling, and a laboratory or materials for conducting HIV testing. HIV counselling and testing must be conducted according to service guidelines described in Section 4.

3.1. Human Resources

HCT must be performed by qualified personnel. Personnel include counsellors, counselling assistants, laboratory personnel, clinicians, and community counselling aides. Only trained counsellors or health workers trained in HCT should provide HIV pre- and post-test information or counselling. When staff is limited, appropriately trained assistants may provide these services. HCT sites should ensure that all HCT providers have sufficient skills to offer comprehensive HCT services.

3.1.1. Qualifications of Counsellor Trainers

HCT Trainers should have counselling skills and must undergo the Training of Trainers (TOT) course recommended by MOH. The background education of counsellor trainers may be medical or non-medical, but counsellor trainers should have strong background knowledge on HIV/AIDS. The trainer's knowledge and skills should be regularly supervised, reviewed and updated.

3.1.2. Counsellor Qualifications

HCT service providers should have an educational background of at least 'O' level or its equivalent. This applies equally to those with or without a medical background.

3.1.3. Training in HIV Counselling and Testing

Initial training for HCT service providers with Ministry of Health approved trainers and curriculum is recommended but not required. Initial HCT counsellor training curricula should include content (see details on topics covered in Implementation Guidelines) for no less than two weeks of classroom instruction and one week of practical experience. All HCT providers (including lay and medical personnel, lab staff, and those who have and have not participated in the standard training) must: 1) meet minimum qualifications, 2) demonstrate mastery of the content of an MOH approved HCT curriculum, 3) complete 3 months of supervised practice with endorsement by a counsellor supervisor and 4) pass a final assessment.

After earning the basic certificate to provide HCT, providers should regularly update their knowledge through refresher and in-service training. Health workers are required to earn 24 hours of continuing medical education (CME) per year as per national guidelines. Non-medical HCT providers should participate in an equivalent number of hours of refresher training per year in order to assure highest-quality HCT services.

3.1.4. Certification and registration of HCT Providers

The process of certification and enrolment in a national register will soon be determined and implemented by Ministry of Health.

3.1.5. HCT Provider support

HCT providers need support to:

- prevent burnout[1]
- share experiences and learn from each other
- receive technical updates
- provide quality control

Regular meetings of HCT providers can support and encourage them. HCT providers should also receive support and should learn through regular meetings with their supervisors. Supervisors can handle administrative and professional issues, and provide personal and professional support during supervision meetings.

3.1.6. Who should perform the HIV test?

Where available, medical laboratory technicians are best suited to perform rapid HIV testing. However, where staff shortages exist, other medically trained personnel or counsellors can be trained to carry out HIV rapid tests. These personnel should be under the supervision of a medical laboratory technician. In Uganda, clients must NOT perform their own HIV tests.

3.2. Environment/Setting

In Uganda, HCT may be conducted in a variety of settings – from a client's home to a busy medical ward. Regardless of the setting, it is essential that confidentiality be provided to the client to allow for free discussion of sensitive personal issues. Basic furniture at a static HCT site is two or three chairs and a table. In community settings HCT may be carried out with the counsellor and client seated on mats. In such cases the counsellor may require a clipboard to make writing easier. In the in-patient setting, counselling may be done at the bedside if confidentiality can be ensured. In all cases there must be access to testing space and/or equipment for HIV testing.

3.3. Monitoring and Evaluation

Monitoring and Evaluation (M&E) of HCT services supports tracking of programme indicators in The National Monitoring and Evaluation Framework for HIV/AIDS in Uganda (Republic of Uganda/UAC, June 2004). M&E is required for all HCT sites and proper record keeping is the responsibility of all HCT staff.

3.3.1. M&E Tools

HCT providers should be familiar with all tools for collecting information for monitoring and evaluation, including:

- Client Cards[2]
- HCT Registers[2]
- Laboratory HIV Test Results Forms
- Health Management Information System (HMIS) Forms

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[1] "Burnout" is a reaction to the stress of HIV counselling and testing work that can affect the provider's physical and emotional well-being.

[2] Samples of these forms can be found in Annexes in the implementation guidelines.

- Logistics Management Information System (LMIS) Forms (Stock logistics forms)
- Special data collection forms (e.g. HCT Annual Review Tool)
- Tally sheets for compiling service statistics

3.3.2. HCT Indicators

Indicators for HCT services included in the HMIS forms are listed below. HCT sites should maintain record keeping systems that accurately track this information. If possible, site registers should include information on the gender of clients, as well as their age, to facilitate accurate reporting of these elements when required.

1. Number of people counselled
2. Number of people tested for HIV
3. Number of first time testers
4. Number of repeat testers
5. Number receiving test results
6. Number testing positive
7. Number of couples counselled and tested
8. Number of clients referred for HCT
9. Number of HIV+ screened for tuberculosis (TB)

3.3.3. Reporting

Data collected on HCT services should be used to make decisions at all levels. Site data should be analysed and shared with site staff. All HCT sites are required to compile service statistics (usually along with data from all Health Centre units) each month and submit them to the Health Sub-District (HSD) as part of the monthly report. The health sub-district must compile and forward these statistics to the Director of District health services (DDHS) on a monthly basis. The DDHS merges data from all HSD and submits quarterly reports to the national level as per HMIS guidelines. Central, district and HSD levels should make sure that reports are sent back to the lower levels.

3.4. Quality Assurance

HCT service standards are set in this document and include:

- Competent personnel (counselling and laboratory)
- Appropriate infrastructure
- Appropriate test kits and protocols

Policy guidelines on assuring that the services meet a minimum standard of quality are detailed in the MOH QA system and policy.

3.4.1 Monitoring Quality of Services

Monitoring quality of services is the responsibility of all members of the health team but always requires support from supervisors and managers. HIV Testing Quality Control must be performed in all HCT sites through collection of 3% of positive and negative samples.

Other methods of monitoring quality of services are described below but the details are in the policy implementation guidelines.

- Analysis of service statistics
- Supportive supervision

- Observation of counselling sessions
- Client Satisfaction Assessment
- Supervision of lab personnel
- External validation of test results by higher-level laboratories
- Validation of test results by mobile lab quality teams

4.0 Service Guidelines

Guidelines for HCT services on confidentiality, informed consent, counselling or HIV information-giving, HIV testing, and referral or are discussed in this section. These guidelines are in line with ethics and code of conduct for health workers. Details of service guidelines for HCT are spelled out in the HCT Policy Implementation Guidelines.

