
A Guide to Establishing Voluntary Counseling and Testing Services for HIV

FAMILY HEALTH INTERNATIONAL

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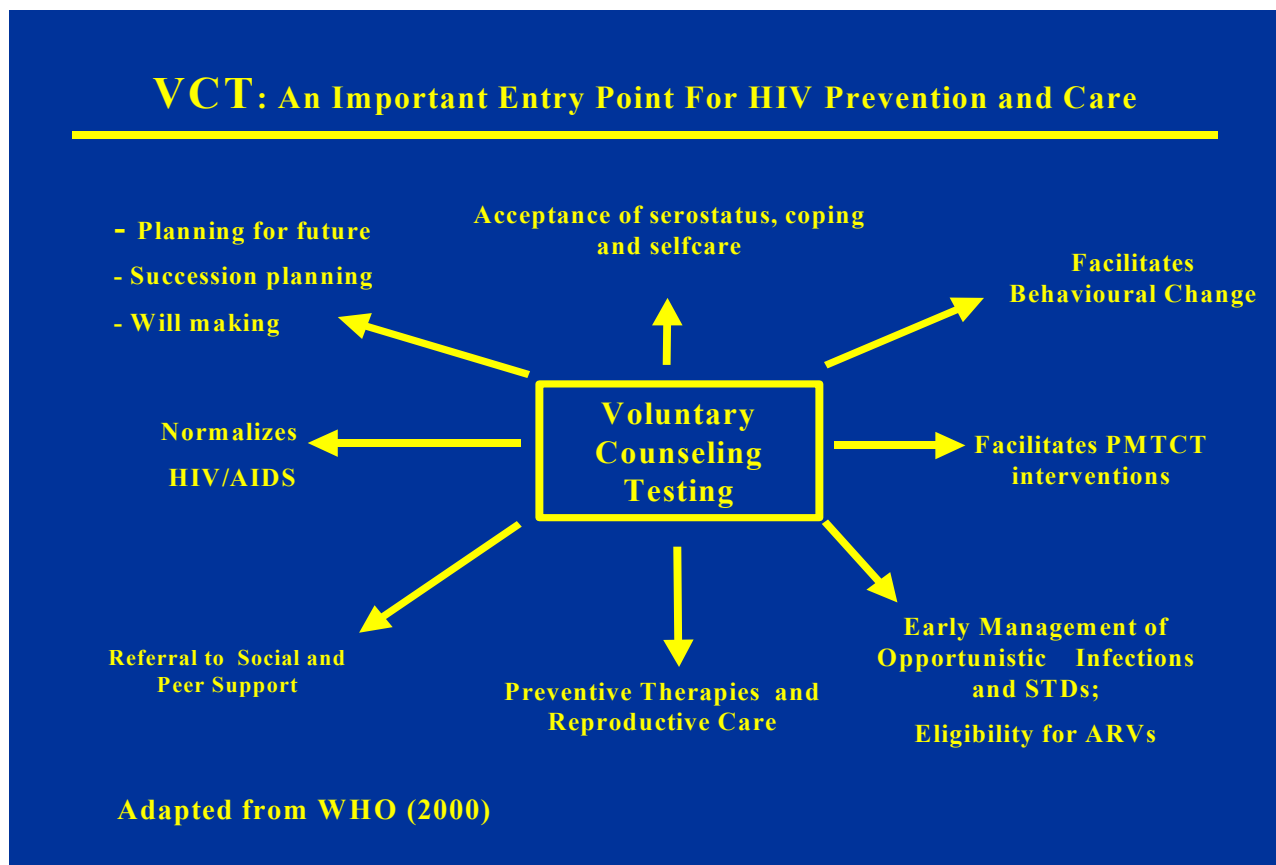
This guide was prepared by Gloria Sangiwa based on her long experience in Tanzania and Zimbabwe and recently as director of Psychosocial Care for the FHI AIDS Institute, Arlington, Va., USA. Technical input was provided by Eric van Praag, Gina Dallabetta and Deborah Boswell; editorial support was provided by Robert Ritzenthaler.

