VCT Service Delivery and Programme Management

Distribute to the participants after all sessions of module six have been covered
Session 1    Establishing VCT Site

PHASES OF PLANNING VCT SITES
The success of VCT services depends on partnership 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.

The planning of VCT services involves three phases:

• Assessment;
• Design;
• Implementation.

Also in planning VCT sites involves three levels, each level has a critical role to play in establishment of VCT services.

• National level
• District level
• Site level

NATIONAL  LEVEL

• Assessment phase
Demand for VCT services using information from existing surveillance of HIV and Syphilis infections

• Design phase
National level activities are designed to promote consensus among stakeholders and implementers on the final design of VCT services in a country.

MOHSW involved in policy, coordination and guidance to ensure quality of services. The following are the three key roles of the MOHSW:

  o Coordination at national level
    The MOHSW coordinate and liaise with public, no-governmental and private organization offering VCT services so that the coverage and scope is equitable. The MOHSW set realistic national targets, identify strategies for realizing these targets and monitor the established VCT services.

  o Training and supervision
    The MOHSW develop, manage and sustain good quality training programmes and supervision system in collaboration with Regional and Council Health Management Teams.
o Promotion of VCT

Sensitization of Regional and District Authorities and the capacity of Regional and Council Health Management Teams (RHMTs and CHMTs) on VCT, emphasizing their role in initiating, promoting, implementing, supervising and financing District VCT programmes.

Special roles and responsibility of the MOHSW:

- Enforcement of VCT standards
- Establishing policies, procedures, minimum standards and for VCT services in line with national needs
- Monitoring and Evaluation
- The MOHSW establish a national management Information system (MIS) on VCT to track the implementation of VCT services.
- Research.

The MOHSW identify priority research agenda on VCT services and facilitate its implementation. Research findings shall be used to inform policy decision makers aimed at improving performance of the VCT programme.

- Implementation at National level
  - Provision of VCT commodities

The MOHSW ensure uninterrupted availability of approved HIV test kits and other supplies in the country.
  - Accreditation of VCT sites

Accreditation of VCT sites that meet required standards is done by a team authorized by the MOHSW.

DISTRICT LEVEL

Health sector reforms have decentralized authority for implementation of services to local government authorities (LGAs). The day to day implementation of health services, including VCT, is the responsibility of council Health Management Teams (CHMTs)

- Assessment phase
  - Site identification and allocation

Before a VCT allowed operating it shall be assessed to determine its suitability, capacity and preparedness to deliver VCT services.

Based on national guideline, CHMTs make decisions on where to locate VCT sites.
Before VCT site starts operating it must receive the official approval of the District Medical officer

❖ Addressing staffing issues that are essential to provide high-quality VCT services (e.g., staff availability, qualifications, selection criteria and how to maintain motivation).

- **Design phase**
  - Integration of VCT into the council Comprehensive Health Plan
    CHMT plan the budget for VCT activities and solicit resources through the MOHSW, PORALG, TACAIDS and other partners to sustain the District VCT programme.

- **Implementation phase**
  - Quality Control
    The District Laboratory technologist provides continuous supervision of HIV testing in all the VCT sites in the District.
  - Management of Information system.
    CHMTs compile all data coming in from the various VCT sites, share it with the partner and forward it to the MOHSW with a copy to the District.
  - Technical support
    CHMTs provide technical support to public, NGOs, FBOs and private sector VCT sites.
  - Promotion of VCT
    CHMTs promote the utilization of VCT services through various community institutions (e.g., schools, churches and mosques).
  - Distribution and utilization of IEC promotion materials in all VCT sites in the Districts.
  - Maintenance of Referral Networks
    CHMTs maintain a referral – networking mechanism among VCT stakeholders.
    Create and regularly update an inventory of different stakeholders providing VCT that linked to care and support services in the district.
    - Training for counselors, counseling supervisors and site staff (e.g., receptionists, site managers, laboratory staff and counselors). Ideally,
o Procuring HIV test kits to the District/NGO/FBOs VCT sites.

o At District level administrative supervision is provided by CHMTs in collaboration with the facility administrative
FACILITY /SITE LEVEL
The roles of facility level are:

- Day to day implementation and management of VCT services
- Provision of Individual and group counselling, follow up and referring clients.
- Assurance of privacy and confidentiality
- Advocacy against stigma and discrimination of PLHIVs
- Attending partners and community meetings
- Adherence to national HIV testing protocol.
- Facilitate formation of Posttest clubs.
- Conduct peer supervision

3. PROCEDURE FOR ORDER AND PROCURE VCT MATERIALS

- The MOHSW is responsible to assure uninterrupted and adequate supplies of test kits and their regular evaluation
- Ordering of test kits and laboratory supplies depends on the Health policy of the facility (FBOs, NGOs or Public Health facility)
- Procurement of test kits and laboratory supplies is done by Medical store Department (MSD) which distributes the supplies to all zonal MSD stores across the Country.
- At District level; The Districts procure and distribute all supplies. DMOs make orders of test kits and laboratory supplies from MSD sign the normal MOHSW indent system used for ordering drugs and other supplies
- Facility level: VCT in charge/ Facility in charge order s of tests and laboratory supplies direct to DMOs every three months by using request form.
- Transport and distribution of test kits and laboratory supplies used mechanism through which drugs and other supplies are distributed nationwide
Session 2  Models of VCT Service Delivery

The choice of a model of VCT service delivery depends upon its accessibility to potential clients, Topography, distance, transport availability and cost. It is important to ensure that VCT sites are easily accessible so as to meet the needs of the population in their catchments area including those of vulnerable population groups such as youth, migrant workers and pastoral communities and people with high-risk behaviour.

It is important to ensure availability of referral facilities for follow up care and treatment.

VCT services delivery can be implemented in different models, each with its own advantages and disadvantages. In Tanzania, the most common models are;

1. Free – standing (stand –Alone) sites
2. Integrated (Facility – Based) VCT services
3. Home testing/Family VCT services
4. Mobile/Community outreach VCT services.

Free – standing (stand - alone) sites is a testing and Counselling centre located outside a health facility. It can be set up in the community centres, youth clubs or learning institutions, but may have links with other care and support services. The establishment of stand –alone sites shall adhere to the following conditions:

- They shall be established on the basis of demand
- They shall be formally linked to affordable prevention, care and support services offered by different facilities/organizations.

ADVANTAGES:

- Community links – Free – standing sites are often situated within communities and have a less rigid management structure. This may facilitates community linkages and partnerships in the design of services and provision of follow up care.

- Post test support groups- Many free- standing VCT sites have incorporated post test support groups into their services.

- Separated from medical services – This encourages people who are asymptomatic to attend VCT, which they might not otherwise do.

- Anonymous testing – Most free-standing services offer VCT that is either confidential or even anonymous (where people can attend without giving their name)

- Flexible opening times – As free-standing services are not within other services (such as health services which have fixed hours), they can arrange or
extend their opening times to be more convenient for clients, for example by offering services at the weekends and evenings

**DISADVANTAGES**

- **Funding** – Majority of such services are provided by NGOs and rely on donor support, ensuring adequate for their continuation has often proved difficult.

- **Potentially stigmatizing** – As free-standing sites are known to have a single service relating to HIV/AIDS, they may be stigmatizing. People may be reluctant to attend, as they fear they will be identified as having HIV. This can be a real obstacle, especially in small communities and in lower prevalence countries where HIV is particularly stigmatized. In these smaller communities, a multipurpose or integrated VCT service that uses a coding system may afford greater privacy and increase the uptake of services

- **Staff burnout** – At dedicated centers staff may suffer burnout and depression, as they have no relief from HIV/AIDS counselling, which can be emotionally exhausting and stressful

**INTERGRATED (FACILITY – BASED ) VCT**

Facility based VCT services are normally provided in an integrated manner alongside other health services in hospitals and clinics run by the government, NGOs, the private sector or Faith – Based organizations (FBOs). In this model, people attending primary health care services or those seeking more specific medical attention, can also receive VCT.

Counselling is usually carried out by clinic staff or by HIV/AIDs counsellors. There is established referral links to routine services in the facility, as well as to care and support services provided by NGOs and FBOs within or outside their catchment area. Routine services such as family planning, prevention mother to child transmission, sexually transmitted infections, CTC clinic etc

The counsellors are able to offer ongoing support and continuity of counselling care to clients diagnosed either on an outpatient or inpatient basis and pregnant women attending the hospital antenatal clinic.