4.1 Confidentiality

HCT services must assure that information gathered from testing or counselling of individuals during HCT is kept strictly confidential. HIV test results and patient records should be kept in a locked file with access limited to HCT personnel. The HCT site will not release test results to anyone other than the client unless the client requests such release in writing or a court order requires it. Counselling must be conducted in an area where privacy and confidentiality can be assured.

4.2. Informed Consent

All HIV testing (except mandatory and diagnostic testing) should be done with the client's knowledge and consent. The individual should feel free to grant or to withhold consent. Where possible, consent should be documented by the client's signature or thumb print. Where not possible, after thorough verbal explanation, the provider may document consent in the patient's records. For the adults unable to consent due to unconsciousness, relatives may consent.

Informed consent for children is discussed in Section 4.1.1 HCT for Children.

Situations such as language barriers or mental disability may hinder obtaining informed consent. See Section 4.5.3 for guidance on obtaining informed consent in these situations.

4.3. HCT Protocol Steps

4.3.1. Initial Contact

The circumstance of first contact with a client or patient at an HCT site will vary according to the type of service (VCT, RTC, HBHCT, etc). In all cases the staff member responsible for the first contact must greet the client(s) respectfully and tell them what to expect, reassure them about confidentiality and answer any questions. In some cases, the first contact will also be the time to register the client(s) and to conduct a health education session.

4.3.2. Pre-test session

The pre-test session is when preparation for HIV testing is done and consent, if required, is obtained. The pre-test session may be conducted during the initial contact (above) or it may stand alone as a separate session with a separate provider. Pre-test HIV information may be

conducted in a group, though individual sessions are preferable if resources allow it. The pre-test session should help the client prepare for the test and, if time permits, make appropriate risk-reduction plans. In Uganda, pre-test counselling has been modified in routine HIV testing in the clinic setting. However, this should not be taken to undermine the client's need for prevention information. Rather, providers should de-emphasize full counselling only if it is causing a barrier to testing itself.

Both the minimum information and the full pre-test counselling to be provided in all pre-test sessions are described in the implementation guidelines:

4.3.3 HIV Testing

The HIV antibody test is used to detect the presence of antibody to HIV, which indicates that a person may be infected. Because the result of an HIV test, especially if it is positive, may have such a significant impact on the person being tested, it is imperative that HCT services assure accurate results. HCT sites must institute mechanisms to guard against all forms of error, both technical and clerical, in HCT centres. For children below 18 months, HIV testing will be done using TNA PCR tests.

HIV testing algorithms

Specimens collected from HCT clients should be tested with rapid kits using either the parallel method or the serial method (see figures 1 and 2 below).