For additional copies, queries and sharing of experiences, please contact:

Gloria Sangiwa (gsangiwa@fhi.org)
FHI AIDS Institute
Family Health International
2101 Wilson Boulevard, Suite 700
Arlington, VA 22201
USA
Tel: 1-703- 516-9779
Fax: 1-703-516-9781
URL: www.fhi.org

INTRODUCTION

Voluntary counseling and testing (VCT) for HIV is an essential link between *HIV prevention* and *HIV care and support*. VCT promotes and sustains behavior change, and links with such interventions as prevention of mother-to-child transmission (PMTCT), prevention of sexually transmitted infections (STIs) and prevention and treatment of tuberculosis (TB) and other opportunistic infections (OIs). VCT also facilitates early referral to comprehensive clinical and community-based prevention, care and support services, including access to antiretroviral therapy (ART). VCT improves quality of life and may play a pivotal role in stigma reduction.



VCT is now a priority intervention in many countries. In these countries, VCT is conducted as a collaborative effort among the host government, development partners (donors) and local and international organizations. VCT is conducted independently or jointly by public and private sector organizations, including non-governmental organizations (NGOs) and community-based organizations (CBOs).

Most VCT programs are guided by the following principles:

- To aim for high-quality VCT;
- To obtain equity and equal access for all people demanding VCT services;
- To allow referral and access to a comprehensive range of prevention, care and support services;

- To advocate for cost-efficient services for clients;
- To aim for sustainable services with a focus on health impact;
- To foster community ownership of VCT services.

Though there are many successful VCT programs, limited practical guidance exists on how to design, implement and monitor VCT services. This guide was developed to address this gap and is based on Family Health International's experience in assisting countries to establish VCT services.

The guide focuses on three levels:

- The **national level:** Implementation at this level is a tripartite partnership among the host government, development partners (donors) and the technical group providing technical management to an implementing agency;
- The **district or NGO level;**
- The **site level (implementing agency):** The implementing agency depends on the chosen model of service delivery but can include institution-based, clinic-based, stand-alone or mobile sites, or a combination of the above.

The guide is intended for governments, development partners and public and private sector organizations, including NGOs, as they begin to establish VCT programs and services. In this document, we refer to the organization establishing VCT services at the site level as the "implementing agency." This guide is meant to be just that — guidance to be used or adapted depending on the specific country epidemiological, political, social, cultural and economic context.

ESTABLISHING VCT SERVICES

As a principle, it is essential to involve communities in all phases in the establishment of VCT services. Involving the community elicits community support and fosters community ownership of the program. In several countries, this step has been identified as a key element in reducing stigma and encouraging demand for VCT among community members.

Establishing VCT services involves three phases:

- Assessment;
- Design;
- Implementation.

Field experience suggests that these phases may last up to nine months (depending on the scope of the planned intervention) for a national program with no previous VCT services. This timeframe can be shortened significantly by adapting and using existing assessment and other tools and building on lessons learned from other sites.

This document presents guidance for each phase at the national, NGO/district and site levels.

1. Assessment Phase

The success of VCT services depends on partnerships among the various organizations working in a community to ensure community support, public awareness and high-quality, comprehensive services. Providing only VCT without appropriate linkages, referrals and associated prevention and care services undermines the potential impact of VCT services for both *HIV prevention* and *HIV care and mitigation*.

Planning VCT service delivery begins with a detailed situational analysis. The situational analysis encourages the development of supportive policies, assists in understanding what each partner expects from the VCT service and ensures that VCT services are tailored to the epidemiological, cultural, behavioral and economic context of each country or site. The situational analysis is conducted using rapid participatory methods and key-informant interviews with all stakeholders, including potential clients and service providers.