**ADVANTAGES**

- Low cost

- Ease of replication/scalling up – In many countries a nation wide network of primary health care clinics has already been established, so replication is ease due to the availability of infrastructure.

- Linkage to medical interventions – The diagnosis of HIV-associated infections, access and monitoring of treatment, and preventive interventions can be facilitated through linkages at the clinic
• Access for young people – VCT can be incorporated into youth-friendly services, which are beginning to be provided in primary health care settings and which already offer family planning, STI services, general health education, drug, alcohol and sex education, peer education and outreach.

DISADVANTAGES:
• Increased workload – Where no additional staff are employed for counselling duties those carrying out counselling may be unable to provide adequate time for in-depth counselling and, in busy clinics, they may be under so much pressure that they avoid promoting VCT.
• Space requirements – VCT requires adequate space for privacy, and small primary health care clinics may be unable to offer suitable accommodation for VCT, with limited opportunity for expansion.
• Limited access for men and couples – Men do not routinely attend primary health care clinics, and people infrequently attend as couples.

HOME TESTING/FAMILY VCT SERVICES
This is a model, which allows people to test themselves for HIV infection at home. Use of self-testing is not recommended in Tanzania.

ADVANTAGES:
• Privacy – They offer complete privacy, provide a service for people who do not seek testing at VCT sites, and could increase the number of people who know their HIV status.
• Access for “special groups” – There are special groups who could benefit from home testing. These include health-care workers who may be reluctant to be screened for HIV after an occupational exposure because they fear they may already be infected, and people who may wish to self-test prior to mandatory testing for travel abroad or for a work permit.
• Cheap for the health system – As the user has to pay for the test and no counselling is available they are a cheap way of providing HIV testing.

DISADVANTAGES
• No pre-test counselling – People using self-test or self-collection kits receive no pre-test counselling.
• Limited post-test counselling or follow-up care or support – There is no information about the quality of the counselling and the behavioural and psychosocial outcomes following testing. It can increased risk of suicide associated with testing without adequate emotional support.
• Coercion – There is a potential for home testing to be misused. People can “persuade” sexual partners to test.
• **Single test** – Users must understand the need for a confirmatory test and be informed about the window period

• **Difficult to perform** – Although self-testing kits are marketed as being “easy-to-use” some are relatively complicated, especially for people who have no technical background or who cannot read English (instructions may not be in locally used languages)

**MOBILE /COMMUNITY OUTREACH VCT**

This model is used for very specific target groups that may otherwise not access health services, such as pastoral communities and other hard to reach remote populations.

One variation of this model is to have a mobile “VCT team” which provides services at fixed times at a variety of sites such as community centres, religious centres or schools. Pre-advertising (via fliers and public announcements), provides potential clients with information and schedules for the mobile service. Using rapid tests makes it possible for results to be given to clients on the same day. However, in some settings it has been more feasible to ask clients to return the following day for their result.

**ADVANTAGES:**

- **Anonymity** – As mobile units can be independent of health or other institutions, they can easily offer anonymity to clients
- **Improved access** – Mobile units can offer greatly increased access over a wide area, and vulnerable and marginalized groups can be reached through mobile and community outreach.
- **Links to permanent services** – Once good relationships have been established, the regular attendees of mobile sites can be better integrated into larger and more comprehensive, permanent services.
- Increase access to hard to reach populations who do not visit formal health settings.

**DISADVANTAGES:**

- **Follow-up and post-test support** – As a mobile service will usually only offer VCT on a limited number of days at each site it may be difficult to provide follow up support for clients who require ongoing counselling care
- **Maintenance** – If the mobile unit consists of a van or caravan, maintenance can be difficult and costly, particularly in remote areas or where roads are poor
- **Confidentiality** – People attending a single-purpose VCT mobile service may be readily identified in small communities
- **It is not cost effective**
Session 3  Clients Flow Management

Facilitating effective client services flow in variety of setting and Managing high volume of client flow

The nature of the epidemic, the testing procedure and availability of resources will need to be considered when you determining how best to conduct services to facilitate effective client flow in a variety of setting. The pre – test and post test counselling either individual counselling or couple counselling and group counselling) outlines the key procedures involved in providing VCT, should be adapted to meet the needs of the service.