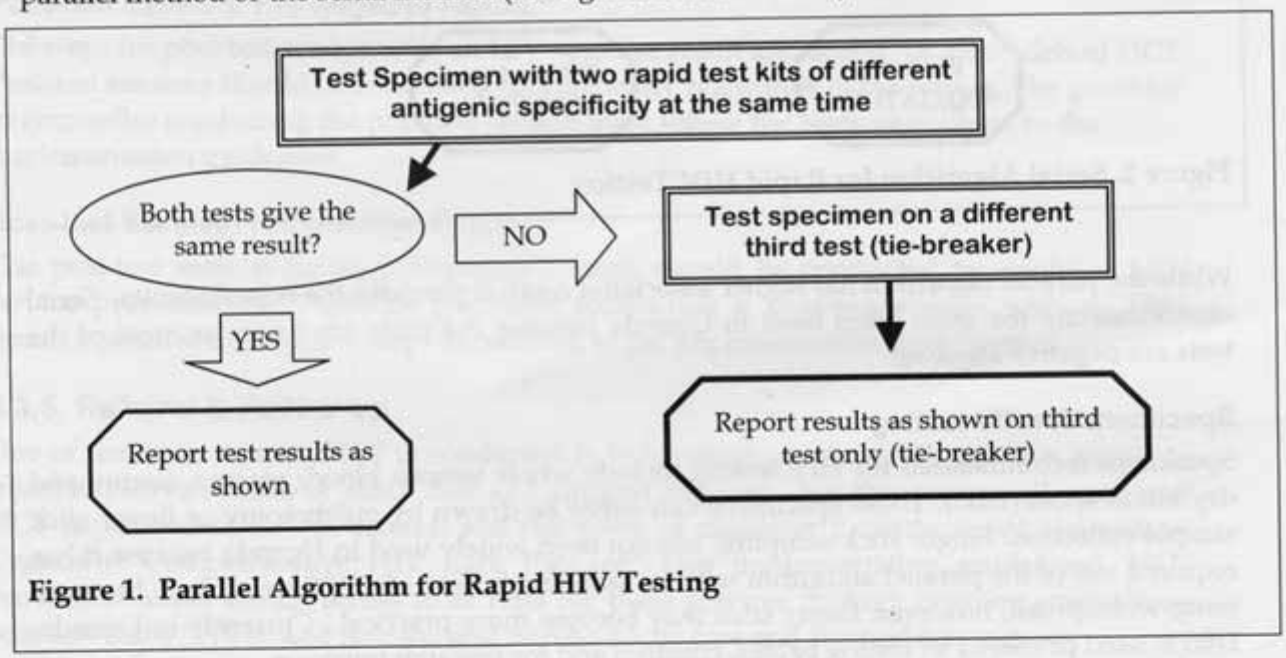


Figure 1. Parallel Algorithm for Rapid HIV Testing

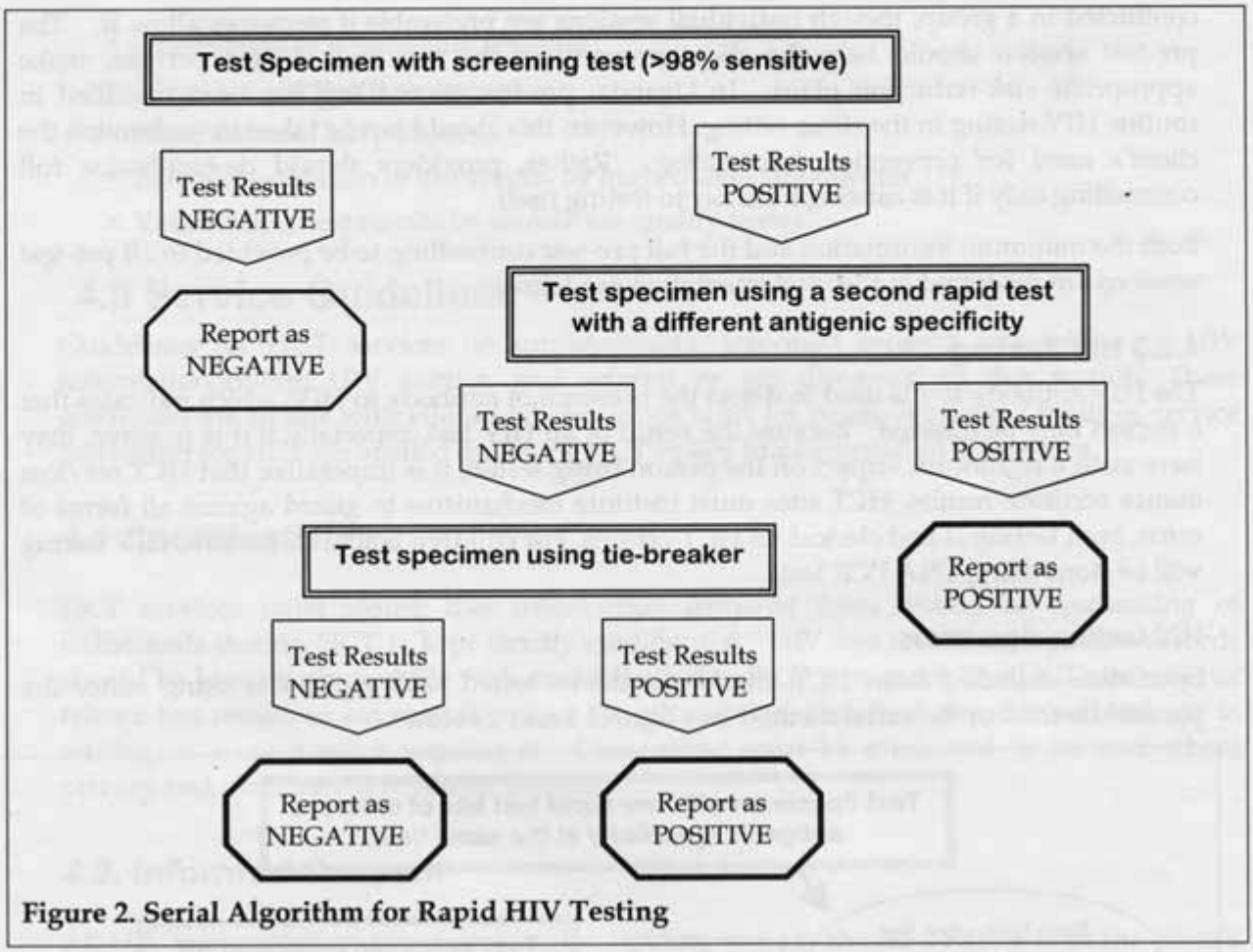


Figure 2. Serial Algorithm for Rapid HIV Testing

While the parallel algorithm has higher associated costs, it provides the fastest results. Serial algorithms are the most often used in Uganda because the costs are lower as most of the tests are negative anyway.

Specimens for HIV testing

Specimens recommended for HIV testing include whole venous blood, plasma, serum, and dry blood spots (DBS). These specimens can either be drawn by phlebotomy or finger stick sample collection. Finger stick sampling has not been widely used in Uganda because it has required use of the parallel algorithm with its associated costs. As DBS technology becomes more widespread, however, finger stick may become more practical. Currently in Uganda, DBS is used primarily in testing babies, children and for research purposes.

HIV testing of urine and saliva must not be conducted in Uganda until the methods are validated and approved by National Health Reference Laboratory (NHRL).

All specimens for HIV testing must be accompanied by a filled in laboratory request form which bears the signature and name of the requesting clinician or counsellor.

HIV Testing in the Private Sector

In situations where clients present directly to the laboratory for testing, the laboratory request form should be filled in and signed by the laboratory staff. Counselling, phlebotomy and testing should be carried out by qualified staff. Pre-test and post-test information should be given by a trained provider. If an HCT provider has requested the test, the results should

be sent back to the requesting health worker or counsellor and never handed directly to the client.

Handling results

Lab staff should send HIV test results directly to the requesting clinician or counsellor. Test results should not be released to the client/patient unless they have received post-test counselling. Test results should not be released to a third person without consent of the client. Confidentiality should be maintained until the results get back to the counsellor.

4.3.4. Post-test Session

The post-test session is when the results of the HIV test are given to the client or patient, along with the appropriate level of information, post-test counselling or any immediate support required. The content and conduct of the post-test session will change depending on whether the result is positive or negative.

Clients must be given face-to-face post-test counselling when HIV test results are given. Partners in a couple should be encouraged to be counselled together but may be counselled individually. As in pre-test counselling, people in polygamous marriages should be given options to come all together, in separate pairs with the husband, or as individuals.

Post-test Session: HIV Negative Result

The steps for post-test session with an HIV negative result are similar for all models of HCT. Post-test sessions should be conducted confidentially regardless of the setting. The provider or counsellor conducting the post-test session must follow the steps as outlined in the implementation guidelines.

Post-test Session: HIV-positive Result

The post-test session for an HIV-positive result should be conducted by qualified HCT service providers. HCT service providers conducting a post-test session with an HIV-positive result should follow steps as outlined in the implementation guidelines.

4.3.5. Referral & Follow-up

One of the main reasons HCT is conducted is to facilitate access of HIV-positive people to treatment services and/or other care and support services. For this reason, all models of HCT require conscientious referral and follow-up of clients or patients as per elements of Uganda's "Comprehensive HIV Care Package" (see implementation guidelines). HCT providers should ensure access to or refer for these services through ongoing counselling, post-test clubs (PTCs), and medical and psycho-social care and support services.

Ongoing counselling

After disclosure of results, ongoing counselling sessions may be scheduled as necessary, and are particularly important in the case of an HIV-positive result. All HCT services should make every effort to provide adequate ongoing counselling services as counselling provided at the time of disclosure (especially disclosure of a positive result) may not be fully effective. The same standards for confidentiality must be maintained in ongoing counselling. All qualified HCT service providers may provide ongoing counselling.

Care and support

At the time of diagnosis, HIV/AIDS treatment and care should be initiated or referral provided for all HIV-positive clients as appropriate. Providers should consider follow-up

support including treatment and prophylaxis for opportunistic infections, and antiretroviral therapy (ART).

