A Handbook for Improving HIV Testing and Counselling Services

Field-test version

World Health Organization

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ABBREVIATIONS AND ACRONYMS

AIDS	acquired immunodeficiency syndrome
ANC	antenatal care
CB0	community-based organization
CDC	centers for Disease Control and Prevention
CHW	community health worker
CITC	client-initiated testing and counselling
DHMT	district health management team
DHS	demographic and Health Survey
EQA	external quality assessment
FBO	faith-based organization
HBTC	home-based testing and counselling
HIV	human immunodeficiency virus
HMIS	health management information system
HTC	HIV testing and counselling
IEC	information, education and communication
IDU	injecting drug-user
MARP	most-at-risk population
M&E	monitoring and evaluation
MSM	men who have sex with men
NGO	nongovernmental organization
PITC	provider-initiated testing and counselling
PMTCT	prevention of mother-to-child transmission (of HIV)
QA	quality assurance
QC	quality control
QI	quality improvement
SOP	standard operating procedure
STI	sexually transmitted infection
SW	sex worker
TB	tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
VCT	voluntary counselling and testing
WHO	World Health Organization

INTRODUCTION

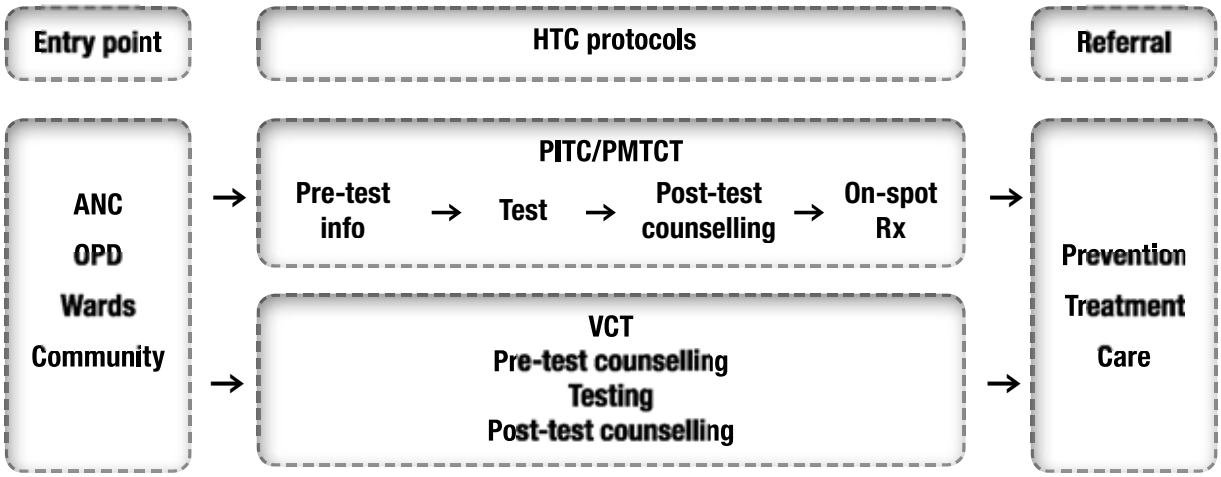
The past decade has seen a rapid global scale-up of HIV testing and counselling (HTC) through a variety of approaches: provider-initiated (PITC) and client-initiated testing and counselling (CITC, often called voluntary counselling and testing [VCT]). Service delivery points are located in health facilities, specially designed stand-alone sites, and mobile, outreach, community- and home-based settings. Existing materials and processes for quality assurance (QA) of HTC are limited; they focus largely on the testing component and few introduce the concept of quality improvement (QI). Updated guidance is urgently needed as it is vital to ensure that scale-up of HTC is not at the cost of quality. This handbook provides a framework and tools for QI that can be adapted to any setting where HTC is provided.

1.1 About this handbook

What is the scope of this handbook?

This handbook provides practical suggestions for improvement of HTC services. It starts at the point of entry to HTC and ends at the point of successful onward referral for prevention, treatment and care services (Figure 1). While we need to scale up HTC services to get more people tested and successfully referred, we must not lose sight of the quality of interaction during HTC (the actual testing and counselling). What happens behind closed doors may have a significant impact on uptake, risk reduction and successful referral to care and treatment, particularly among vulnerable populations.

Figure 1. The HTC journey



This handbook can be used on its own or alongside other WHO materials. It assumes that HTC is being provided in accordance with existing WHO guidance such as the Guidelines for assuring the accuracy and reliability of HIV rapid testing (WHO, 2005). It has been designed to complement the *WHO Operations manual for delivery of HIV services at primary health centres* (WHO, 2008a); used together, they promote an integrated approach to improving quality.

Who is it targeted at?

The handbook is directed at both the public health systems that deliver HIV services and the multiple nongovernmental organization (NGO) partners that assist these public health programmes to improve access to and quality of HIV services. It targets programme managers and providers of HTC and prevention of mother-to-child transmission (PMTCT) services. Programme managers will find an outline of the key

building blocks for QI of HTC in section 2 and example quality indicators in section 3. Service providers will find practical tools and examples in sections 4 and 5. The handbook is further accompanied by a short technical briefing paper targeted at policy-makers. When used together, these will guide countries in building quality into the implementation of their national HIV strategy and HTC guidelines.

We encourage the application of this handbook in naturally occurring referral systems or networks (e.g. administrative divisions such as subdistrict or district) rather than in isolated facilities, because different aspects of comprehensive HIV services are delivered across different locations within the health services. The engagement of district management staff and strengthening of referral networks will facilitate the uptake of the principles of QI to other HIV and non-HIV services.

Which HTC service settings?

HTC is being offered in many different settings. This handbook is suitable for use in any setting where HTC is provided and in any type of epidemic. In medical settings, health-care workers are encouraged to routinely offer testing in tuberculosis (TB) and sexually transmitted infection (STI) clinics. In addition, HTC is offered to all women attending antenatal services. The handbook is thus suitable for use in health facilities providing PITC, PMTCT or integrated VCT services.

This handbook is equally applicable in settings where HTC is provided outside of health facilities. In concentrated epidemics, HTC services target most-at-risk populations (MARPs). By providing a focus on quality in HTC sites that work with MARPs, the uptake of and benefit for stigmatized groups may be maximized. The handbook is also applicable for use in home-based and community settings, as well as mobile and outreach services in workplaces, schools, churches, etc.

The different settings for and purposes of testing mean that the details of the accompanying counselling may vary (for example, counselling in antenatal clinics will focus more on PMTCT, while counselling of an unwell patient in a hospital may focus more on supporting access to treatment). The details of the test procedure may also vary. However, all HTC should observe some standard conditions: consent, confidentiality and counselling, and should be accompanied by an accurate test result.

How should the handbook and tools be used?

This handbook is intended as part of a planned approach to improving quality using the described framework (section 2), indicators (section 3) and tools (section 4). Section 5 provides illustrative examples of QI based on the previous sections. The handbook is non-prescriptive throughout and gives examples intended for local adaptation rather than definitive suggestions. It breaks down the processes into simple, easy-to-understand steps that arise from real-life examples. This handbook can be used as a resource for teams wanting to maintain and improve the quality of HTC provision. The roles and responsibilities at the national, subnational and facility levels are set out in the building blocks (section 2.1) and a suggested way forward for implementing this handbook at different levels is described in section 2.2.

1.2 What is quality HIV testing and counselling?

Quality HIV testing and counselling can be defined as accessible HTC services that meet the needs of clients and providers, in an equitable and acceptable manner, within the resources available and in line with national guidelines.

The availability of HIV test kits with excellent performance characteristics does not automatically guarantee reliable test results. Errors can occur during any of the many steps involved in specimen collection, the testing procedure, and interpretation of results and reporting. Measures to assure the quality of HIV testing are vital, since the consequences of either a false-positive or a false-negative result are damaging. Decisions

on whether to use laboratory-based HIV testing or rapid point-of-care tests should take into account the local context including cost, availability, convenience, expertise, client flow and setting. This handbook provides a sample log book for the recording of HIV rapid test results as a tool in section 4. However, this is only one part of a wider laboratory quality management system that includes internal and external QA, including kit assessment, repeat testing at reference laboratories and proficiency panels. Excellent tools, training manuals and guidelines already exist for HIV testing (section 6).

Quality testing is said to occur when an HIV test is conducted without coercion, is correctly and safely performed using standard operating procedures, is confidential, gives a swift, valid and reliable result, and the provider/facility participates in external quality assessment (EQA).

The discussions that take place between the provider and client before and after an HIV test are an integral component of HTC. While standard protocols for HTC outline the appropriate information that accompanies testing, it is the use of counselling skills that impact on the client's experience of HTC. Measures that assure the quality of counselling are important for ensuring that human rights are respected and the client's needs are met. This is particularly relevant to vulnerable and at-risk populations.

Quality counselling is non-judgemental, accessible and client centred. Counselling should increase knowledge of HIV prevention and help the client to focus on solutions for risk reduction. Quality counselling also results in appropriate, timely and acceptable referral, follow up and treatment adherence.