All counselling session in all settings should be conducted in an environment that ensures privacy and confidentiality and adequate time and attention should be provided to the client.

INDIVIDUAL PRE – TEST AND POST TEST COUNSELLING

Individual pre test counselling is one to one dialogue between the client and the counsellor; this approach can be adapted both in freestanding VCT, Integrated or Mobile VCT depending to the need of Service.

Individual pre test counselling is considered to be the most effective pre test counselling strategy.

Individual pre test and post test Counselling Client flow

- Client visit the VCT centre received at the reception area for registration or direct to the counsellor. (Client received cards with Number)
- Waits in the waiting area or direct meet with Counsellor
- Counsellor call a client for Pre test Counselling session
- Blood draw for rapid testing, client consent for testing. Where applicable. (Non medical Counsellor do not draw blood)
- Counsellor takes blood to laboratory for testing
- HIV testing can be done in the Counselling room or in the laboratory of health facility. (By medical back ground Counsellor/ tester) .
- Fills part of client form and Counsellor Tester tests blood sample.
- Client waits for results in the waiting room/area
- Client receipts of results and posttest counselling.
- Supportive counselling and appropriate referral
- Referral client for on going support, if applicable
- Complete all administrative issues (filling forms)
GROUP COUNSELLING:
Group information giving – combining with group pre test counselling. In many settings the demand for VCT is high and resources are limited, often clients are kept waiting in busy waiting rooms for long periods of time. Group counselling could be utilized to reduce the amount of individual counselling time required.

In group counselling approach, the information components of pre test counselling could be provided in a group setting while specific issues for individual person could be discussed on an individual level. HIV test results are never provided on a group basis.

Group Counselling Client flow
- Client visit the VCT centre received at the reception area for registration or direct to the Counsellor. (Client received cards with Number)
- Client discuss with a counsellor information in groups of 5-15.
  - Basic information about HIV and AIDS
  - Basic information about HIV transmission /TB/STIs and HIV risk reduction.
  - Basic information about ARVs
  - Basic information about Family planning
  - Meaning of HIV tests
  - The benefits of testing.
  - The testing procedures (Negative test result, Positive results and indeterminate results) and procedure for result provision.
- Counsellor call a client for individual Pre test Counselling session
  - Person risk assessment and feedback of individualized risk
  - Exploration of Individual risk reduction plans
  - Likely reaction of HIV test results, if HIV test result is positive, Negative and indeterminate, and he possible ways of coping.
  - Demonstration and discuss about condom use.
- Blood draw for rapid testing, client consent for testing. Where applicable. (Non medical Counsellor do not draw blood)
- Counsellor takes blood to laboratory for testing
- HIV testing can be done in the Counselling room or in the laboratory of health facility. (by medical back ground Counsellor/tester).
- Fills part of client form and Counsellor Tester tests blood sample.
- Client waits for results in the waiting room/area
- Client receipts of results and posttest counselling.
• Supportive counselling and appropriate referral
• Referral client for on going support, if applicable
• Complete all administrative issues (filling forms)

COUPLE COUNSELLING:
Persons in polygamous marriage, those planning to get married and those already in a relationship who wish to make informed decisions about having children and plan for their future, should be encouraged to receive counselling together in a group or separately, with husband – wife as couples.

Couples should not be coerced into being counselled together but should be given the opportunity to make informed decisions about being counselled together, Separation and join together for results.

Confidentiality is important and couples should be informed about what it covers and its limits. It is important that individual risk assessments are conducted.

The counsellor should attentively listen to the couple as they explain why they have come for the test.

Each partner in the couple should be given equal opportunity to talk and ask questions, and the Counsellor should be non-judgmental and respectful in responding to the couple. Couples should be given the relevant and accurate facts about HIV/AIDS/TB/STIs/ARV to help them make informed decisions.

They should be helped to explore the implications their test results may have on their relationship, marriage, sex life, family planning and plans for childbearing. Most aspects of counselling can be provided to couples together but risk assessment; risk reduction plan, testing and disclosure should be conducted individually unless otherwise specified.

Couples should also explore together the practicability of any changes in their sexual practice like abstinence, condom use or non-penetrative sex.