Referrals

Referral should be made for services not available at the HCT site including PTCs. The referring provider should explain to the client the purpose of the referral and what takes place at the referral site. A referral slip should be filled with the client's name and the reasons for referral. The information must also be entered in a referral register. In some cases a client may need to bring written documentation of his or her HIV test results in order to access care at a referral site. The provider may provide written results if the client request is documented. Mechanisms for feedback between referral sites should be in place. All referrals should be addressed to institutions, departments or units rather than individuals.

4.4. Approaches and Protocols for HCT

4.4.1. Voluntary Counselling and Testing (VCT)

VCT has been and remains the primary approach for delivery of HCT services in Uganda. VCT is client-initiated and can be offered in stand-alone sites or as a specialized service in health centres or outreach sites. VCT clients are assured of full confidentiality – that is, HIV test results linked to the client's name are only known by the counsellor. The client may request the counsellor to provide results to a third party, but otherwise there is no sharing of results.

For VCT the basic steps are adapted as below.

Voluntary Counselling and Testing Protocol	
Protocol Step	**Description**
1. Initial Contact	Registration General health education session
2. Pre-Test Session	Pre-test counselling Offer of HIV testing Client consent obtained and documented
3. HIV Testing	Rapid test Same-day results if possible
4. Post Test Session	Post-test counselling
5. Referral & Follow-up	During post-test counselling session

4.4.2 Home-Based HIV Counselling and Testing (HBHCT)

Home-based HCT (HBHCT) is a modified model of VCT provided to individuals and families in the home environment. Home-based HCT, also called "family-based HCT", may be initiated through different entry points. Two approaches in Uganda are: 1) "home-to-home" campaigns, in which residents of all homes in a selected area are offered testing, and 2) HCT service provision for families of people living with HIV/AIDS (PHAs) enrolled in treatment and care programmes, such as antiretroviral therapy. HBHCT improves access to services and adherence to ART for PHA whose families participate in HBHCT. With any home-based approach, normal procedures for entry into the community should be observed. The protocol for HBHCT is shown below.

Home-based HCT Protocol	
Protocol Step	**Description**
1. Initial Contact	Household education session Identify those for testing and divide into groups: • Adults aged 18 and above • Children ages 12 to less than 18 • Children under age 12 Registration
2. Pre-Test Session	Delivered to individuals, couples or groups according to categories listed above. Each session includes: • Pre-test counselling • Offer of HIV testing • Client consent obtained and documented
3. HIV Testing	Rapid test Same-day results
4. Post-Test Session	Post-test counselling for individuals or couples
5. Referral & Follow-up	During post-test counselling session

4.4.3. Routine Testing and Counselling (RTC)

Routine testing and counselling (RTC) is HIV testing done routinely as part of health care services. The RTC approach is provider-initiated and shifts the burden of seeking services from the individual to the service provider, making HCT services more accessible and removing much of the fear and stigma associated with taking an HIV test. RTC also facilitates access to care and follow-up. In RTC, HIV counselling and testing services are offered during the clinical evaluation of all patients along with any other tests or investigations being recommended to the patient. If the resources are available, RTC may be offered to any and all patients presenting for services of any kind. However, if personnel or supplies are limited, RTC should be offered first in hospital units or clinics where HIV rates are likely to be highest such as antenatal clinics (ANC), labour and delivery wards, medical wards, sexually transmitted infection (STI), and general medical units of hospitals. In Uganda, the approach used for prevention of mother-to-child transmission of HIV (PMTCT) services is a modified RTC approach. Diagnostic HCT, in which HIV testing is conducted when a client's clinical status suggests HIV infection, also follows the RTC protocol.

In the RTC protocol, patients are registered as usual for services and then they receive information about HIV testing during a routine health education talk. Patients are informed that the site recommends and offers an HIV test along with other tests or investigations being conducted. In RTC, patients always have the right to accept, reject or to defer testing. Routine testing is not mandatory.

Another variation from VCT is that in RTC, full pre-test counselling and specific consent for HIV testing are not required. The RTC protocol calls for "information giving" about all investigations being planned (including the HIV test) rather than specific pre-test HIV counselling. The provider must document that the patient was fully informed and consented to the full plan of investigations being recommended.

In the post-test session, the provider must confidentially inform the patient of his or her test results and should provide immediate support, include recommendations on HIV care or prevention, and discuss partner referral and disclosure.

Referral and follow-up are critical in RTC, especially for HIV positive patients. All patients receiving an HIV positive result in RTC must be referred for HIV post-test counselling as well as any needed care and support. The provider may use his or her own best judgement to determine if the client needs urgent post-test counselling.

In this way RTC reduces total counselling time for all patients, and allows fully qualified HCT counsellors to focus on providing counselling to HIV positive patients - emphasising HIV/AIDS care and support, and proper follow-up.

Routine Testing and Counselling Protocol	
Protocol Step	**Description**
1. Initial Contact	Registration Health education session – Notify patient of RTC and ensure understanding of benefits of testing
2. Pre-Test Session	Initial history and physical exam HIV test "information-giving" during discussion of plan Recommend and offer HIV testing along with other investigations Document client/patient consent to full plan of investigations
3. HIV Testing	Blood collected and rapid HIV test performed along with other lab tests
4. Post-Test Session	HIV- result: Inform test result Address partner referral and risk reduction HIV+ result: Inform test result All health workers and counsellors should: • Provide emotional support • Make HIV clinical care recommendations • Address disclosure and partner referral • Provide or refer for post-test counselling, to include: o Identifying options and resources for support o Allowing time for emotional response and discussion of personal implications Discussion of plan to reduce risk of transmission
5. Referral & Follow-up	HIV positive patients referred for ongoing post-test counselling if needed Referral and follow-up information provided during post-test session, as part of care plan

4.4.4. Routine Counselling and Testing (RCT)

Routine counselling and testing (RCT) is HIV testing done routinely as part of health care services in health care settings where the clients or patients are not very sick e.g. ante natal care. The RCT approach is provider-initiated, is intended to increase access to HCT Services. RCT facilitates couples counselling and follow-up of services. The protocols and other details are described in the revised policy on PMTCT.