Only individuals who have been trained in accordance with national guidelines may conduct HTC adhering to national protocols.

1.3 What do we mean by quality assurance and quality improvement?

A range of QA and QI methods have been applied in health care over the past two decades in middle- and low-income countries. Deciding on which one to use for HTC will depend on the country context, commitment of policy-makers and programme managers, as well as the complexity of problems that need to be addressed. Substantial literature is widely and freely available and referenced in this handbook (section 6). Ultimately, countries must decide on their own vision and level of effort to systematically assure and improve the quality of HTC.

What is quality assurance?

Quality assurance (QA) should be considered as an integral management component of any health service organization. While no QA approach guarantees error-free health services, it should promote confidence, improve communications and allow a clearer understanding of client needs and expectations. The key principle of QA is that it is a systematic and planned approach to monitoring, improving and evaluating the quality of services on a continuous basis. QA should:

1. Meet the needs and expectations of the client and the community
2. Focus on understanding how processes of care function within the system
3. Employ evidence-based standards to ensure an acceptable level of quality
4. Use data to measure performance in accordance with standards
5. Encourage a multidisciplinary team approach to problem-solving and QI.

In practice, QA is a continuous process and the QA cycle can be used to guide activities as illustrated in Figure 2. The concepts of the cycle are applicable at the national, subnational and facility levels. At the

Plan
- Develop the purpose and vision of QA efforts in HTC.
- Determine the scope of initial activities.
- Form multidisciplinary QA teams.
- Assign responsibilities.
- (Re)allocate resources.

Define
- The quality that is expected for HTC
- Standards that should be applicable to and feasible for all HTC approaches and setting

Monitor
- Select HTC indicators.
- Select information sources.
- Strengthen the data collection system.
- Implement monitoring.
- Analyse and use HTC data.

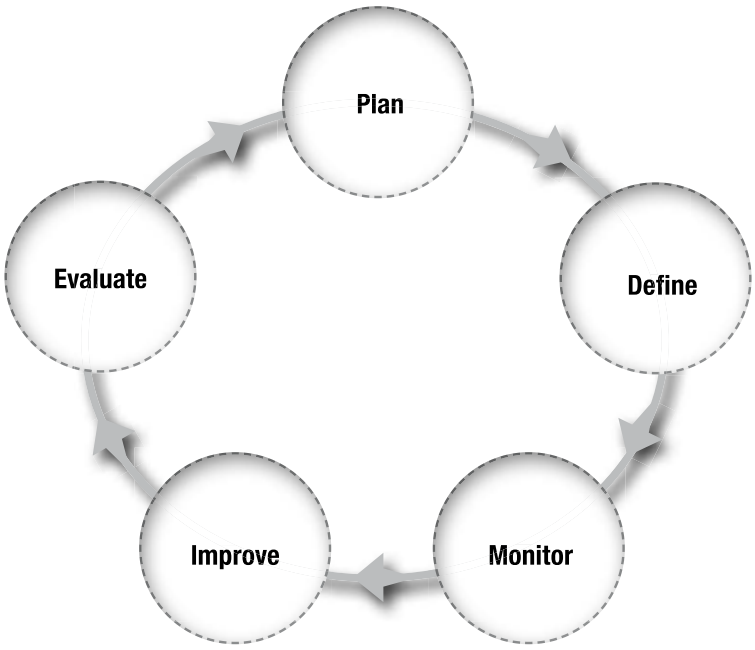
Improve
- Identify problems with quality (from monitoring information).
- Prioritize the problem to be worked on.
- Analyse/understand what is causing the problem.
- Develop solutions.
- Make an action plan to overcome the problem.
- Test and implement the solution.

Evaluate
- Evaluate whether you have overcome the problem.

Share best practices.

national level, the QA vision starts with planning and defining national standards. The subnational level takes on the national vision, using routine monitoring data to support facility efforts at QI. Facilities can start at any stage in the cycle except at the stage of evaluation.

Figure 2: The quality assurance cycle



What is quality improvement?

Quality improvement (QI) is an integral part of the QA cycle and is an approach to the study and improvement of the processes of providing health-care services that respond to client needs. Modern QI methods seek to improve processes of care for optimum compliance with evidence-based standards, which is the ultimate goal for QI of both clinical and preventive care.

A variety of QA/QI tools and approaches have been developed and successfully used. Numerous resource documents, toolkits and training manuals that describe these tools are available (section 6).

Summary

This handbook seeks to address the quality gap that has resulted from rapid worldwide scale up of HTC services. It provides a guide to the use of QI methods to improve the processes of testing and counselling as well as example tools for facility use. It sets out the fundamental building blocks for all levels to plan, define, monitor, improve and evaluate quality in all HTC settings.

2. BUILDING BLOCKS OF THE QUALITY IMPROVEMENT FRAMEWORK

2.1 Building blocks

Building on existing experiences, this section sets out a QI framework for HTC services. It has two main aims:

1. To mainstream thinking among all stakeholders about the importance of building quality into the establishment and scale-up of HTC services
2. To outline what needs to be done in ten simple building blocks.

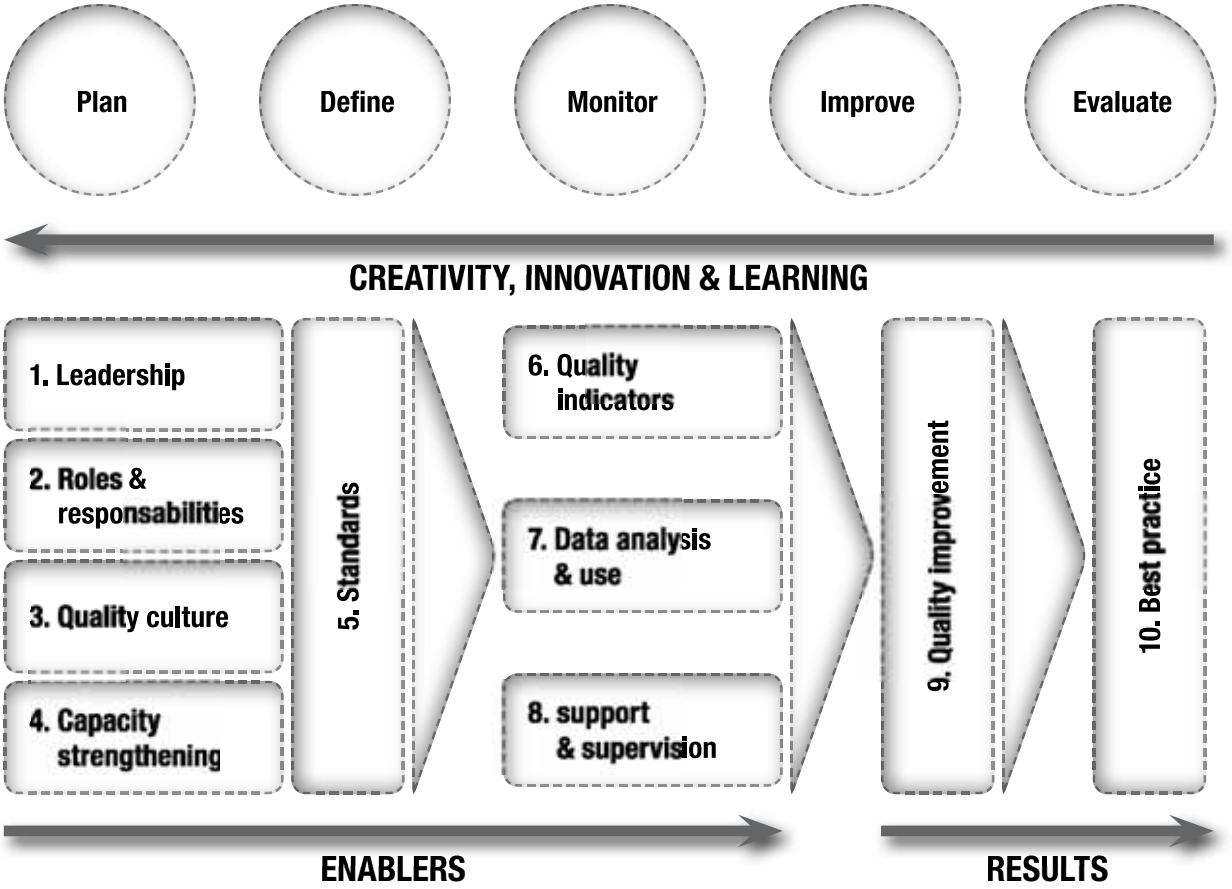
This QI framework is designed to be flexible and easy to use. It can be adapted to different country contexts to encourage stakeholders to develop innovative approaches to QI, which fit their own context. This framework is based on the different stages of the QA cycle and is derived from some of the key problems/concerns that countries face in the scale-up of HTC services as outlined in Table 1.