A client’s status should not be disclosed to their partner without their consent. Couples who come together for VCT should agree on the modality of receiving results insisting the benefits of receiving results together.
Session 4  Referral and Network Development

Introduction:
- Sometimes the best counselling process is to facilitate a referral of a client to a source of help that is well suited to meet the specific needs of the client’s case.
- A decision by someone to go to counsellor for help does not imply that counsellor is the best counsellor for that client. There may be some precipitating factors.
- A counsellor should not feel incompetent when he/she realizes the need to refer.
- We must recognize that people vary so widely in their differences from each other, and that human problems are complex and widely variant.
- It is therefore, unreasonable to expect that a counsellor can effectively meet all these varieties of needs.
- Each counsellor’s personality, personal history and training may be effective with some clients and not with all individuals needing counselling.

Rationale:
Problems posed by HIV and AIDS epidemic are multidimensional and cannot be addressed effectively by one sector or an institution. This calls for working in partnership in meeting the need of these problems.
- Voluntary Counselling and Testing (VCT) for HIV and AIDS is an entry point to preventive care and support services where an individual knows his/her sero status and thereafter linked is to other services according to identified needs.
- In order to be effective, the implementation of VCT services requires many key elements including community awareness, education and mobilization.
- Networking of these elements is important to ensure those wishing to be tested understand the process.
- Networking ensures that those who are tested and found infected get other services and supported in coping with the infection.
- Therefore, development of networks for supporting the needs of clients is of prime importance.

Definitions:
Referral can be defined as an arrangement of other assistance for a client when the initial helping situation is not or cannot be effective. It can also be referred to as the act of transferring a client to another counselor or agency for services not available
from the referring sources, or for help by other counselors who can handle the client’s need more appropriately.

Once the problem has been clarified and acknowledged by the client as one needing resolutions, the counsellor can decide whether or not he/she is able to provide help for that kind of problem. If the counsellor feels he/she is unable to provide help, he/she can aid the client in obtaining assistance elsewhere by means of a referral.

**Partnership** refers to a group of people or institutions working together for a common goal.

The challenges for provision of services in HIV and AIDS are immense and variable. They are so diverse that it is impossible for one institution to offer all the services. In all these needs, VCT is the entry point to all other services. These services may include, home based care, PMTCT, management of opportunistic infections, antiretroviral therapy (ART) and many more. This situation, therefore, demands for a close system of institutions working together as partners so that the combination provides a holistic arrangement for dealing with issues of HIV and AIDS.

**Networking** is a process of collaboration between organizations, institutions, individuals, and Community Based Organizations (CBOs) working and aiming at a certain goal.

It can also be defined as the process by which two or more organizations or individuals work together to achieve a common goal.

Networking requires one to be free and ready to share various issues including failures.

The process of networking involves the needs to:

- Identify the reasons to develop networks
- Identify and access potential network members
- Develop a new network or join an available one

**Resources to facilitate referral at VCT sites:**

Referral inventory consisting of:

- Active HIV and AIDS counsellors (list their names, address and sex)
- Marriage /family counsellors (their names, addresses and sex)
- Adolescent counsellors their names, addresses and sex)
- Psychiatrists /psychologists/ social welfare (workers) counsellors (their names, addresses and sex).
- Spiritual Counsellor (their names, addresses and sex)
- Legal counsellors (list their agencies names, address and sex)
- Counselors from agencies (list their agencies names, addresses and sex)
• Counseling and testing register
• Referral form

Conducting referrals as part of clinical duties at VCT sites:
The counselor cannot work in isolation. He/she must establish a mechanism of cooperating with others, with a purpose of helping a client to access other professional services. It also involves a counselor seeking professional growth and advice of colleagues especially with those he/she is able to be open with and receive cooperation.

Process of facilitating referrals:
Identify the need to refer. The counselor should:
• Be familiar with referral resources
• Know the location of the resources
• Know the directions of getting to the location
• Establish procedures for scheduling appointments
• Know the contact person of the place you are referring the client
• Prepare the client for referral
• Coordinate the referral

The counselor must discuss the possibility of referral with the client. The procedure should be relaxed and easy, not hurriedly approached. The counselor discusses this with assurance, using counseling skills. The referring counselor should also focus on the client’s need for the referral and not on why the counselor is not able to effectively provide those services.