4.4.5 HIV Testing for Post Exposure Prophylaxis (PEP)

Testing following accidental exposure to bodily fluids usually involves testing of two people: the person who was presumed to be exposed to HIV (the "exposed person") and the person to whose body fluids they were exposed (the "source person"). The exposed person is usually the one who instigates testing and is tested according to the VCT protocol. For now since there is no mandatory testing law, the source person must also consent to testing. If the source person tests positive for HIV, or his/her status is unknown (e.g. he/she refuses to test), the exposed person should consider taking post-exposure prophylaxis (PEP) to decrease the chances of HIV transmission. PEP consists of a short-course of ART.

4.5. HIV Counselling and Testing for Special Groups

4.5.1. HCT for Children

Principles

In Uganda, a child is an individual under 18 years of age. HCT services for children in Uganda are guided by the UN Convention on the Rights of the Child (UNCRC). Specifically, any intervention for children should be done in the best interest of the child and should be aimed at improving health, development, and social well-being. HCT service providers must also protect a child's rights to privacy and access to appropriate information while respecting the rights and duties of parents and guardians to guide and direct children in the exercise of their rights.

Testing children below 18 months

For children below 18 months TNA PCR will be done after counselling the caretakers. Fig 3 and 4 below give the testing algorithms.

Figure 3: Algorithm for testing Asymptomatic Babies Born to HIV Infected Mothers

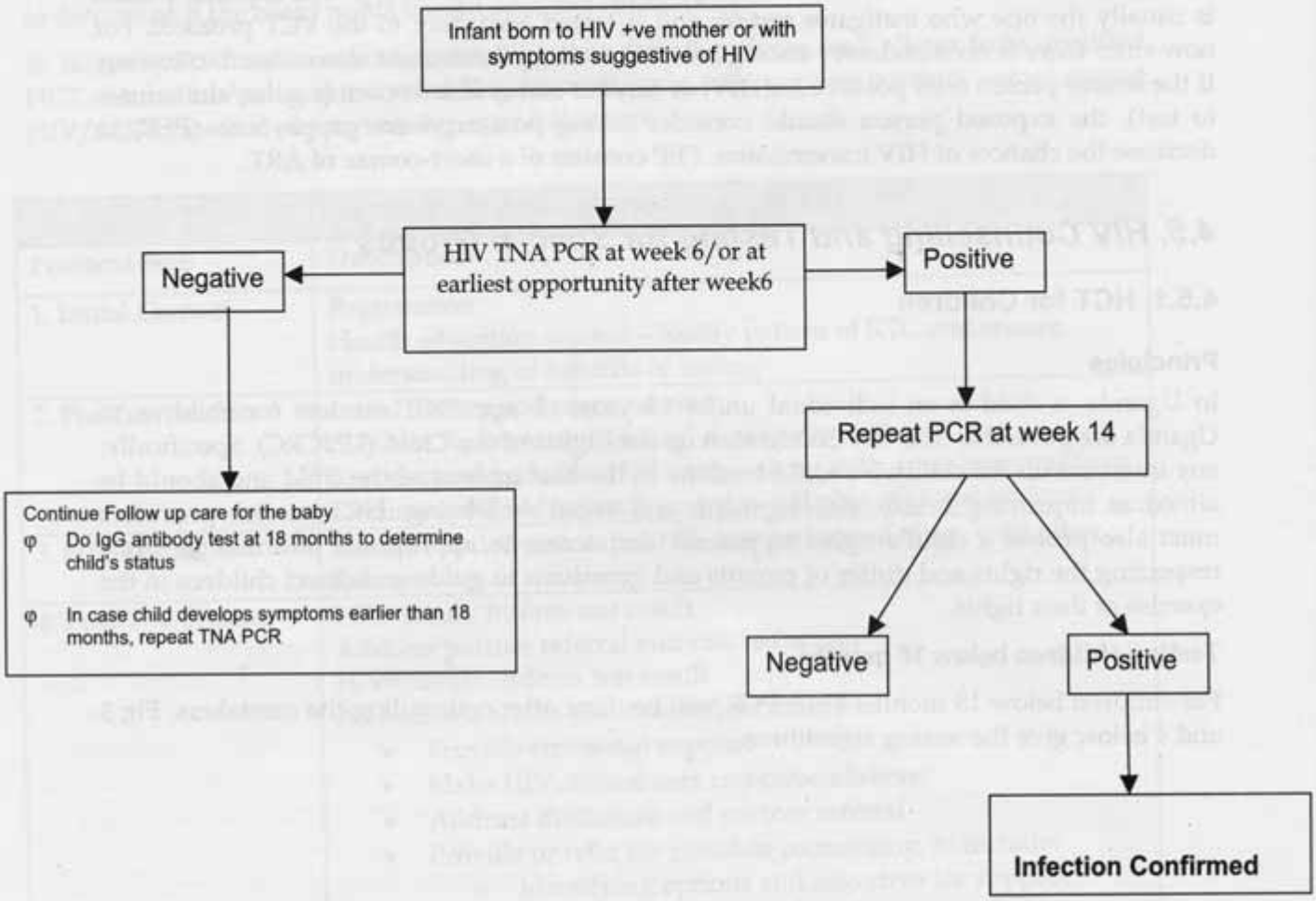
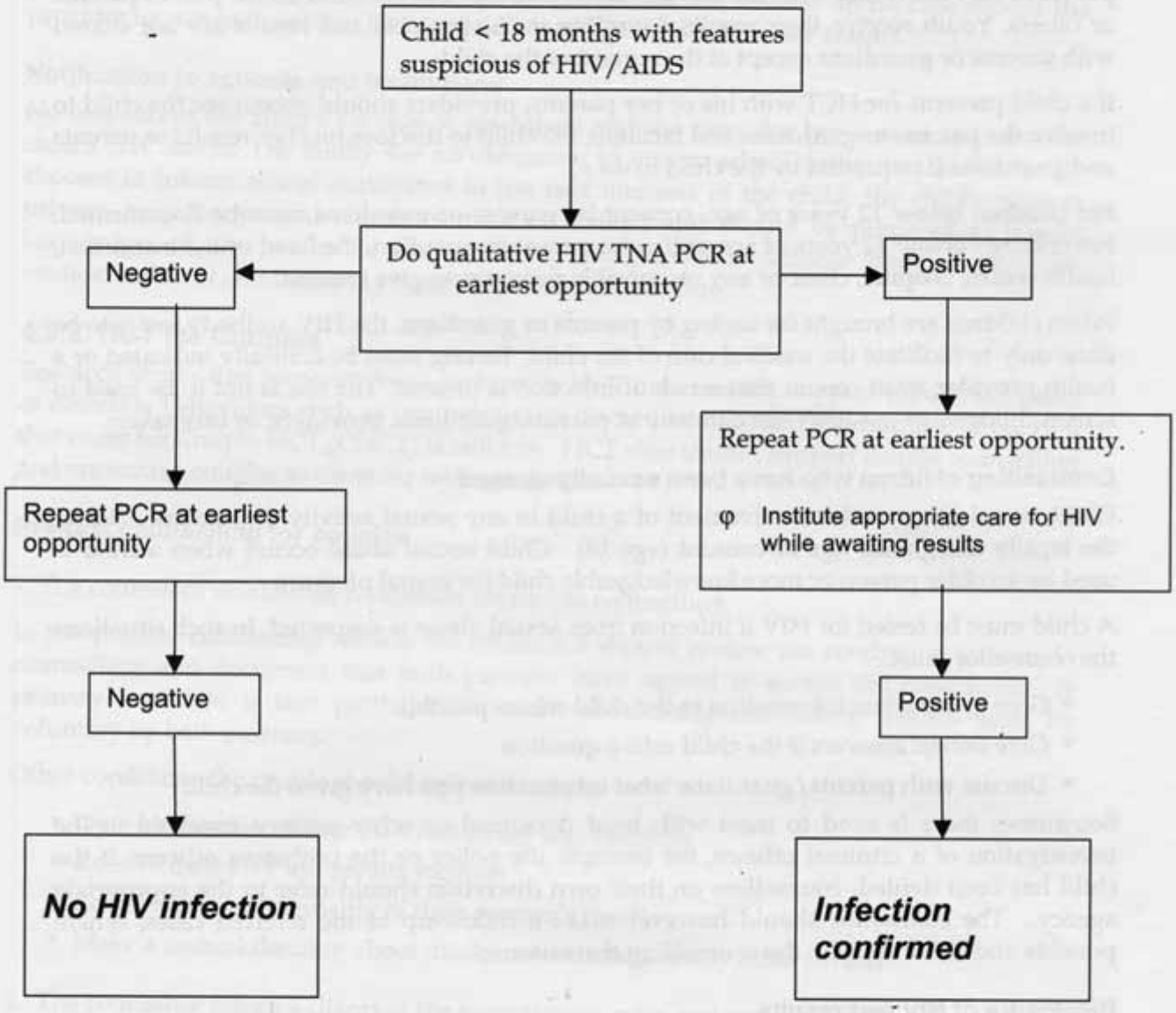