A. NATIONAL-LEVEL ASSESSMENTS

Key information to be covered in the situational analysis is described below:

- Information on **existing VCT services or HIV testing** in the country/region/municipality obtained through a review of existing reports and publications and through interviews with program managers at various levels. It is important to assess public, private and NGO sector services. Combining interviews with reports is essential, as actual service delivery may differ from what is reported.
- Country-specific **policies and strategic plans on HIV/AIDS**, including where VCT is placed in the country's HIV response (e.g. Is VCT seen as a health intervention, a multi-sectoral responsibility or both?). Other aspects to be assessed to determine the VCT design include:

Health services:

- Existing health service infrastructure and referral patterns;
- Models of VCT service delivery being advocated or accepted;
- Cost-sharing or user fees;
- HIV infant feeding for HIV-positive women;
- Commodity management systems (including drugs) and clinical capacity to manage HIV-related illnesses;
- STI screening and treatment;
- TB screening procedures and preventive therapy;
- Nutrition and HIV/AIDS;
- Laboratory quality assurance systems;
- Legal issues related to AIDS and orphans and vulnerable children;
- Responsibilities for establishing and funding referral services and developing linkages.

Policies:

- Age of consent for HIV testing;
 - Legal restrictions on who can conduct HIV testing and counseling;
 - Partner/parental notification and disclosure of results;
 - Provision of written results;
 - Promotion/advertising regulations with particular reference to health services advertising;
 - Existing mandatory practices of testing specific groups;
 - Distinction between anonymous, unlinked HIV testing through routine sentinel surveillance and VCT services.
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- **Presence or absence of national guidelines** on counseling, HIV testing, counseling training and other relevant protocols.
 - **Views of health and non-health authorities about VCT and its place in the health system**, or other sectors including NGOs and CBOs (information to be gathered through key-informant interviews).
 - **Pharmaceutical regulations** regarding HIV diagnostics and related drugs (e.g., registration, procurement, distribution).
 - Accepted **HIV testing protocols** used in the public, private and NGO sectors.
 - **Quality assurance protocols** for HIV testing; a list of the current HIV test kits registered in the country, including all laboratory regulations.
 - **Availability and costs of different HIV tests** worldwide and in country (including those that are currently registered).
 - **Health information systems, existing methods of monitoring and evaluation and quality assurance tools**, either for counseling and testing services or other HIV clinical care services.
 - **Demand** for VCT services. This can be assessed using information from existing behavioral surveys, if available, and through formative/consumer research. It is crucial to identify target audiences for VCT services and to gain in-depth understanding of clients' needs, fears and misconceptions regarding VCT. Outcomes of the formative/consumer research should guide each step in designing the counseling protocol. The research should also assist in developing country-specific VCT promotion strategies and messages.
 - **Documents and information** that can help define regional/district VCT focus at the national level. These include:

- Studies of clients (e.g., knowledge, attitude, behavior and practice studies on HIV/AIDS and testing or health service delivery);
- Recent health surveys;
- Census data to determine where VCT has high potential impact;
- National and provincial health profiles and available health services;
- National HIV or behavioral surveillance reports.

B. DISTRICT- AND FACILITY-LEVEL ASSESSMENTS

Assessments at this level should include:

- **Key-informant interviews with health and non-health authorities** on their views about VCT and its place in the health system, or other sectors including NGOs and CBOs.
- **Identifying potential VCT partners** at the district level.
- Determining the role of the **District Health Management Team**, if applicable.
- Determining the need to form a **District VCT Advisory Committee** or VCT Project Management Team.
- Addressing **staffing issues** that are essential to provide high-quality VCT services (e.g., staff availability, qualifications, selection criteria and how to maintain motivation). Identifying both monetary and non-monetary incentives is especially important for government- or municipal-based counselors, who are often de-motivated due to work overload, poor working conditions and delays in payment of salaries.
- **Mapping all health and social services** available in the intervention area.
- Rapid assessment of **care and support needs of people living with HIV/AIDS** and their families, including an appraisal of **existing referral mechanisms**. It is important to determine if there is a directory of NGOs, AIDS service organizations and care and support organizations in a country/region/municipality.
- Assessing the **impact of stigma** on current efforts, with consideration of confounding factors such as denial, fear and secrecy, which are major barriers to VCT service utilization in most settings.