The next step demands the client to accept or reject the referral. Referral is best when the client can fully decide and own the decision as his/her own. In some cases referral is urgently needed, so the counselor acts promptly using appropriate counseling skills, including confrontation, if appropriate.

Once a decision has been made to accept the referral, the counselor facilitates all necessary procedures for example, informing the referral resource, and informing client how to find them.

The counselor must develop an inventory of networks where clients can be referred. There must be a formal way of facilitating referrals and mechanism of soliciting feedback of referrals that will be agreed by partners. All referrals should be documented in a referral register book.

At that juncture the referral process is terminated unless the referral resource solicits continued cooperation, and in cases where referrals do not necessitate closure of the counseling relationship with the referring counselor.
An example of a Local Networking for a counselor in Dar es Salaam:

COUNSELOR

- MOH Policy and Guidelines Counselors
- TACAIDS Policy and guideline Advocacy
- AMREF Training of VCT
- WAMATA Peer Support Orphan Support
- SHIDEFA + Support Counselling Orphan Support
- IDC TB Vaccination Treatment of STI
- HOSPITAL PMTC Counselling TB Treatment
- CCBRT Legal Support Social Support
- PASADA Treatment Psychosocial support
- WLAC Legal support

Counsellor and other Networking Services / Mechanisms.

- Health Related Services
- Donor Agent
- Legal Unit
- Entire
- Individual Support
- Faith Based
- TBAS & Traditional
- Public Sector
- PMTCT
- Supervisor
- Community Leaders
- CBO
- DRS & Others
- Other Counselors
Session 5  Monitoring and Evaluation of VCT Services

Monitoring and Evaluation

Monitoring is a system designed to follow on the status of implementation of a program, project or activity. On the other hand, evaluation is finding out whether the set goals of an activity, program or project have or have not been met. Both activities are important in the planning and implementation of an intervention. In initiating and expanding the PITC interventions monitoring and evaluation are important in order to ascertain coverage quality funding and the overall intervention. Monitoring and Evaluation of PITC interventions in Tanzania will be based on guiding principles laid down for voluntary counselling and testing service.

Data needed at various levels of the health service delivery system:

- The village and ward requires data to be able to monitor the trend of HIV and AIDS in the community. Village government needs to be well informed about Testing and Counselling Service among other service in order. They may incorporate the information in their village and ward development plans and in turn having this information incorporated in council development plans.

- **At the health facility level** counselling and testing data helps to plan for ordering resources and accounting for those resources. At this level data also helps to serve as basis for planning and developing HIV interventions.

- **At the council (Distinct) level data will assists** the council authorities to plan interventions, monitor activities at the health facility, ward and village levels. In so doing the council can effectively incorporate ward and village HIV and AIDS control plans into the overall council plans.

- **At the central level** and the national level in general the data will help in drawing up national HIV and AIDS plans and budget. At this level data provides the basis for monitoring the trend of the epidemic and for policy planning.

The provider should be responsible for recording information for each patient in a register, recording information for each patient on a separate row. Site in charge at each site is responsible for compiling the information from all registers into the site monthly summary forms.
Session 6  Data Collection and Reporting Tools

The Counsellor is part of data collection team by filling the relevant forms at the site. He/she should at all times be vigilant in filling the forms and registers at the site. The information below gives the guideline for filling the register and various forms.

Filling the register and forms

- **Date:** The date of the counselling
- **Counsellors name:** Fill in the name of the counsellor
- **Client's code:** The code assigned to the client by the counsellor
- **Partner’s code:** To be filled only if the client is a member of a couple where the partner is also a counselling client. If not, it is left blank. Note that the partner will also have their own row in the register, so the partner’s code is filled here also only for easy cross-referencing.
- **Type of attendance:** N=New client, RT=Return visit for re-test outside the window period, RW=Return visit for a window-period re-test, RS=supportive follow up visit. New client means the client has never been counselled and tested before. The window period is defined by clinics as three (3) months after the initial test. Some clients come back as recommended after three months for a confirmation test – these clients should be marked RW. Other clients may have been tested a long time ago, but since then they have been exposed to new risks and so are coming back for another test – these should be marked RT. Some clients may have been tested before but have come back for supportive counselling due to being tested positive or to get further advice – these should be marked RS.
- **Sex (M/F):** M=Male, F=Female
- **Client’s age (years):** The age or estimated age of the client in years
- **District and ward of usual residence:**

The district and ward where the client lives. This is collected so that the site can see if its clients come from nearby or far away.