Table 1: Rationale for the QI framework

QA stage	Problems/concerns	Priorities
Plan	• Lack of clarity about who is responsible for quality at each level • Lack of buy-in from key stakeholders and fear that QA/QI programmes will hinder scale-up • Poor dissemination and implementation of agreed guidelines/quality standards • Lack of capacity in QA and QI	• Strengthening leadership, structures and systems for QI • Building ownership of and active participation in QI among key stakeholders • Conducting advocacy for QI through the dissemination of national guidelines and a QI strategy • Strengthening capacity and skills in QA and QI
Define	• Separate and often conflicting guidelines developed for VCT, PMTCT, PITC, etc. • Existing guidelines not used	• Ensuring that standards, guidelines, protocols are evidence based and relevant to different HTC models
Monitor	• Lack of agreed quality indicators and standardized tools for HTC • Poor data quality • Data not routinely analysed • Weak referral and tracking systems • Weak supervision	• Strengthening the use of tools for routine monitoring of the quality of HTC services • Strengthening data quality and routine analysis • Strengthening referral and tracking systems • Strengthening support supervision
Improve	• Wide variation in the quality of HTC services • Limited use of data to improve quality	• Enhancing provider capacity and performance through introduction of the QI methodology and a multidisciplinary team approach to improving quality
Evaluate	• Different approaches to HTC have not been evaluated • Lack of data on what works and what does not work	• Identifying examples of best practices and systems changes required to improve the quality of HTC

Using the stages of the QA cycle and the priority actions derived from Table 1, a systematic approach is set out in Figure 3 consisting of ten building blocks that form the basis of the QI framework for HTC.

Figure 3. The quality improvement framework for HTC



The first four building blocks in this framework relate to planning. Planning needs to be undertaken at all levels to allow for a bottom–up and top–down approach at the same time to enable a more rapid scale-up of QI. National HIV programmes require leadership in driving the quality agenda and clarity in defining responsibilities for supporting QI activities at each level of the system. Building ownership and active participation among key stakeholders is pivotal for establishing a successful QI programme. Capacity and skills strengthening in QA and QI at each level of the system is a fundamental part of planning and creating a culture of quality within HTC programmes.

Building block 1: Leadership

To obtain strong engagement, a wide cross-section of stakeholders who are directly involved in the delivery of all aspects of HTC services should meet regularly in a forum that provides leadership and direction for the quality of HTC. This forum may be part of an existing task force or a specifically dedicated team. For example, some countries have an HTC technical working group with a quality subcommittee. Others have a national QA/QI department within the ministry of health with potential for a subcommittee on HIV services. Members should be co-opted from:

- Ministry of health personnel involved in HTC at the national and subnational levels
- Professional associations (those involved in counselling and laboratories)
- Donors

- International agencies
- Implementers (NGOs, private sector, faith-based organization [FBOs], etc.)
- Service users, including people living with HIV.

The main purpose of this group is to provide strategic oversight and direction through:

- reviewing and updating HTC guidelines and protocols
- defining quality indicators for HTC
- defining roles and responsibilities for the achievement of quality
- having a complete picture of the status of HTC across the country
- identifying priority areas for improvement
- providing recognition of high-performing HTC services
- sharing best practices.

Building block 2: Roles and responsibilities

To obtain a coherent, functioning quality management system that addresses national, subnational, facility and community concerns, it is vital that quality is monitored and improved at each level with the active involvement of all stakeholders. This assumes well-defined roles and responsibilities in relation to monitoring, improving and evaluating the quality of HTC. Countries will have varied institutional structures and individual role definitions for each level. However, all countries will require a system for oversight, coordination and implementation of HTC, which takes into account counselling, laboratory services, logistics, and monitoring and evaluation. Table 2 describes summary responsibilities for quality in HTC at each level of the health system.

Table 2. Responsibilities for quality in HTC by level of facility

LEVEL	Summary responsibilities
NATIONAL	• Provide leadership, vision and strategy for HTC. • Formulate and update national standards and guidelines for HTC. • Advocate for and institutionalize QA systems and the QI methodology for HTC. • Agree on training curricula for HTC; authorize training manuals and institutions. • Ensure that laboratory quality control (QC) and EQA systems are established and maintained. • Select test kits; define algorithms; evaluate new testing technologies. • Forecast, procure, store and distribute equipment, kits, reagents and consumables. • Maintain a national database for HTC (e.g. numbers of people tested each year, disaggregated by sex). • Conduct monitoring and evaluation (M&E) of the national HTC programme. • Recognize and share best practices.
SUBNATIONAL	• Support consistent goals for quality. • Have a complete picture of HTC service provision at the subnational level. • Identify priorities for HTC. • Ensure that all HTC services comply with minimum standards. • Supervise HTC providers (laboratory and counsellor support). • Support failing sites. • Ensure that QI of HTC is factored into local health plans. • Ensure that HTC providers participate in EQA for testing and receive feedback. • Review subnational data and provide feedback to HTC managers. • Submit aggregated HTC data to the national level. • Encourage innovation and highlight success stories.

LEVEL	Summary responsibilities
SERVICE DELIVERY POINT	• Adhere to standard operating procedures and use national guidelines. • Participate in regular QI team meetings. • Ensure adequate stocks of kits, reagents and other consumables. • Ensure that interventions are in place to prevent stress and burnout of staff. • Ensure accurate recording and reporting of HTC data. • Complete and analyse monthly HTC statistics. • Monitor and analyse agreed quality indicators. • Identify, analyse and develop solutions for problems related to quality. • Give feedback to the community, service users and other facility staff.
COMMUNITY	• Advocate for quality. • Raise awareness of home-based, mobile, outreach and facility services. • Provide feedback through community meetings. • Conduct client exit interviews with service users.

Building block 3: A culture of quality

Rapid scale-up of HTC services without building on quality could actually be counter-productive if service providers are unable to guarantee adherence to minimum standards. Poor communication and dissemination of HTC guidelines and the national QI strategy for HTC can result in a lack of understanding of standards at the facility and community levels, and a feeling of not being part of the QI programme. Advocacy for QI through the dissemination of national guidelines and a clear framework will be vital for developing a culture of quality within the health system. In this context, providers of HTC services view users as their clients and understand the importance of monitoring, improving and evaluating quality on a continuous basis, such that all clients can access quality HTC services that meet their needs in an equitable and acceptable manner, and within the resources available. National- and local-level fora for exchanging experiences, sharing best practices and recognizing high-performing teams can act as motivators to service providers and reinforce a culture of measurement and improvement.

Building block 4: Strengthening capacity and skills

The approach to QA and QI, as outlined in this framework, is still new to many health workers. Most basic training programmes for health workers do not include the concepts of QA and QI. An initial training effort will be required to strengthen capacity and skills in QI. Authorities at the national level have to ensure that this is factored into their national plan and strategy, and that it is costed accordingly. Decisions should be made on how capacity is to be strengthened and phased in at each level. Training teams rather than individuals can often be more effective for long-term sustainability and for overcoming issues of high staff turnover.

Building block 5: Setting standards

The fifth building block relates to defining the quality of HTC. Considerable effort goes into the development of guidelines, standards and protocols for HTC. However, they are often not disseminated to or used by the right people (service providers and managers). Additionally, separate programme guidelines for HTC in various settings (VCT, PITC, PMTCT, child testing, etc.) have the potential to convey conflicting messages. The challenge is to ensure that national guidance is developed in a collaborative manner with standardized messages.

With the development of new testing technologies and the increasing flexibility in approaches to HTC, there is a need to keep abreast of changes and reflect them in national documents. Definitions of standards, guidelines, policies and protocols can be found in the glossary (section 7). Regardless of whether countries choose to have one set of HTC guidelines or separate programme-specific guidelines, these should be

up-to-date and evidence based, as well as relevant to the different HTC approaches within the country. It is the responsibility of those at the national level to ensure that there is a regular system for doing this.

Consideration should be given to the following questions:

- What are the key reference documents available?
- Where have HTC programmes and experiences been the most successful (at the local, regional, international level)?
- How does the content of counselling services vary by approach (CITC/PITC/PMTCT), setting (facility-based, community-based) and client (male/female, injecting drug users [IDUs], sex workers [SWs], men who have sex with men [MSM], youth, couples)?
- Which new testing technologies have become available since the last revision?
- What is the proposed scope of the guideline?

Monitoring the quality of HTC service provision is a key concern for managers and providers. Building blocks 6, 7 and 8 relate to monitoring quality. Even when data are routinely collected, data recording and reporting may still be weak, with little, if any, data analysis and use for improvement of quality at the facility level. Feedback and supervision from higher levels may be sporadic and viewed as control rather than support. Unless quality is monitored on a regular basis, facility staff and their managers will not know whether a quality service is being provided to the end-user in line with the national guidelines.

Building block 6: Quality indicators

There is a lack of consensus on what the quality indicators for HTC should be and few countries have the tools for and systematic approaches to monitoring, improving and evaluating HTC quality. These gaps mean that managers and providers are unable to demonstrate compliance with national guidelines and the importance of quality is undervalued. This document specifically sets out to address these gaps. For facilities and individuals providing HTC services, example quality indicators are described in section 3 and sample tools in section 4. These indicators and tools can be used for routine monitoring at the facility level as part of a QI programme. When facilities perform poorly against selected quality indicators, these tools will signify where QI efforts should be focused. Depending on the local context and HTC approach, a range of quality indicators can be developed and routinely monitored.