2. Design Phase

Suggested design activities assume that a country has limited or uncoordinated VCT services and is planning to establish VCT services on a wide scale. For smaller-scale VCT start-up activities (district or community level), many national-level activities are

irrelevant. However, we strongly suggest that VCT services be established within a national framework, where possible.

A. NATIONAL-LEVEL DESIGN

Suggested national-level activities are designed to promote consensus among stakeholders and implementers on the final design of VCT services in a country. Key outcomes of these activities include an overall vision, plans to address policy and infrastructure issues, national policies, procedures and minimum standards for service delivery and a detailed implementation plan. Suggested activities include:

- Holding a national **planning workshop and/or sensitization workshop** that includes outside experts, government, implementers, funders and all interested parties. This workshop will create awareness, facilitate “buy in” and influence the attitudes of community members. This forum can be used to disseminate information from the situational analysis and the formative/consumer research. Participants can map out strategic directions, reach consensus on the design of the VCT program and resolve policy issues that might have an impact on VCT service delivery. These might include identification of potential partners for collaboration and alliance building, and leveraging of funds for some activities.

Policy issues to be discussed at this meeting include:

- How can partner notification be improved while protecting the rights of the VCT clients?
- What is the role of shared confidentiality in relation to VCT as an entry point to prevention, care and support?
- How sustainable are the current models of VCT in the particular country/organization?
- How will the success of the VCT program be measured?
- Should VCT be used as a targeted service for HIV prevention and care or should it be universally offered? (this issue will need to be addressed only in some settings)
- Who is responsible for setting up referral services? Who should pay for them?
- Should VCT be provided as a confidential/anonymous service? What are the pros and cons?
- What mechanisms need to be in place to ensure high quality?
- Who is allowed to conduct HIV testing?
- Should VCT services be provided for people less than 18 years/age of consent?
- Should VCT services be free or fee-based; if fee-based, should the fees be standardized and how much should the service cost?
- Is there any need to standardize training models?
- In the era of antiretroviral (ARV) drugs, how should VCT be promoted and provided and how can VCT services cope with an increased in demand?

- How will the role of counseling be recognized and validated?
- How can the VCT program encourage supportive attitudes by health care providers?
- How should scaling up of VCT services be approached?
- Establishing **policies, procedures and minimum standards** for VCT services. Such activities would include:
 - Determining the most affordable, effective, acceptable and feasible HIV testing method for a VCT program in the country;
 - Developing standard operating procedures for service delivery;
 - Developing a national monitoring and evaluation plan and data collection instruments;
 - Developing/adapting VCT counseling and testing protocols based on appropriate standards and policies (pre-test, obtain approval from advisory committee and finalize);
 - Developing a training curriculum, accompanying training manuals and a training plan for counselors and trainers; obtaining approval from advisory committee;
 - Identifying and training VCT trainers;
 - Designing and developing a support system for counselors.
- Holding a **national design workshop for stakeholders, implementers and funders** to:
 - Ensure consensus on the design and service delivery models to be implemented. It is common practice, in any country, to have a combination of models (Table 1) to maximize coverage and ensure accessibility, acceptability and affordability of VCT services to the entire population.
 - Identify sustainability needs and opportunities.
 - Determine where in the government structure VCT services should be managed.
- Reaching consensus on **short-listed potential VCT sites, selecting one learning site** in low-prevalence settings or phasing in sites in high-prevalence settings. It is imperative to determine the number of sites to be developed, including the number of phases and sites per phase. A detailed implementation plan is useful. Scaling up of services can occur either through a strategic phased approach (planned expansion), by replication of successful models or through demand by the community.
- Developing **geographical and site selection criteria**. This decision process is multifaceted and involves such criteria as:
 - National or regional targets for the VCT program in terms of numbers of clinics and population coverage;
 - Type of services desired (see Table 1);

- Needs of specific target populations (will determine both the geographic focus and the type of service delivery model).