- **Education level:** NE=None, PI=Primary incomplete, PC=Primary completed, SO=Secondary and above. The site can analyse this column to see how its counselling and counselling training should be pitched.
- **Marital status:** S=Single, C=Cohabiting, MM=Married monogamous, MP=Married polygamous, S/D=Separated/Divorced, W=Widow/widowed
- **Pregnancy status:** YP=Yes, NP=No, DN=Don’t know, NA=Not applicable (i.e. male client)
- **Referred from (source of clients):** TB = TB clinic (out-patients), STI = STI clinic (out-patients), OP = Out-patient health services (not STI or TB), IP = In-patient health services, BTS = Blood Transfusion Services, HBC = From home based care, SR = Self referral.

- **Type of counselling:** Whether the client was counselled on their own, as part of a couple, as part of a group or with their guardian. I=Individual, C=Couple, G=Group, P=Client with parent/Guardian. Note that each counseled person is one line on the register, so for example if a couple is counselled they will be two rows filled and each row will be marked ‘C’.

- **Pre-test counselled (Y/N):** Whether or not pre-test counselling was given to the client. This may be ‘N’ if the client left before getting pre-test counselling or if the client was pre-test counselled on a previous visit and does not need it again.

- **Agreed and tested for HIV (Y/N):** Y=Whether the client agreed to be tested and was tested. If for some reason the test did not go ahead because the patient did not agree, because the patient has been tested recently before or for some other reason, this should be ‘N’.

- **Post-test counselled and results given (Y/N):** Whether or not the client was given test results and post test counselled=Y. For example, this can be ‘N’ if the client left before the test result was given or if the client was not tested.

- **HIV final test results:** P=Positive, N=Negative, INC=inconclusive, NT=not tested

- **Disclosure planned to who:** Who the client says they will disclose their test result to. S=Spouse, SX=Sexual partner who is not spouse, F=Family member, FR=Friend, RL=Religious leader, O=Other, N=None. Here the counsellor can fill one or more codes if applicable.

- **Referred to:** Here the counsellor can fill one or more codes if applicable. CTC=Care and treatment centre, PMTCT=PMTCT centre, TB=TB clinic, OTH=Other services (for example, PLHA group, orphan support, etc)

- **Remarks:** Here the counsellor can write any additional remarks they may have.

**Monthly Summary Forms (site/facility, district, regional)**

Each month the supervising counsellor / CT site-in-charge / focal person in charge of reporting will fill the monthly report. They will fill the name of the
site, e.g. KCMC VCT centre.. They will also fill their own name and contact details. They will fill the name of the district where their site is located. They will fill the reporting month/year and date of reporting to district.

**Site/facility level- site monthly summary form**

Every month, the facility-in-charge/ designated person within a site will fill the monthly report. He/she will fill the forms entirely from the registers gathered from counsellors under his/her supervision.

A table will be filled showing the number of counsellors active during the month. This means the number of counsellors who were regularly counselling for HIV tests during the month, and includes medical staff that also do HIV test counselling as part of their duties. The number is broken down into full time (HIV test counselling is the main duty) and part time (counsellor also has substantial other duties). It is also broken down into how many counsellors have been trained according to the national guidelines and how many have not.

There is also a place to fill number of counsellors attended training according to the national guidelines during the month. This includes those attending first time training or refresher training.

The main section of the report contains numbers of clients. The totals for each indicator (listed in the left, Column 2) are in Column 3 and the totals for Column 3 are disaggregated by sex and age group, in Columns 6-15. Therefore, Columns 6-15 are subsets of Column 3 by age group and sex. Rows 2-5 are numbers of new clients, by indicator. Rows 3-5 are subsets of Row 2. Rows 6-9 are numbers of return and follow-up visits clients, Rows 7-9 are subsets of Row 6. The totals for each row are in Column 3 of each row.

Row 2, of this table, is the number of new clients who have never been counselled and tested before (marked ‘N’). Total number of new clients who have never been counselled and tested in Row 2, Column 3. Row 3 of this table is the number of new clients who agreed to be tested. Total number for clients who agreed to be tested is Row 3, Column 3. Row 4 is the number of clients post-test counselled and received results. Total number of new clients post-test counselled and received results is Row 4, Column 3. Row 5 is number of new clients who are HIV positive. Total number of new clients who are HIV positive is Row 5, Column 3. Rows 3-5 are subsets of Row 2.