Figure 4: Algorithm for testing symptomatic Babies



Informed Consent for Children

Children age 12 and older may receive HIV testing services at all HCT sites without knowledge or consent of their parent(s) or guardian(s) provided they have the capacity to understand the implications of the results of the HIV test. Children age 12 and older may be provided services if they seek the services freely and without coercion on the part of parents or others. Youth receive their results according to the protocol and results are not shared with parents or guardians except at the request of the child.

If a child presents for HCT with his or her parents, providers should encourage the child to involve the parents or guardians and facilitate the child to disclose his/her results to parents and guardians if requested by the child to do so.

For children below 12 years of age, consent by parents or guardians must be documented. For children below 12 years of age without a parent or guardian, the head of the institution, health centre, hospital, clinic or any responsible person may give consent.

When children are brought for testing by parents or guardians, the HIV antibody test is to be done only to facilitate the medical care of the child. Testing must be clinically indicated or a health provider must concur that a risk of infection is present. The test is not to be used to screen children, or to satisfy the curiosity of parents, guardians, providers, or care takers.

Counselling children who have been sexually abused

Child sexual abuse is the involvement of a child in any sexual activity that occurs prior to the legally recognized age of consent (age 18). Child sexual abuse occurs when a child is used by an older person or more knowledgeable child for sexual pleasure.

A child must be tested for HIV if infection from sexual abuse is suspected. In such situations the counsellor must:

- Give appropriate information to the child where possible
- Give honest answers if the child asks a question
- Discuss with parents/guardians what information you have given the child

Sometimes there is need to meet with legal personnel or other persons involved in the investigation of a criminal offence, for example the police or the probation officers. If the child has been defiled, counsellors on their own discretion should refer to the appropriate agency. The counsellor should however make a follow-up of the referred cases, where possible and continue with the counselling thereafter.

Disclosure of HIV test results

Providers must plan how test results will be disclosed before conducting testing. Providers should determine with the parent or guardian in advance whether the result will be disclosed to the child and, if so, how it will be done. If there is no parent or guardian involved, the provider must determine the child's readiness to receive results and arrange for the child to have a support person of his or her choice present at the post-test session, if appropriate.

Results may be provided to children who are 12 years and above at their request, after proper counselling and if the provider judges them to be capable of dealing with the result (especially a positive result). Providers should always encourage a child to involve the parent or guardian if appropriate. Children below 12 years of age should be given results only with the consent of parents or guardians and, again, with proper counselling.

Before disclosing results, the counsellor should assess if the parent or guardian is willing to discuss HIV and the test results with the child openly. If the child is HIV positive the counsellor should work with the parent of guardian to plan for the child's future care. For children who can not clearly understand the results, the parent or guardian may choose to disclose results at a later date. The counsellor should provide ongoing support and counselling until the child is old enough to understand the results. In no case should the provider or parent/guardian lie to a child of any age about their HIV results.

Notification to schools and Institutions

No one except the child's parents or guardians and the provider has a need to know the child's HIV status. The family has no obligation to inform school authorities. If the family chooses to inform school authorities in the best interests of the child, the child's right to privacy must be assured. Teachers must be trained and should be prepared to handle knowledge of the status of the children. Teachers and schools must respect the confidentiality of children and young people under their care.

4.5.2. HCT for Couples

Research shows that involving both partners in HCT increases the support for and adoption of desirable behaviours such as condom use in discordant couples. The number of couples that come for Couple HCT (CHCT) is still low. HCT sites should support couple counselling and encourage couples to come for testing together.

Pre-test counselling for couples

1. The counsellor establishes conditions for couple counselling

In the pre-test counselling session the counsellor should review the conditions for couple counselling and document that both partners have agreed to accept the conditions. A primary condition is that participation in the counselling and testing session must be voluntary by both partners.