If wide coverage and a large number of service delivery sites are anticipated, we recommend that VCT services be implemented in phases. This approach will generate lessons learned, create capacity and build networks necessary for expanding services to other sites. These networks will also create a “country-specific VCT model” that can serve as a model for all organizations providing VCT services in the country.

Identifying potential partners and evaluating the current availability of VCT services should follow explicit, agreed-upon criteria and involve all stakeholders in the public, private and NGO sectors. We recommend that an assessment tool be developed as part of this process.

Table 1: Models of VCT Service Delivery

Model	Benefits	Constraints
<p>Stand-alone</p> <p>For reasons of cost and cost-benefit, located in high population density areas and where HIV infection rates are high.</p>	<p>Attracts populations that otherwise would not attend services.</p> <p>More flexibility with staffing and hours of operation.</p> <p>Easier to link with post-test clubs and support groups for people living with HIV/AIDS.</p>	<p>Often not linked with other medical/social services.</p> <p>High set-up and operating costs.</p> <p>Limited geographic accessibility.</p> <p>Can be stigmatizing as facilities associated with HIV.</p>
<p>Integrated</p> <p>VCT services integrated into existing services, usually public sector such as hospitals, STI clinics, TB clinics, ANC clinics or outpatient clinics.</p>	<p>VCT part of routine health services, thus normalizing HIV/AIDS.</p> <p>Health care providers can work in HIV prevention.</p> <p>Direct referral to relevant HIV-related care.</p> <p>High volume of potential clients at public sector facilities.</p> <p>Staff can provide services other than VCT.</p> <p>Huge potential for scale up.</p>	<p>Dilution of other services and potentially lower-quality VCT services.</p> <p>Possible regulations disallowing the use of non-health care providers for counseling services.</p> <p>Low motivation in public sector personnel.</p> <p>Quality assurance more difficult to implement.</p> <p>Limited management capability to run complex services.</p> <p>Long waiting times.</p> <p>Possible client perception of poor quality of care.</p>

Model	Benefits	Constraints
NGO Existing NGOs integrate VCT into service or provide VCT services in public clinics.	Improved management due to limited focus. Flexibility in staffing and clinic hours. Quality easier to assure.	Contingent on outside funding. Limited capacity to scale up. Potential for stigma as a stand-alone site. Potential diversion from core NGO activities.
Private Sector	Need high quality to attract clients. Perceived to be more private and confidential. Responsive to client needs.	Inaccessible to the poor and uninsured. Adherence to government standards. Counseling is time-consuming and does not fit a direct-fee model.
Mobile/Outreach There is limited experience with these models — current models offer temporary, rotating services for hard-to-reach groups such as injecting drug users, sex workers and truck drivers.	Improved access for populations not using stand-alone services or for rural populations.	Expensive. Difficult to ensure confidential services and follow-up after post-test counseling. Limited capacity.

B. DISTRICT- AND FACILITY-LEVEL DESIGN

General VCT site protocols will vary depending on the service delivery model. Site protocols might include:

- Minimum staffing requirements: counselors, on-site laboratory technician (if country policies do not permit non-laboratory personnel to conduct HIV testing), community coordinator, data entry clerk /receptionist, on-site coordinator;
- Minimum space requirements;
- Local adaptation of national counseling protocols;
- Blood-taking and testing protocols;
- Monitoring and evaluation protocols (record-keeping, data collection, etc.);
- Confidentiality protocols;
- Quality assurance protocols;
- Management protocols;
- Informed consent procedure;
- Care and support referral protocols.

We recommend that a team representing all stakeholders determine the site selection process and criteria. The site selection process can be multi-staged and examine the following issues at each potential facility:

- Accessible to potential clients?
- Acceptable?
 - Discretion: Are other services being offered?
 - Confidentiality: Are measures in place?
 - Convenience: Are operating hours and waiting times convenient for clients?
- Able to provide affordable VCT services (affordability will partly be determined by the formative/consumer research)?
- Appealing to potential clients?
- Adequate number of counselors?
- Able to adhere to strict quality assurance and supervision measures?
- Monitoring and evaluation reporting structures?
- Staff knowledgeable about the care and prevention referral network?
- Space available, laboratory on-site and close to reference laboratory for quality assurance purposes?
- Absorptive capacity with or without additional inputs, especially within integrated sites? (i.e., What will be the impact on existing health services and availability of staff if VCT were an “add on”?)
- Able to commit to provide or “add on” VCT services, especially if these are integrated services?