Row 6, of this table, is the total number of return/follow up visits clients pre-test counseled (marked RT or RW or RS). Total number of return visits is Row 6, Column 3. Row 7 is the number of return /follow-up visits clients agreed and tested for HIV. Total number of return /follow-up visits clients agreed and tested for HIV is Row 7, Column 3. Row 8 is the number of return /follow-up visits clients post-test counselled and received results. Total number of return /follow-up visits clients post-test counselled and received results is Row 8, Column 3. Row 9 is number of
return/follow-up visits who are HIV positive. Total number of return/follow-up visits clients who are HIV positive is Row 9, Column 3. Rows 7-9 are subsets of Row 6.

Row 10 is the number of clients saying they will disclose test results to sexual partner. This includes both new and return clients. It is the number of clients who have marked ‘S’ and/or ‘SX’ in their disclosure column. This is disaggregated by male and female only, not age.

Row 11 is the number of inconclusive test results, where ‘INC’ was in the HIV status column. Row 12 is the number of patients referred from each source, listed by various services that referred them to counselling and testing, disaggregated by sex. Row 13 is the number of patients referred to each service, listed by various services. It is a count of the number of times each refer-to-service has been noted on the register. If two codes are written in the column in the register for the same client, then there are two referrals counted, one of each type.
Session 7  Data Management and Data Flow

Data utilization and management
Data utilization and management starts with compiling the monthly summaries at every level. Each level should be able to analyse the data for relevant improvement of services at their level. The monthly summary form should be filled out by age group and sex for each indicator, unless otherwise indicated. Please double check the data to ensure it is accurate. This is essential to capture a more accurate picture of the site’s patient flow, services and will help highlight best practices and identifying areas that need to be strengthened.

District-level- district monthly summary form
The guidance is similar as that for completing the site/facility monthly summary form, except a district monthly summary form is used, compiling data from all the sites in the designated district. On the district monthly summary forms, “Number of Sites by Type”. should each be totalled from all the site/facility monthly summary forms. All the indicators should be totalled from all site/facility monthly summary forms in the district.

Once completed and the data is checked, forward a copy to the regional office and keep a copy at the district-level, for records.

Region-level- regional monthly summary form
The guidance is similar as that for completing the district monthly summary form, except a regional monthly summary form is used, compiling data from all the sites in the designated district. On the regional monthly summary forms, “Number of Sites by Type”. should each be totalled from all the district monthly summary forms. All the indicators should be totalled from all district monthly summary forms in the region.

Once completed and the data is checked, forward a copy to the national level/NACP office and keep a copy at the regional-level, for records.

In summary, the data are collected at facility-level and moved up the national level. As previously mentioned, the flow of data from facility to national level is as follows:

The counsellor is responsible for filling out the register and submits it to the site in charge or counsellor supervisor at the end of the month.

The site-in-charge or counsellor supervisor is responsible for tallying and preparing the monthly report in duplicate (one for the site, one for the district)

The form is sent to the DMO by the 7th of the next month

The district report should be filled in duplicate – one for the district and one for the region. The report is sent to the RMO by the 14th of the next month.
The RMO reviews district reports and compiles one region report. He/she sends the report to the NACP by the 21st of the next month. They are filled in duplicate – one for the region and one for NACP.

Feedback reports sent from NACP to regions, districts and sites

**Data flow:**
Facility level generates a summary report within the first seven days of the next month

**Facilities sending the summary reports to the DMO**
District aggregating a summary report from the facilities within the second week of the next month (7-14 days of the next month)

**Districts sending the summary reports to the RMO**
Regions aggregating a summary report from the districts in the third week of the next month (14-21 days of the next month)

**Regions sending the summary reports to the MOHSW-NACP**
This means that the MOHSW-National AIDS Control Programme receives the data of one month from all regions at the end of the third week of the next month

VCT performance indicators are shown in the official CT summary forms
HIV and AIDS Voluntary Counselling and Testing

MODULE 6

VCT Service Delivery and Programme Management

National AIDS Control Programme
February 2008