Other conditions the couple should agree to include:

- Open discussion of their HIV risk issues and concerns
- Receive their HIV test results together
- Respect the confidentiality of their partner's result
- Make a mutual decision about disclosure of results to any other person

2. The counsellor informs clients of the expectations, roles and responsibilities of each partner. Specifically, each partner is expected to:
   - Treat the other with respect and dignity
   - Encourage equal participation of the other
   - Listen and respond
   - Engage in candid and open discussion
   - Provide understanding and support to the other
3. The counsellor reviews the test process and meaning of results - especially discordance and concordance.

4. The counsellor assesses the client's readiness to receive the test results - especially discordant test results.

Post-test counselling for couples

When both partners in a couple have the same result, providers should follow the protocol for the appropriate post-test session in section 4.3.4. When the results are discordant, the provider should follow the protocol for HIV discordant couples. The major objectives of counselling discordant couples are:

- To help the couple develop a plan for keeping the HIV-negative partner uninfected
- To help the couple plan for ongoing care and support of the HIV-positive partner
- To assess the likelihood of violence or abuse and develop strategies for avoiding it

4.5.3. HCT for People with Disabilities (PWD)

Rights of PWD

PWD have equal or greater exposure to all known risk factors for HIV infection. Given the size of the global disabled population (an estimated 10% of the world's citizens), the AIDS crisis cannot be addressed successfully unless individuals with disability are routinely included in all AIDS outreach efforts and provided equal access to services.

HCT services must be provided to PWD who freely seek services without any force or coercion. The human rights of PWD to quality health care, access to information and right to privacy must be respected at all time. HCT must be provided only in the best interests of the PWD. PWD must always have a choice to test or not, except when mental disabilities or intellectual impairment make it impossible for the PWD to understand informed consent or the implications of testing. The provider must use his or her best judgement that testing is being done in the best interests of the PWD, is clinically indicated, will facilitate medical care, and that a risk of infection is present. The test is not to be used for screening of PWD, nor to satisfy the curiosity of parents, guardians, providers, or care takers.

Informed consent for PWD

In cases of hearing, language or other disability that makes consent difficult to obtain, the provider must use his or her best judgement and obtain consent through a translator or guardian if need be. If special services such as sign language interpretation or a translator are required and not available on site, the client should be referred. The client may use a translator or interpreter of his or her own choice to interpret counselling sessions. In such a case the counsellor should follow the couple counselling protocol for shared confidentiality.

PWD Access to HCT services

Disability varies both in severity and the way it influences the life of the individual living with the disability. HCT sites and providers must take this variation into consideration in the provision of services. Sites should attempt to increase availability to PWD through provision of special services if possible. The nature of these services will depend on the individual disability, but ramps, sign language interpretation, and more verbal presentation and demonstration for blind people are some common measures that can easily be taken. Other measures include AIDS talks for those with intellectual impairments that are simple, straightforward and that emphasize repetition of key themes, and education sessions for those who are blind that allow them, for example, to actually feel condoms rather than simply having someone in the front of the room hold one up.

PWDs should intentionally be targeted with outreach services and other HCT approaches such as home-based HCT as this enhances access to services.

Counsellors should have good knowledge and skills for handling PWDs in their different categories and states.

When disability hinders obtaining informed consent, the provider must use his or her best judgement and obtain consent through a translator or guardian if need be. If special services such as sign language interpretation or a translator are required and not available at the site, the client should be referred. The client may use a translator or interpreter of his or her own choice to interpret counselling sessions. In such a case the counsellor should follow the couple counselling protocol for shared confidentiality.

Community knowledge and awareness about HIV/AIDS

PWDs must have knowledge about HCT services and benefits. Media communication should target and inform PWDs through sign language interpretation, special materials for the blind etc. PWDs themselves should be trained as peer educators to ease communication issues and improve access to information for PWD.

Glossary of HCT terminology

The aim of this glossary is to standardize the interpretation of the policies stated in this document by clarifying terms as they are used in the context of HCT. The glossary thus does not represent a universal definition of the terms.

ART	Antiretroviral therapy consists of drugs that can suppress the HIV virus. These drugs are used in managing people infected with HIV/AIDS, as post-HIV exposure prophylaxis, and for reducing the risk of mother-to-child transmission of HIV.
burnout	"Burnout" is a reaction to the stress of HIV counselling and testing work that can affect the provider's physical and emotional well-being.
care and support	Comprehensive services provided to people with HIV/AIDS and their families. They include ongoing counselling, nursing care, diagnosis, treatment and prevention of opportunistic infections, socio-economic support and home-based care.
child	A person below 18 years of age.
client	A person seeking or receiving HIV counselling or testing or both.
consent	Voluntary agreement by a fully cognizant adult person to have a procedure (HIV test, operation, etc.) performed on oneself or on a specimen from one's body. It also applies to agreement to give information about oneself such as in research or to have such information used for any purpose.
counselling	A confidential dialogue between the client and a care provider, to enable the client to cope with stress and make an informed decision relating to a situation.
counselling aide	A cadre of providers that is below the level of a counselling assistant. According to the Ministry of Health, counselling aides should have received at least 2 weeks of training in HIV counselling and they may operate at a health facility level II.
counselling assistant	A cadre of providers below the level of a full counsellor. According to the Ministry of Health, a counselling assistant should have received at least 8 weeks of training in HIV counselling and may operate at a health facility level III.
counsellor	A cadre of providers comprehensively trained to provide HIV counselling. According to the Ministry of Health, the counsellor should operate at the level of a district or national health facility and should have received at least 4 months of training in HIV counselling.
couple counselling	Counselling provided to sexual partners or intending sexual partners.
couple HCT	Pre-test counselling, HIV testing and post-test counselling provided together to current or intending sexual partners.