3. Implementation Phase

A. NATIONAL-LEVEL IMPLEMENTATION

Suggested implementation activities at the national level include:

- Identifying and recruiting **central-level project staff** if VCT services are being instituted as a national program, where there are adequate resources and plans for more than one site. Ideally, the program coordinator should have direct experience managing VCT projects. Other central-level staff should include: 1) a training coordinator responsible for implementing the training program and for providing ongoing facilitative supervision to the counselors (or where funds permit the counselor supervisory role may be provided by an additional staff member); 2) a laboratory person responsible for all HIV testing issues, including procurement and quality assurance; 3) a monitoring and evaluation officer; 4) an information, education and communication officer; and 5) a grant and financial manager.

Central-level project staff should closely monitor and support the initial site(s) to resolve initial problems and ensure quality. Once the initial centers are operating smoothly and require less direct supervision and support, central-level project staff may continue to open other sites. Also, central-level project staff should review the “ad” briefs and technical content and be available for radio and television interviews, if applicable.

- Identifying the **government VCT focal point** who will be the contact person when there is need to resolve policy-related issues.
- Holding a **meeting with all key stakeholders** to finalize roles and responsibilities and determine modes of operation and communication channels.
- Procuring **HIV test kits** according to donor/country regulations and contextual needs.
- Developing a **VCT communication strategy**. The main objectives of VCT communication activities are to:
 - Promote awareness among target populations of the availability of high-quality VCT services;
 - Encourage the target population to use VCT services;
 - Promote understanding of VCT and its benefits among the target population;
 - Encourage political leaders, public and private health providers and policy-makers to endorse the use of VCT centers;
 - Reduce stigma and discrimination;
 - Encourage sustained behavior change after a person has visited a VCT site.
- Developing **promotional campaigns**. To minimize creation of demand without supply, it is important that sites are operational before the promotional campaign begins. Due to complexity and lack of capacity for most organizations to implement promotional campaigns, it may be appropriate for the VCT program to contract out this activity or collaborate with another organization for mass media and interpersonal communication.

B. DISTRICT/NGO-LEVEL IMPLEMENTATION

Suggested implementation activities at the district/NGO level include:

- Finalizing the **organization and management structure** at the central, district/NGO and site levels.
- Conducting a **team-building session**.
- Conducting **participatory needs assessments** at each site, conducting proposal writing and awarding grants to these sites (as appropriate); developing operating agreements that describe the roles and responsibilities of all partners in VCT services and ensuring funding mechanisms.
- Concurrently, conducting an in-depth assessment or “**pre-implementation assessment**” at each site to determine the specific breakdown of each site’s “in-kind” contributions. Sites or implementing agencies should be encouraged to contribute, financially and in-kind, to foster ownership of the program and

ensure sustainable, high-quality services. This should be clearly articulated and added to the operating agreements.