Building block 7: Analysis and use of data

Normally, the routine health management information system (HMIS) does not include indicators that specifically relate to HTC service quality or to attrition (people who are gradually lost to HIV prevention, treatment and care services after being referred). However, collecting additional data that is not used can demotivate health-care workers. In sections 4 and 5, examples are given of how routine HTC data can be collected using observed practice, a standardized laboratory log book, client exit interviews and self-assessment tools, and how these data can be used to monitor the quality of HTC services at the point of delivery. Through the use of graphs, tables and charts, providers can monitor and analyse the quality of service provision over time. Once routine analysis and use of monitoring data becomes institutionalized, QI teams can set about identifying problems. If providers are involved in identifying quality indicators and collecting data related to their analysis and use, then the quality of data and their immediate use is likely to improve. An important aspect of QI is that much of the data collected stays at the facility level for analysis and use by the facility to improve the quality of service delivery and systems performance, thus contributing to the sense of team work and to the whole systems measures described in Figure 4 (section 3).

Building block 8: Support and supervision

Weak, irregular supervision that acts as a form of control rather than support is still a common problem in many countries. Supervision often has an emphasis on quantity (number of visits) rather than quality; consequently, supervision often has little impact on performance improvement. A key role of supervisors

should be to support, mentor and coach HTC service providers and QI teams at service delivery points, and impart knowledge and skills through continuing education. There are specific laboratory and counselling components for HTC, which require specialized expertise that only certified laboratory and counselling professionals are eligible to undertake. The country context will determine how supervision is managed. Good supervision will motivate counsellors and sustain quality but facilities need to build in additional approaches to prevent burnout. Preventing burnout is critical for professional development, improving the quality of counselling interactions, decreasing staff turnover and ensuring the sustainability of services.

Building block 9: Quality improvement teams at the facility level

It is essential to reduce variation in the quality of HTC provision such that all users can access high-quality HTC services, whether it is client- or provider-initiated, facility- or community-based. To improve quality, the capacity of providers at all levels should be strengthened through training and coaching in the QA/QI methodology such that they possess the skills to monitor, improve and evaluate quality using a team-based approach. Sections 4 and 5 give concrete examples of QI tools and methodologies that have been used in the context of HTC. While the national and subnational levels can advocate for QI, allocate resources and support providers, it will be the teams at the point of service delivery who will ultimately be responsible for improving quality. Team members should be encouraged to work together to recognize and understand client needs and expectations, analyse their way of working (processes and systems) and to develop, test and implement solutions to improve performance. It is the establishment of QI teams at the point of service delivery which will determine the overall success of the QI programme. As confidence and skills increase in the use of the QI methodology, the scope and ambition for QI increase. The context and complexity of the problems identified will determine whether a collaborative approach is used, where multiple teams all try to make improvements in the same topic area, or whether individual teams work on finding solutions to their individual problems. This in part will also depend upon the in-country expertise and experience that exists in modern QI methodology as well as the available resources to support QI activity.

Building block 10: Sharing best practices

This leads us to the final evaluation stage of the QA cycle and the final building block for achieving quality HTC services. Since the range of approaches to delivering HTC have not yet been fully evaluated, there is a paucity of data on what works and what does not work in different settings. As discussed in building block 1 (leadership), facilities at the national level should play a key role in identifying international, regional and country best practices and in recognizing innovation, synthesizing lessons learned and disseminating best practices to all service providers. At a local level, QI teams that improve the processes of care and bring about system changes can disseminate success stories by becoming demonstration sites. Through exchange visits to poor-performing sites, they can motivate these sites to raise their standards through example. If a culture of QI is to be achieved, leaders at a national level must play a key role in recognizing good performance and in encouraging “friendly competition” between areas and service delivery points. Recognition in itself can act as a key motivator for improved performance. This can be achieved through regular dissemination fora in which success stories are highlighted and shared with other providers. Where a collaborative approach to QI is used, diffusion of successful QI strategies is easier, however the extent of sharing and scaling up of the lessons learned will depend upon the resources allocated to QI activities. Scaling up can be done in a phased manner until the whole country has been covered.

2.2. The way forward

In many countries, the fundamental building blocks described in this framework will already be in place and can simply be strengthened and adapted to HTC services. It is important that QI of HTC is *not* introduced as a new vertical structure but integrated into existing structures. For those countries which lack experience in QI, establishing a QI programme for HTC may initially seem overwhelming. A key priority for all countries will be to ensure national-level commitment while simultaneously encouraging the formation of QI teams,

since it is at the points of service delivery that quality can be improved. A suggested sequence of activities describing how to implement this handbook at different levels is given below.

Suggested activities for getting started at the national level

1. Map existing QI initiatives (including those provided by NGOs and others).
2. Consider where a task force should be placed (within the HIV programme or across services).
3. Set up a task force or mandate an existing task force with clear terms of reference (refer to Table 2).
4. Ensure that funding mechanisms and resources are available and sustained for strengthening human capacity to monitor, improve and evaluate quality.

Suggested activities for getting started at the subnational level

Facilities and districts should not be put off by the absence of leadership or advocacy at the national level. Demonstrating performance improvement locally is a powerful mechanism for motivating service providers and for influencing those at the national level.

1. Identifying a unit to start the improvement work

Choose a small referral unit (e.g. 10–20 health centres, VCT sites and a referral hospital) where a complete set of HIV services is offered and managed by a single team (e.g. district-level health management team). This team should be functional and supportive, and work well with other implementing partners (e.g. NGOs, mission hospitals, etc.).

2. Setting a local aim

Set clear aims. The aim might be to quantify access coverage (number of people to be tested each year) as well as measures of quality (e.g. reliability of testing, patient satisfaction). Set goals that can be accomplished over a year. These should be set according to the population's needs (e.g. 95% of pregnant women tested and received results), not according to past performance (e.g. 10% more/better than last year).

3. Understanding the HTC process

Describe the HTC journey from the time an individual is identified as needing testing (e.g. all antenatal care [ANC], STI clients) to the point where they are safely in care (e.g. started on antiretroviral therapy [ART]). An example that describes the stages of this journey is given in section 3.2. Each project should draft a similar process map that outlines the relevant stages.

4. Documenting and reporting performance through a simple set of indicators

Record the performance of each step of the process using reliable data (as far as possible, indicators should be drawn from existing data). Suggested indicators are described in section 3.3. Examples of practical tools for monitoring HTC services which have been successfully field-tested in a variety of resource-constrained settings are given in section 4. These may be used and adapted to the local context.

5. Applying a quality improvement framework to improve the system

Use QI methods systematically. Section 5 outlines a systematic approach to using data to measure the performance of the system, and practical steps to identify the root causes of process failure, and how to derive and test ideas for improving the system.

6. Disseminating changes throughout the system?

From the outset, have in mind a scale-up plan for disseminating the improvements to neighbouring regions and national programmes. This initial phase should be used to improve local knowledge about best practices for HTC and to build the will of national leaders to rapidly scale up improvements to all regions, and use QI methods more widely for HIV and non-HIV health system improvements.

3. QUALITY MONITORING SYSTEM FOR HIV TESTING AND COUNSELLING

This section describes how quality indicators can be systematically developed and provides example indicators as a basis for routine monitoring of the quality of HTC services at service delivery points. This section links closely to the WHO Guide for monitoring and evaluating national HTC programmes (under development). It describes how the national-level quality indicator (Indicator 2: percentage of HTC sites that meet national service quality standards) can be derived from a number of site-level indicators. These can be collected through routine monitoring and using tools such as those described in this handbook. The final choice of indicators will depend upon the national HTC guidelines and the country context.

3.1 Key quality monitoring principles

The quality of services is a dimension of performance of the system that delivers these services and is usually expressed in terms of service providers' compliance with evidence-based standards of care. Quality indicators for HTC would then measure the performance of service providers against explicit standards that define "good" counselling and testing processes. Example tools are described in section 4 of this handbook. Whereas the process of performing an HIV test can be easily described through a series of steps and instructions (procedures, protocols), counselling services are more difficult to standardize.

The results expected from HTC services, whether outputs or outcomes, do not depend only on providers' performance but also on the following factors that can be measured:

- Continuity of services: It is unlikely that one counselling session will be sufficient to induce behaviour change. Attrition rates (clients dropping out before all steps of the process are completed) or clients lost to follow up (clients completing all steps but not coming back for the next session) are examples of measures of continuity (or discontinuity) of services.
- Clients' satisfaction: services might be technically excellent, but clients might dislike the way they are delivered (inconvenient hours, unfriendly location, rudeness of staff, excessive costs, long waiting times, etc.), hence decreasing their motivation to receive the services and potentially decreasing the effects of these services.
- Clients' adherence to counselling advice: counselling sessions customized to each client's situation are more likely to address their needs effectively, but clients' behaviour change can be difficult to measure.