discordant couple	Sexual partners with one testing HIV negative and the other testing HIV positive.
discordant test results	A laboratory term used to refer to a specimen that tests HIV positive on one HIV test kit but HIV negative on a different kit.
Evaluation	Is assessing the quality, effectiveness, or achievements of a programme. Evaluation is generally more formal than monitoring and is often done by someone external to the programme. Evaluations should measure results toward achieving programme objectives. Evaluation is usually done at the mid-point or end of a set programme period.
HCT Provider support	A process aimed at supporting the counsellor to prevent burn-out and to strengthen the quality of counselling. It takes into consideration the counsellor's own emotional well-being as well as the administrative constraints that may affect the well-being of the counsellor or their ability to deliver. It is usually carried out together with quality control of counselling. It also includes technical updates in knowledge.
health facility, levels I to IV	An established location where health care services are provided; level I is the lowest and level IV the highest of the health centres.
HIV Sentinel Surveillance	HIV testing carried out to monitor prevalence of HIV in a country.
HIV test	An HIV test is either an antibody test that detects the body's response to the virus or an antigen test that detects the presence of the actual virus or its components.
HIV test algorithm	A combination of HIV tests that have been tested and agreed upon by a reference laboratory to represent HIV testing for a given purpose.
HMIS	Health Management Information Systems are computerized systems for recording and analyzing information about health services. HMIS are designed to make information available for decision making by programme managers
indeterminate result	An HIV test result that is neither clearly positive nor clearly negative.
indicators	Indicators are measures used in monitoring or evaluation that describe a concept or phenomenon that a programme or project wishes to track. Since the concept or phenomenon may be complex, programmes choose simple measures that give an "indication" of it. Indicators allow programmes to quantify the phenomenon. An indicator can be expressed as an absolute number, a percentage, a rate or "yes/no".
informed consent	An agreement the client makes with the service provider or researcher after having received and understood the purpose of the procedure or the exchange of information.
legal age of consent	The age at which consent is legal. In Uganda this age is currently 18 years.

medically trained counsellor	A provider with a medical background who is also trained as an HIV counsellor and is currently serving as counsellor. Usually such counsellors are nurses or midwives but they could be clinical officers, physiotherapists, doctors, laboratory personnel, pharmacists, dentists or other medical professionals.
Monitoring and Evaluation	Is a process for evaluating performance and impact of a programme using "indicators" that help measure progress toward targets or goals
Monitoring	Is a process of continuous assessment of progress in achieving a plan. Monitoring of HCT services requires review and analysis of service statistics, indicators and other data. Monitoring can be done in person through supervision visits or through regular review of data and other reports.
non-medical counsellor	A provider without a medical background who is trained as an HIV counsellor and is currently serving as a counsellor. Usually these counsellors are psychologists, graduates in social sciences, social work, religious workers, teachers or persons trained in other non-medical professions.
ongoing counselling	Provision of follow-up HIV/AIDS psychosocial support to individuals and their families after learning their HIV test results. Counselling or clinical staff usually provides ongoing counselling as part of comprehensive care. It may be provided in a clinic or at the home of the client.
PCR	Polymerase chain reaction is a technique that amplifies the genetic material (DNA or RNA) of HIV to allow detection of the virus even when present in small quantities. This is an antigen test that detects the presence of the actual virus rather than antibodies to the virus. PCR has been used to detect infection in babies as early as 1 day after birth who were infected by their mothers. While PCR is not a routine HIV test, it is emerging as a major tool to measure the effectiveness of PMTCT programmes.
TNA/PCR	Total Nucleic Acid- Polymerase Chain Reaction
PMTCT	Prevention of mother-to-child transmission of HIV is a package of services that aims to reduce the chances of mothers transmitting HIV to their babies.
post-test counselling	A discussion held between a provider and a client with the aim of informing the client of their HIV results and assisting them to cope with the results. This discussion consists of giving the test results clearly, without ambiguity, assessing the client's emotional and mental understanding of the test results, addressing any immediate emotional reactions, making plans for involving significant others, making ongoing plans for care and risk reduction, and making arrangement for follow-up support.
pre-test counselling	A discussion held between a provider and a client aimed at preparing the client for the HIV test. It consists of clarifying the client's knowledge about HIV/AIDS, informing the client about test procedures and how HIV test results are managed, preparing the client for the outcome of the test, assisting the client to make a decision about testing, obtaining the informed consent of the client, and counselling about safer sex.

pre-test counselling, group	Discussion between a provider and a number of clients, usually not more than five, aimed at preparing the clients for the HIV test. Before commencing the session the clients should have it explained to them and be asked to consent verbally to the group process.
PTC	Post-test clubs are a package of services that aim to help VCT clients cope with the knowledge of their HIV status and to live positively with their status. PTC targets both HIV-positive and HIV-negative persons.
quality control of counselling	A process aimed at monitoring and strengthening the quality of counselling. In counselling, quality control is usually carried together with counsellor support and supervision.
quality control of HIV testing	A process aimed at monitoring and strengthening the quality of HIV testing. It involves retaining a percentage of the HIV-positive and HIV-negative samples and sending them to a reference laboratory for retesting. This process helps detect faults and strengthen the testing process and technique.
rapid test, parallel	A rapid HIV test is one that usually provides a result within less than 2 hours. Parallel testing means that two different HIV rapid tests are applied together (in parallel) to all blood samples. Those samples that show HIV-positive results on both tests are reported as positive. Those that show HIV-negative results on both tests are reported as HIV negative. Samples that show positive results on one test and negative on the other are not reported to the client but instead a third test is carried out—a tie-breaker, different from the first two. If the tie-breaker shows a positive result it is reported as positive and if it shows negative it is reported as negative.
rapid test, serial	A rapid HIV test is one that usually provides a result within less than 2 hours. Serial testing means that two different tests are applied one after another (serially). Each blood sample is subjected to one rapid test, and if it tests negative it is reported as HIV negative. But if it tests positive it is subjected to a different rapid test, and if the second rapid test is positive it is reported as positive. If the second rapid test is negative when the first one was positive a third test, the tie-breaker, is applied. If the third test is positive it is reported as HIV positive and if it is negative it is reported as HIV negative.
referral system	Arrangements between institutions providing related services that allow providers to send clients from one institution to another to seek services that the client needs but may not be provided at the first institution. These arrangements usually consist of a referral slip, a referral directory and an informal or formal agreement between the institutions regarding the type and purpose of referrals that can be made to and from the various institutions participating in the arrangement. The arrangement should usually include a feedback mechanism from the recipient organization to the referring institution.

repeat testing	HIV testing undertaken by a client who has already been tested and informed of the test results. It usually requires that the client provides another sample. The commonest reasons for repeat testing are to rule out the window period and to satisfy clients in denial, who may doubt the first test result. It does not refer to the repetition of tests on a sample before the results are given to the client.
tie-breaker	See under rapid test, parallel, and rapid test, serial.
UVRI	Uganda Virus Research Institute, a government research laboratory that has carried out much HIV research in the country. It is a reference laboratory for HIV testing.
WB	Western Blot test for HIV is a sophisticated antibody test. In Uganda it is used only for research purposes.
window period	The period between being exposed to HIV and the time when the body produces enough antibodies against HIV to be detected on routine HIV tests used. This period ranges from 2 to 3 weeks.