- Conducting **district-level training** for counselors, counseling supervisors and site staff (e.g., receptionists, site managers, laboratory staff and counselors). Ideally, this training should be supplemented with a short-term on-site counselor before service provision begins to ensure quality and provide supportive supervision, training and stress management sessions.
- Procuring **HIV test kits**. District/NGO/technical partner laboratory personnel should establish:
 - Procurement procedures using local HIV test kit distributors if applicable;
 - An inventory, distribution and storage system for rapid HIV test kits;
 - An HIV testing quality control procedure, to be implemented in collaboration with the national program. For instance, during the initial three-months, all HIV-positive test kits and 10-20 percent of all negative samples should be sent to a reference laboratory for quality control testing.
- Developing **local promotional strategies** that complement the national strategy, if one exists. For low-level VCT start-up, it is recommended that either a locally based NGO that is conducting behavior-change communication (BCC) or counselors and VCT site coordinators be trained in interpersonal skills to ensure potential clients understand the meaning of their decision to:
 - Obtain VCT;
 - Assess their risk;
 - Adopt positive behavior changes;
 - Become aware of care and support services within their locality (as described for the national level but limited to the district/province/NGO catchment area).
- Facilitating formation of a **counselor support network** and **caring for carers' programs** either at the workplace or within districts/municipalities.
- Developing district/NGO-level **monitoring and evaluation** plans and tools that provide relevant information to manage VCT services and are consistent with national-levels plans; the district/NGO/technical partner should develop a comprehensive monitoring and evaluation plan. Site-level monitoring activities should include measures to address how well services are being performed, service use, service delivery, adherence to protocols and confidentiality, staff performance and program effectiveness. These site-level process indicators may be reported but they should also be used as a tool for service delivery management.
- Developing or adopting ongoing counseling and testing **quality assurance measures**.

C. FACILITY-LEVEL IMPLEMENTATION

Suggested implementation activities at the facility level include:

- Defining the **relationship with the site's management body**. This includes identifying a site management protocol and developing site-specific protocols and contractual agreements (including a liability clause) for integrated sites, i.e., government and NGO sites as opposed to stand-alone models.
- Finalizing the **organization and management structure**.
- Ensuring that all site staff are clear about their roles and relationships. It may be useful to conduct a **team-building** session to facilitate the development of supportive working relationships across the multidisciplinary team.
- **Preparing sites** through renovation and furnishing.
- Conducting a **dress rehearsal** (mimicking all steps that clients will go through to ensure that staff understand client-flow procedures at the site level). It is important to conduct this activity prior to opening each site. It is also beneficial to provide “start-up” support to the VCT team, which may extend to one week after the site is operational.
- Determining a **date by which the site will be operational**.
- Piloting **modified operating hours** (e.g., during lunch hours, after hours and over weekends to determine the impact on accessibility).
- Identifying, strengthening and **formalizing referral networks** and developing interpersonal linkages with care and support program providers. Referral for VCT services is a two-way process that creates linkages both with the community and clinic-based organizations. It is also recognized that community care and support services contribute significantly to the continuum of care through home-base care, family care and volunteers. To promote long-term social support for tested clients, it will be important for the sites to:
 - Maintain linkages with community support groups;
 - In situations where VCT services use an anonymous system, **ensure that care and support organizations** near VCT sites accept clients identified by code rather than name. These organizations need to respect clients' wishes, including the fact they may not reveal their sero-status. (Referral agents may have a sample VCT referral form. This form facilitates acceptance of the client and minimizes the risk of the client being re-tested before receiving further support);
 - Refer clients to community support groups when available (or if not, consider facilitating the establishment of a PLHA support group as appropriate);
 - Engage in community mobilization/support efforts;

- Ensure that the community coordinator or other appropriate site staff meet community partners on a regular basis to create demand for VCT and to support clients.
- Introducing **on-site TB screening, treatment and preventive therapy**, including treatment of OIs. In some settings, alternatively refer clients for these services. (First link with outside services and explore the possibility of introducing on-site services).
- Linking with the **PMTCT intervention** in some VCT settings.
- Facilitating formation of **post-test clubs**. To provide a continuum in which clients can continue to make positive life choices, each VCT site should be encouraged to establish a post-test club for both clients who test positive and negative. These clubs should be organized and operated in collaboration with a local HIV/AIDS support organization.
- Providing ongoing individual and group **counselor supervision** support and monitoring of VCT staff performance.
- Adhering to agreed-upon **monitoring and evaluation** and **quality assurance** procedures.
- Developing **public relations and advocacy strategies** aimed at press, politicians and key influencers.

MINIMUM REQUISITE STAFF, SPACE, EQUIPMENT AND SUPPLIES

1. Staff

In a VCT setting where 10-20 new clients per day are anticipated, the following complement of staff is recommended:

VCT Coordinator: At least 50 percent of this individual's time should be dedicated to the project.