Because every service delivery system can be described in terms of inputs, processes, outputs and outcomes, a quality monitoring system can theoretically measure each one of these components:

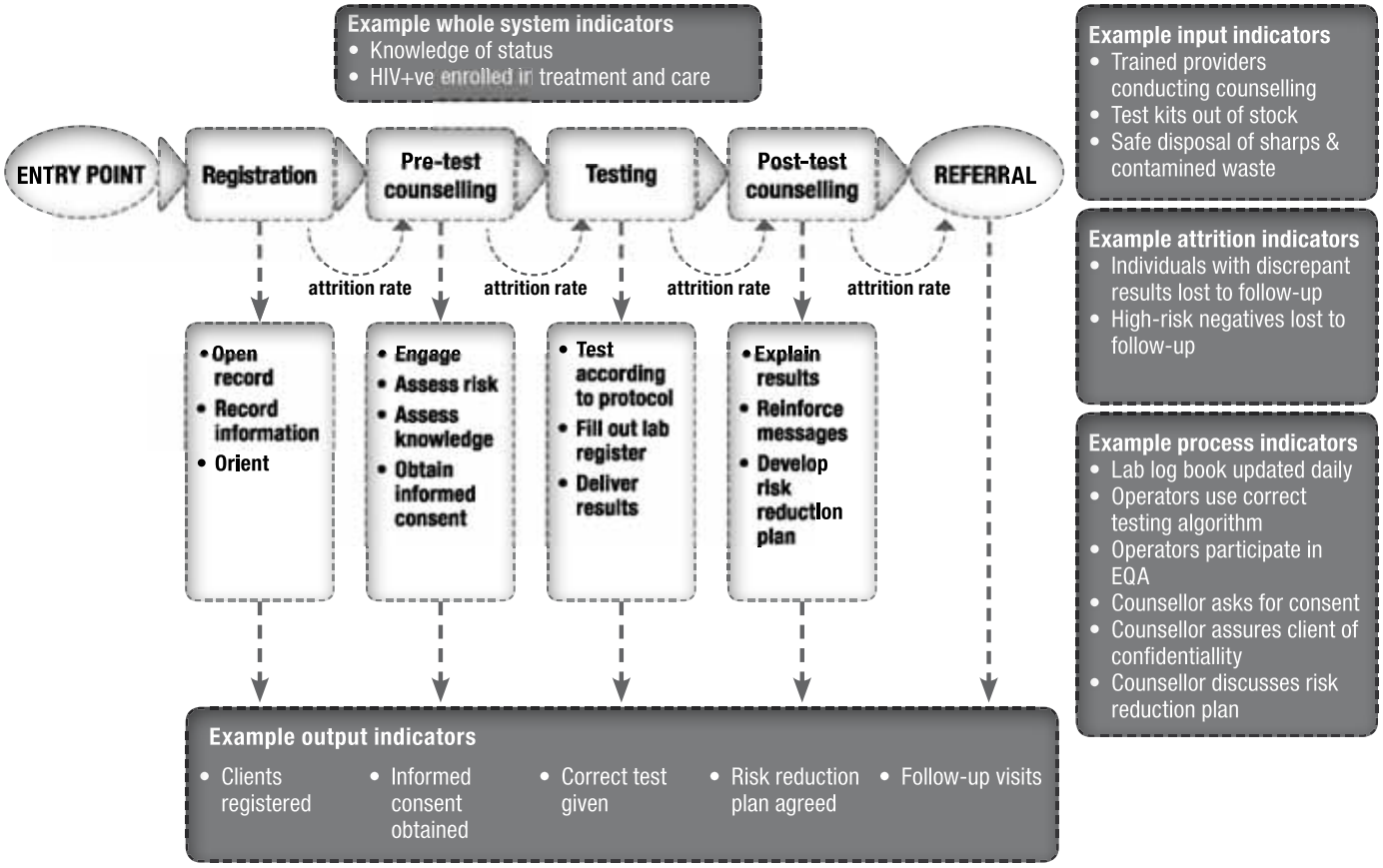
- Availability of inputs and their meeting explicit criteria: for example, certified counsellors and trained laboratory technician for HIV testing
- Service providers' performance against process standards of testing and counselling: quality of services
- Outputs (intermediate results) of each step of the various processes: for example, at the end of the pre-test counselling session the client accepts to be tested and, as an output of the testing protocol, a valid result is then communicated to the client
- Outcomes of each process/system must be explicitly defined and measured (if possible): anticipated behaviour change, knowledge of HIV status, and enrolment in care and treatment, to name a few.

However, it is important to design the quality monitoring system in the context of a broader improvement framework. One should not overload the health system with measures that will not be used for improvement, and the team involved in improving the HTC services/system must be able to justify the rationale for the measurement system and indicators selected around specific improvement aims and objectives. The development of improvement measures can be facilitated by mapping the HTC process/system.

3.2 Process map for development of HTC indicators at facility level

Using the HTC journey map (Figure 1, section 1), each step can be further broken down. As an example we have selected the HTC protocol for VCT.

Figure 4: Detailed process map for VCT with example quality indicators



This visual representation helps to identify five types of measures of performance of the system:

1. Whole-system measures are the outcomes of the entire system and all processes.
2. Input measures focus on the characteristics of available resources.
3. Attrition rates measure the flow of clients through all steps of the process.
4. Process measures focus on the quality of services.
5. Output measures express what is expected from each process taken independently.

These measures can be transformed into indicators as described in the grey boxes in Figure 4.

3.3 Example quality indicators at facility level

The indicators described in Table 3 are illustrative examples of service quality and system performance indicators for facilities and individuals providing HTC services, derived logically from the process map. These are just examples of quality indicators and, depending on context and approach, other quality indicators could be selected or devised.

Table 3: Example indicators for quality improvement of HTC services

Indicator area	Denominator	Numerator	Source of information	Rationale
Counselling	The number of counselling sessions	The number of counselling sessions that meet national guidelines	Client exit interviews, observed practice, self-assessment	Standards of counselling are explicit in national guidelines. If not, WHO standards should be used
HIV testing	The number of tests performed	The number of correct results given	Results of proficiency testing and/or retesting	Wrong HIV test results can lead to dramatic consequences for clients and the health system
Follow-up counselling and testing	The number of clients who have been asked to return for follow-up HTC	The number of tested clients who return	Client records and lab registers	Clients may be asked to return for different reasons, e.g. high-risk negative persons for support with behaviour change and retesting, those with indeterminate results, returning with partner for partner testing
Linkage to care	The number of clients who have tested positive	The number of HIV-positive clients who have been enrolled in care	Referral form or any evidence of a clinical visit with CD4 results	Enrolment could be defined as evidence of "a clinical visit", "CD4 test", "receiving appropriate care" (wellness, ART services, etc.) or a "formal referral" to a care and treatment service
Knowledge of status	The number of clients who have been tested	The number of tested clients who know their results	Client records and lab registers	In most cases, test results are immediately available; if this is not the case, then this indicator might inform about necessary changes that should be made in the system

3.4 Relationship with HTC indicators at national level

While the national level can give guidance on monitoring the quality of service provision to districts and facilities, each site must ultimately decide on the utility of routine monitoring of quality indicators for HTC services as described in this section. The draft WHO Guide for monitoring and evaluating national HIV testing and counselling programmes recommends five core indicators for national-level M&E of HTC:

addressing standards, quality, coverage and success of referral as shown in Table 4. These national-level indicators are reinforced in this handbook, which gives examples of what data facilities might collect in order to report upwards to the national level.

Table 4: Proposed national indicators for HTC

National indicators for:
Standards
1. Existence of HTC policies and guidelines that are consistent with international standards
Quality
2. % of HTC sites which meet national service quality standards
Coverage
3. % of women and men aged 15–49 years who received an HIV test in the past 12 months and who know the results
4. % of MARPs (SW, IDU, or MSM/transgender persons) who have received an HIV test in the past 12 months and know the results
Referral success
1. Ratio of # of new patients receiving care/pre-ART or ART services: # of new people who test positive for HIV

Section 4 describes different tools which have already been used by different countries for monitoring the quality of HTC services and section 5 gives detailed descriptions of how these tools can be used as part of a facility-based QI effort.

4. EXAMPLE TOOLS AND INSTRUCTION GUIDES FOR MONITORING THE QUALITY OF HIV TESTING AND COUNSELLING SERVICES

This section describes a range of tools that can be used on a systematic basis for routine monitoring of the quality of HTC at service delivery points. All the tools included have been tried and tested in the field, and build on the lessons learned from both successes and failures. These tools can be adapted by service providers and programme managers to different country and local settings, and used to initiate and/or strengthen quality improvement activities at service delivery points.

Five different example tools are described in this section. These have been selected as they provide examples of how the information that makes up the data for the core quality indicators outlined in chapter 3 can be collected, as well as the national-level indicators suggested by the WHO Guide for monitoring and evaluating national HTC programmes (in development). Tools 1–4 are accompanied by guidelines on how they should be administered and used. The example tools for site assessment are country-specific tools provided as examples only. Each country would need to adapt a similar tool from their own national guidelines for HTC and agree on minimum standards. Managers and providers should be cognizant of the fact that no single tool provides a complete picture of quality and that each tool has its own limitations. A combination of tools for monitoring the quality of service provision will provide the most comprehensive overview from both user and provider perspectives. Table 5 provides a direct comparison of administering the different tools, which is useful for planning and making decisions about which tool/s to select and use.

Table 5: Comparison of administering different tools

	Lab log book	Self-reflection	Observed pratice	Exit interview	Site assessment
Who?	Counsellor/ clinician/ lab technician	Counsellor	Senior counsellor/ supervisor	Neutral person / volunteer from community	Subnational-level supervisor
How?	Included in HTC training	Included in HTC training	Requires specific training	Health centre committee to identify individuals. Staff provide orientation and make a token payment	Requires specific orientation
When?	End of each day	Immediately after session	During session	After receiving all services	Before site opens and biannually thereafter
How many?	All	One per day	Four per year	100 (depends on client flow)	One per year
Duration	Continuous	Continuous	One day	Over two weeks	One day
How often?	End of month analysis	End of month analysis	Every quarter	Every 6–12 months	Annually
Where?	Counselling room	Counselling room	Counselling room	Somewhere where there is privacy	Whole facility
Analysis	Facility QI team	Counsellor and discuss issues with supervisor	Discussion between counsellor and supervisor	Facility QI team	Subnational QI team

4.1a Standardized laboratory logbook

Instructions for using a standardized logbook to record the results of HIV rapid testing

1. Introduction and background

This logbook is being used as a test to streamline your work process. Our airm is to make your workload lighter.

The other aim is to improve the quality of data recorded. For example, never use “white-out” if a mistake is made. Instead, put a single line through the mistake and initial it for quality assurance purposes. Everyone makes mistakes. Knowing where mistakes occur most often will help systems.

PAGE TOTALS at the bottom of each page will be used to evaluate the performance of individual kits. Please try to be consistent and use the same test kit repeatedly for Test-1 and Test-2. When the same kit cannot be used, please start a new page so that PAGE TOTALS are restricted to one test kit.

Please use black or blue ink. Please do not record data with a pencil.

Guidelines are provided below for each of the data fields (columns) in the logbook. The guidelines for interpretation of results are representative of most kits, but please be aware of differences in kits and follow manufacturer guidelines fully. Also, these guidelines are based on a serial testing algorithm, but can also be applied to a parallel testing algorithm (see chart in 2.8).

2. Columns in the logbook

2.1 Serial no.

Print consecutive numbers in each row. Each row is associated with one patient/client. Some patients/clients might have data recorded in more than one row; for example, if one of the tests is invalid (INV) and repeat testing needs to be performed. In this case, a note is made in the Comments field and the results of the repeat test are recorded in a subsequent row – ideally the very next row (see sample form).

2.2 Client or patient code

Transfer client code or patient code – might be known as IP (inpatient) or OP (outpatient) or VCT code – from the registration form if available.

Most sites have intake registration forms that contain patient information. If possible, please avoid printing patient names on this rapid test logbook for confidentiality reasons.

2.3 Age

Print the age in years. If the exact age is not known, please estimate.

2.4 Sex

Circle **M** for male and **F** for female.

2.5 Date tested

Print the exact date when the test was performed using this format: day/month/year.

2.6 Test-1 name, lot number, expiry date

Write the kit name, lot number and expiry date in the space provided at the top of the column. When the same kit cannot be used, please start a new page so that PAGE TOTALS are restricted to one test kit. Keeping track of this information is critical for quality assurance.

Test-1 results

Record results of the tests performed in this section – according to individual kit instructions.

For a **NON-REACTIVE** result, circle **NR**.

1 red line (or dot) appears in the control window. No SECOND test is needed. Proceed to the section on Final result given to client and circle NEG.

For a **REACTIVE** result, circle **R**.

2 red lines (or dots) appear on the test strip – one in the control window and another line in the patient/test window. For all positive FIRST tests, a *different* SECOND test most be done immediately (those results are recorded in the Test-2 section).

For an **INVALID** result, circle **INV**.

The test is invalid if there is no line in the control window – even if there is a line in the patient/test window.

If this happens, record this result (circle **INV**) and repeat using the *same* test.

Record the results of the repeat test in the next row (see the form *4.1b. Logbook revised*, rows 1 and 2).

2.7 Test-2 name, lot number, expiry date

Same as 2.6

Test-2 results

Record the results of the tests performed in this section – according to individual kit instructions.

For a **REACTIVE** result, circle **R**.

2 red lines (or dots) appear on the test strip – one in the control window and another in the patient/test window.

For a **NON-REACTIVE** result, circle **NR**.

1 red line (or dot) appears in the control window. Proceed to the section on Final result given to client and circle IND. Repeat testing immediately and if again NR, perform retesting after specific time frame as per country guideline.

For an **INVALID** result, circle **INV**.

The test is invalid if there is no line in the control window – even if there is a line in the patient/test window.

If this happens, record this result (circle **INV**) and repeat using the *same* test.

Record the results of the repeat test in the next row (see the form *4.1b. Logbook revised*, rows 1 and 2).

2.8 Final results

Use the following table as a guide for interpreting the final results.

Serial scenario	Test-1	Test-2	Final results
1	NR	Not needed	NEG
2	R	R	POS
3	R	NR	IND
4	R	INV	Repeat Test-2
5	INV		Repeat Test-1 and proceed to Test-2 if needed

Serial scenario	Test-1	Test-2	Final results
1	NR	NR	NEG
2	R	R	POS
4	R	NR	IND
5	NR	R	IND
6	NR or R	INV	Repeat Test-2
7	INV	NR or R	Repeat Test-1

2.9 Testing personnel

Print the name of the person performing this test.

2.10 Specimen for external quality assessment or confirmation

Keeping track of this information is critical for monitoring testing quality. Tick the box if specimen sent for confirmation or EQA testing.

2.11 Date when specimen sent (important for EQA records)

Print the exact date when the specimen was received or sent for EQA or confirmation using this format: day/month/year.

2.12 Final EQA or confirmation result

Keeping track of this information is critical for monitoring testing quality. When the result becomes available, please circle.

2.13 Date result received

Print exact date when the test result was received, using this format: day/month/year.

2.14 Comments

Use this section for recording additional information. For example, if a test is recorded as invalid (INV), this field can be used to indicate the row number below in which results of the repeat test performed are recorded (see sample form). Another example: if the person tested should return for additional testing (i.e. repeated indeterminate results), please write this in the Comments field.

3. Page totals

This feature is meant to assist with ongoing quality assurance. Rates of concordance (compiled weekly or monthly depending on volume) between tests should be high and consistent between different sites. Any major deviation may suggest problems with test kits or testing personnel. This will also assist in preparing monthly reports. **Page totals should be tallied after each page is completed.** This will help to identify higher than normal levels of indeterminate/discrepant results.

4.1b. Logbook revised

1	2	3	4	5	6	7	8	9	10	11	12	13	14
Serial n°	Client or patient code	Age (years)	Sex	Date tested	Test-1 Kit Name Lot n° Exp. date	Test-2 Kit Name Lot n° Exp. date	Final results given to client	Testing personnel	Specimen for EQA testing/ confirmation	Date specimen sent	Final EQA/ confirmation results	Date results received	Comments
1			M F	/ /	R NR INV	R NR INV	P N IND		☐	/ /	P N IND	/ /	
2			M F	/ /	R NR INV	R NR INV	P N IND		☐	/ /	P N IND	/ /	
3			M F	/ /	R NR INV	R NR INV	P N IND		☐	/ /	P N IND	/ /	
4			M F	/ /	R NR INV	R NR INV	P N IND		☐	/ /	P N IND	/ /	
5			M F	/ /	R NR INV	R NR INV	P N IND		☐	/ /	P N IND	/ /	
6			M F	/ /	R NR INV	R NR INV	P N IND		☐	/ /	P N IND	/ /	
7			M F	/ /	R NR INV	R NR INV	P N IND		☐	/ /	P N IND	/ /	
8			M F	/ /	R NR INV	R NR INV	P N IND		☐	/ /	P N IND	/ /	
9			M F	/ /	R NR INV	R NR INV	P N IND		☐	/ /	P N IND	/ /	
10			M F	/ /	R NR INV	R NR INV	P N IND		☐	/ /	P N IND	/ /	
11			M F	/ /	R NR INV	R NR INV	P N IND		☐	/ /	P N IND	/ /	
12			M F	/ /	R NR INV	R NR INV	P N IND		☐	/ /	P N IND	/ /	
13			M F	/ /	R NR INV	R NR INV	P N IND		☐	/ /	P N IND	/ /	
14			M F	/ /	R NR INV	R NR INV	P N IND		☐	/ /	P N IND	/ /	
15			M F	/ /	R NR INV	R NR INV	P N IND		☐	/ /	P N IND	/ /	
16			M F	/ /	R NR INV	R NR INV	P N IND		☐	/ /	P N IND	/ /	
17			M F	/ /	R NR INV	R NR INV	P N IND		☐	/ /	P N IND	/ /	
18			M F	/ /	R NR INV	R NR INV	P N IND		☐	/ /	P N IND	/ /	
19			M F	/ /	R NR INV	R NR INV	P N IND		☐	/ /	P N IND	/ /	
20			M F	/ /	R NR INV	R NR INV	P N IND		☐	/ /	P N IND	/ /	