Receptionist: This should be a full-time position dedicated to the project. The role of the receptionist is to welcome clients, register clients, collect user fees (if applicable), explain procedures, provide educational materials and enter data, where applicable.

Counselors: During the project start-up phase, each site should have at least one counselor dedicated to the project full-time. This number will increase as demand increases. Ideally, there should be one counselor for every five clients.

Laboratory Technician: This individual will be dedicated to the project full-time if country/clinic policies do not allow counselors to draw blood samples or run laboratory procedures. Alternatively, this position may have the dual role of laboratory technician and counselor (e.g., where clinical officers and nurses are employed as counselors).

Community Coordinator: At least 50 percent of this individual's time should be dedicated to the VCT project. The role of the community coordinator is to link the service with the community and clinic-based facilities both for demand creation and support and care of VCT clients. Additional roles may be in community mobilization and post-test clubs. It may be possible to combine this role with that of the VCT Coordinator.

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

- Minimum of two staff to serve as VCT counselors. These counselors must have the capacity to serve as VCT site coordinators, community coordinators and even receptionists.
- Volunteer and/or sessional (paid according to sessions worked) VCT counselors may provide VCT services, but there should be at least one formally employed VCT provider or counselor per site. Volunteer/sessional counselors should be interviewed prior to assignment and receive the same training and supervision as employed VCT providers and counselors. VCT site coordinators should assign volunteers clear and regular duties and working hours.
- Where an integrated VCT service delivery model is used, site management should allow those selected to devote most of their time to provision of VCT services.

2. Space For VCT Services

People who wish to know their sero-status have concerns about confidentiality and privacy. There is also evidence that assurance of confidentiality and trust facilitates disclosure of risk behaviors. Consequently, service providers should ensure that there is adequate space to provide VCT services in a private and confidential manner. Thus, we recommend that space be made available as follows, depending on volume and financial resources. It is imperative that the VCT rooms, reception area and laboratory appear attractive and comfortable to clients.

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

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

3. Equipment for VCT Sites

In addition, we recommend the following equipment for each room.

Counseling Room

- Three “easy” chairs;
- Desk and chair;
- Two steel filing cabinets;
- Storage space for communication materials;
- Storage space for blood drawing equipment (e.g., syringes, needles) and medical consumables;
- Disposal container for sharp objects;
- Fan (optional);
- Heater (optional);
- Glass, water, tissues (optional).

Reception/Screening Room

- Cash box;
- Desk and chair;
- Two upright chairs;
- Steel filing cabinet;
- Office supplies;
- Telefax machine;
- Fan (optional);
- Heater (optional);
- Computer for data entry (optional).

Waiting Area

- Television and VCR;
- Two benches and enough chairs to seat 20 people at any given time;
- Open display for educational materials.

Laboratory

- Working counter;
- Refrigerator;
- Desk and chair;
- Sink with elbow taps;
- Running water (hot and cold);
- Soap and towel;
- Medical consumables, including gloves, needles and syringes or lancets, swabs, spirits, etc.
- Lockable storage for test kits;
- Standard contaminated waste disposal facilities;
- Adequate light source and ventilation;

- Fan (optional);
- Heater (optional).

4. Supplies

The quantity of supplies depends on the volume of clients expected and the testing protocols adopted. Additionally, if other medical testing is envisaged as part of the VCT service in stand-alone clinics, the following supplies will be necessary (e.g., TB screening, STI screening).

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

SUMMARY

To offer high-quality VCT services at any site, VCT program planners need to address the following key issues:

1. National policy issues and plans regarding VCT services;
2. Establishment of design, management and partnerships at all levels;
3. Site selection, development, support and maintenance processes;
4. Counseling and testing protocols;
5. Training needs;
6. Community support and linkages with other services, including formation of post-test clubs;
7. Promotion and advocacy, including the need for communication materials;
8. Monitoring and evaluation, including quality assurance measures;
9. Care for counselors.