PAGE TOTAL					
Total tested					
Total reactive/positive					
Total non-reactive/negative					
Total invalid (or indeterminate)					

R = Reactive, NR = Non-reactive, and INV = Invalid

P = Positive, N = Negative and IND = Indeterminate

4.2. HTC service provider self-reflection tool

Date	DD/MM/YY	Site:		Counsellor		Supervisor	
Date ☐ VCT ☐ ... Home-based ☐ ANC ☐						Couple ☐ Individual ☐	

Characteristics	Client/Patient	Counsellor's age
Age group	10–19, 20–29, 30–39, 40–49, >50	10–19, 20–29, 30–39, 40–49, >50
Sex	Male/Female	Male / Female
Tribe/ethnicity		
Most at risk?	Sex work ☐ Drug use ☐ use MSM ☐	
HIV status	Positive ☐ Negative ☐ Indeterminate ☐	

STATEMENTS ABOUT THE SESSION

1. I provided the client with helpful information.

☐ Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree

2. I was able to help the client fully understand their test results.

☐ Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree

3. After my explanation of the test results, the client understood the meaning of their test results better.

☐ Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree

4. The risk assessment I performed helped the client understand the connection between their behaviours and the risk of HIV transmission.

☐ Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree

5. I was respectful of the client's emotional response to their test results (negative or positive).

☐ Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree

6. I helped the client with their emotional response to their test results (negative or positive).

☐ Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree

7. I was able to keep my own emotional response fully in check during the counselling session.

☐ Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree

8. The client and I fully discussed their options.

☐ Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree

9. I conducted all elements of the counselling session from a client-centred perspective.

☐ Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree

10. I helped the client identify behaviours that could be changed to reduce the risk of HIV transmission to another person or to prevent them from getting HIV.

☐ Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree

11. With my help, the client was able to develop a plan of action that included proposed behaviour change.

☐ Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree

12. I felt my own values and attitudes affected the session.

☐ Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree

Counsellor improvement

1. I rate my counselling performance with this client as:

☐ Excellent ☐ Good ☐ Fair ☐ Poor

2. What could I have done differently to improve the counselling experience?

3. What counselling skill would I like to learn more about?

Guidelines for counsellor self-reflection

Rationale

The text boxes give some questions that you can ask yourself.

No counsellor can be observed continuously or attend supervision after every client. The ultimate responsibility for quality rests with the individual counsellor and the trust that their clients put in them. Despite tools and measures of quality assurance, no one else can know what goes on behind the closed doors of a counselling room. A self-reflection form has been developed which counsellors can complete after seeing individual clients. This can be used to find areas where they require additional support as well as monitor improvements in their performance over time. The results of self-reflection are best brought to a supportive supervisor or a senior counsellor. Supervision by an experienced senior counsellor may be conducted in groups and this is the most common model used in many countries. Groups meeting in the absence of a supervisor may be trained in peer supervision. From time to time, where there is a need and resources are available, counsellors may have one-to-one individual support sessions with a supervisor. The criteria for self-reflection can be adapted and the questions changed according to the counsellor's concerns and after discussion with their supervisor.

When to use counsellor self-reflection

It is recommended that each counsellor fill out ten self-reflection forms every month. Alternatively, at the end of every day, they can pick one client that they can remember well and fill out the form.

Am I filling this out honestly?

Instructions for conducting counsellor self-assessment

The counsellor self-assessment tool is designed to be easy to use and takes less than four minutes to complete. The information can be used to help you reflect on your performance.

First, fill in the demographic and personal characteristics of the person receiving the counselling – age, gender, ethnicity or tribal group, and HIV status. The information from these characteristics will assist you in reflecting on your performance with people of different groups (e.g. women, men, older persons, young persons, members of different tribes or ethnic groups). Your own HIV status may impact the way you handle a session so be aware of this and, if you feel able to share it with your supervisor, this may help you to address issues and grow professionally.

Next, fill in the items presented as statements. These are aimed at capturing information about how you feel about your own performance and how you feel the person(s) who received the counselling perceived the counselling experience. The statements reflect the aims of the session and so they ask questions about your effectiveness in helping the client or patient

- To learn more (knowledge),
- To realize the situation they are in and their options (attitude, hope), and
- To consider what they will do now, whether the test results are negative or positive (proposed behaviour change).

The statements are presented and you pick one of the four choices:

Strongly Agree Agree Neutral Disagree

The counsellor self-assessment tool then ends with three questions aimed at capturing your perception of your own performance and ideas about improvement – the ongoing goal of the self-assessment process. The first question is merely a global self-assessment rating with a response set of excellent, good, fair, poor. The second question is: What could I have done differently to improve the counselling experience? The third question is: What counselling skill would I like to learn more about?

Is the form confidential to me?

Yes, or you may wish to share it with your supervisor or your supervision group.

4.3a Client exit interview – Out patient department (OPD) PITC services

Date	DD/MM/YY	Province:		District:		Site:		No:		Sex: M ☐ F ☐

We are conducting a survey with users of our health centre to find out what you think about our services. This will help us to improve the quality of services we provide to our clients. Your answers are strictly confidential and we thank you for your participation and honesty.

1. Which outpatient service did you attend today?

☐ Gen ☐ TB ☐ Antenatal ☐ STI ☐ Other ☐ Lab

2. How long did you wait before you were attended to?

☐ <30 min ☐ 30 min-1hr ☐ 1-2 hrs ☐ >2 hrs

3. Did the clinician listen to you describe your concerns?

☐ Yes ☐ No ☐ N/A

4. Did the clinician examine you?

☐ Yes ☐ No ☐ N/A

5. Were you asked to give any of the following samples?

a) sputum ☐ c) venous blood ☐
b) urine ☐ d) finger prick ☐

6. Were you offered an HIV test today?

☐ Yes ☐ No ☐ N/A

7. Did you agree to being tested?

☐ Yes ☐ No ☐ N/A

8. Did s/he explain that you could decline the test?

☐ Yes ☐ No ☐ N/A

9. Did s/he explain that the result would be confidential?

☐ Yes ☐ No ☐ N/A

10. Where was the test conducted?

☐ Consultation room ☐ Lab ☐ Counselling room ☐ Other

11. Did you receive your test results?

☐ Yes ☐ No ☐ N/A

12. Did you understand the result?

☐ Yes ☐ No ☐ N/A

13. Were you given time to ask questions?

☐ Yes ☐ No ☐ N/A

14. Were you given condoms and guidance on their use?

☐ Yes ☐ No ☐ N/A

15. Were you prescribed any drugs?

☐ Yes ☐ No ☐ N/A

16. Did you receive all the drugs prescribed?

☐ Yes ☐ No ☐ N/A

17. Were you given instructions about how to take them?

☐ Yes ☐ No ☐ N/A

18. How long did you wait to receive your drugs?

☐ <15 mins ☐ 15-30 mins ☐ 30 mins-1h ☐ 1h ☐ N/A

19. Did you have privacy during the session?

☐ Yes ☐ No ☐ N/A

20. Did you have enough time with the clinician?

☐ Yes ☐ No ☐ N/A

21. How was the attitude of the clinician towards you?

☐ Friendly ☐ Neutral ☐ Unfriendly

22. How was the attitude of the pharmacist towards you?

☐ Friendly ☐ Neutral ☐ Unfriendly

23. How was the attitude of the lab technician towards you?

☐ Friendly ☐ Neutral ☐ Unfriendly

24. How was the attitude of the reception staff towards you?

☐ Friendly ☐ Neutral ☐ Unfriendly

25. How was the attitude of the watchman towards you?

☐ Friendly ☐ Neutral ☐ Unfriendly

26. How was the cleanliness of the facility and surroundings?

☐ Very clean ☐ Fair ☐ Dirty

27. Overall, what do you think about the service you received today?

☐ Very good ☐ Fair ☐ Dirty

28. Are there any special comments you wish to make?

Thank you very much for your patience and time!

4.3b Client exit interview – CITC services

Date	DD/MM/YY	Province:		District:		Site:		No:		Sex: M ☐ F ☐

We are conducting a survey with users of our health centre to find out what you think about our services. This will help us to improve the quality of services we provide to our clients. Your answers are strictly confidential and we thank you for your participation and honesty.

1. How long did you wait to see the service provider?

☐ <30 mins ☐ 30 mins-1 hr ☐ 1-2 hrs ☐ >2 hrs

2. How was the service provider's attitude towards you?

☐ Warm ☐ Neutral ☐ Cold

3. Did the counsellor help you to feel free to talk about all your concerns and personal issues?

☐ Yes ☐ No ☐ N/A

4. Did you feel the counsellor listened to you?

☐ Yes ☐ No ☐ N/A

5. Did you feel your personal issues would remain safe between you and the counsellor?

☐ Yes ☐ No ☐ N/A

6. Did the service provider discuss the following issues with you?

a) Benefits of knowing your HIV status?

☐ Yes ☐ No ☐ N/A

b) Your HIV infection risks?

☐ Yes ☐ No ☐ N/A

c) Disclosure of your HIV status?

☐ Yes ☐ No ☐ N/A

d) HIV prevention options?

☐ Yes ☐ No ☐ N/A

7. Was condom use demonstrated?

☐ Yes ☐ No ☐ N/A

8. Were you tested today?

☐ Yes ☐ No ☐ N/A

9. If yes, did the service provider obtain your consent before carrying out the test?

☐ Yes ☐ No ☐ N/A

10. Did the service provider show you your test results as soon as they were ready?

☐ Yes ☐ No ☐ N/A

11. In your opinion, was the time taken with the HTC service provider

☐ Too long ☐ Just right ☐ Too short

12. How was the attitude of the other staff?

☐ Friendly ☐ Neutral ☐ Unfriendly

13. How would you rate the following about the site/facility?

a) Cleanliness

☐ High ☐ PoorL ☐ Very poor

b) Availability of toilets?

☐ Available ☐ Not available

c) Adequate waiting space?

☐ Adequate ☐ Not adequate ☐ N/A

14. Did the service provider refer you for any other services?

☐ Yes ☐ No ☐ N/A

15. Overall, how would you rate the services you received today?

☐ Very good ☐ Fair ☐ Poor ☐ N/A

16. Are there any special comments you wish to make?

Thank you very much for your patience and time!

4.3c Client exit interview – antenatal services

Date	DD/MM/YY	Province:		District:		Site:		No:		Sex: M ☐ F ☐

We are conducting a survey with users of our health centre to find out what you think about our services. This will help us to improve the quality of services we provide to our clients. Your answers are strictly confidential and we thank you for your participation and honesty.

1. What did you think of the health talk?

☐ Excellent – I learnt someting ☐ Good – I learnt something
☐ Fair – I learnt nothing new ☐ Poor – I did not like it

2. How long did you wait before you were attended to?

☐ <30 min ☐ 30 min-1 hr ☐ 1-2 hrs ☐ >2 hrs

3. Did the clinician lListen to you describe your concerns?

☐ Yes ☐ No ☐ N/A

4. Did you have your blood pressure checked?

☐ Yes ☐ No ☐ N/A

5. Were you asked to give any of the following samples?

a) urine ☐ c) finger prick ☐
b) venous blood ☐

6. Were you offered any of the following tests today?

a) HIV test

☐ Yes ☐ No ☐ N/A

b) Syphilis test

☐ Yes ☐ No ☐ N/A

c) Malaria test

☐ Yes ☐ No ☐ N/A

d) Blood count

☐ Yes ☐ No ☐ N/A

The following questions relate to HIV testing:

7. Where did the HIV test take place?

☐ Consultation room ☐ Lab ☐ Counselling room ☐ Other

8. Did you agree to being tested?

☐ Yes ☐ No ☐ N/A

9. Did s/he explain that you could decline the test?

☐ Yes ☐ No ☐ N/A

10. Did s/he explain that the result would be confidential?

☐ Yes ☐ No ☐ N/A

11. Did you receive your test result?

☐ Consultation room ☐ Lab ☐ Counselling room ☐ Other

12. Did you understand the result?

☐ Yes ☐ No ☐ N/A

13. Were you given time to ask questions?

☐ Yes ☐ No ☐ N/A

14. Were you given condoms and guidance on their use?

☐ Yes ☐ No ☐ N/A

15. Were the following discussed with you?

a) Antiretrovirals ☐ c) Partner testing ☐
b) Infant feeding ☐

16. Did you have privacy during the session?

☐ Yes ☐ No ☐ N/A

17. Did you have enough time with the clinician?

☐ Yes ☐ No ☐ N/A

18. How was the attitude of the clinician towards you?

☐ Warm ☐ Neutral ☐ Cold ☐ N/A

19. How was the cleanliness of the facility and surroundings?

☐ Very clean ☐ Fair ☐ Dirty

20. Overall, what do you think about the service you received today?

☐ Very good ☐ Fair ☐ Poor

21. Are there any special comments you wish to make?

Thank you very much for your patience and time!

4.3d Client exit interview – home-based testing and counselling (HBTC)

Date	DD/MM/YY	Province:		District:		Site:		No:		Sex: M ☐ F ☐

We are conducting a survey with users of the HBTC services for their feedback to help us improve on the quality of services for our clients. Your answers will be treated with strict confidentiality and we thank you for your participation and honesty.

1. How did you learn about the HBTC services?

☐ Community health worker (CHW)
☐ Service provider
☐ Others (specify)

2. Did the community health worker inform you of what to expect from the HBTC team?

☐ Yes ☐ No ☐ N/A

3. How was the service provider's approach towards you?

☐ Friendly ☐ Neutral ☐ Unfriendly

4. Did the service provider explain to you what to expect during the session?

☐ Yes ☐ No ☐ N/A

5. Did the service provider explain to you about the benefits of knowing your HIV status?

☐ Yes ☐ No ☐ N/A

6. You were offered services as:

☐ Individual ☐ Couple ☐ Immediate family
☐ Relatives ☐ Friends

7. If as an individual, did the service provider inform you of the benefits of attending as a couple or as a family?

☐ Yes ☐ No ☐ N/A

8. Did you take an HIV test today?

☐ Yes ☐ No ☐ N/A

9. If yes, did the service provider obtain your consent before testing you?

☐ Yes ☐ No ☐ N/A

10. Did the service provider explain to you how to read your results?

☐ Yes ☐ No ☐ N/A

11. Did the service provider inform you how long it would take for the results to be ready?

☐ Consultation room ☐ LabL ☐ Counselling room ☐ Other

12. Did the service provider show you your test result as soon as it was ready?

☐ Yes ☐ No ☐ N/A

13. Have you ever been tested before?

☐ Yes ☐ No ☐ N/A

14. Did the service provider discuss with you the benefits of disclosure of your HIV status?

☐ Yes ☐ No ☐ N/A

15. Did the service provider refer you for other services?

☐ Yes ☐ No ☐ N/A

16. In your opinion, the time taken with the service provider was:

☐ Just right ☐ Too short ☐ Too long

17. Did the HBTC services given to you today meet your expectations?

☐ Yes ☐ No ☐ N/A

18. If no, what do you suggest could be done to improve our services?

19. Are there any special comments you wish to make?

Thank you very much for your patience and time!

4.3e Guidelines for client exit interviews

The text boxes give some suggested phrases for conducting exit interviews.

Rationale

It is possible to capture client perceptions of, and satisfaction with HTC through the use of short exit interview questionnaires. For HTC services provided within an existing health facility, client perceptions should be gathered across a range of services offered and not just for HTC; otherwise, services may become disjointed and standards may vary widely. This will be unsatisfactory for clients and frustrating for staff. Exit interviews should be kept short, locally relevant and agreed upon by the QI team. Typical questions include factors such as waiting time, cleanliness, counsellor attitude and overall satisfaction with the service. Rather than asking clients about levels of satisfaction with different aspects of the service and making value judgements, it is often easier and less threatening to ask clients whether the core aspects of counselling actually took place such as discussion of a risk reduction plan or whether disclosure was discussed.

"We are conducting a survey with users of our health centre to find out what you think about our services. This will help us to improve the quality of services for future clients."

When to use client exit interviews

Client exit interviews are appropriate for use as part of a regular and systematic approach to monitoring quality. HTC service delivery points should conduct client exit interviews on a 6–12 monthly basis so that they can assess their progress in improving quality. Exit interviews may be self-administered (where literacy rates are high) or administered by volunteers from the community (which gives a higher response rate).

How to complete the tool:

Whom do I interview?

The PITC questionnaire can be used with anyone who attends a health facility. It is most suitable for use in an outpatient setting. In particular, it can be adapted to TB, STI and antenatal clinics. It can also be used with ward inpatients. In all these cases, it will require some adaptation to the clinical setting where it is being used. If the patient is a child then interview the adult who has brought the child. Using the VCT questionnaire, interview only those who have come specifically for HTC services.

How many clients do I interview?

- Interview 100 patients who come for services. Try and conduct 10 interviews per day over a two-week period. If you normally have between 20 and 30 people attending the health centre, then interview every second person who arrives at the health centre. If between 30 and 40 people attend daily, then interview every third person, if more than 40 attend daily, then interview every fourth person.
- Alternatively, interview all those clients who come for VCT services over a two-week period.

Who should conduct the interview?

Make sure the same person interviews the patients to ensure that the questions are always asked in the same way. Try to get an outsider, e.g. a community volunteer or a member of staff from one of the other

health centres who will not be known by the patients who use your health facility. If it is a member of staff conducting the interview, it is better if s/he does not wear a uniform. If the literacy rate is high, you might want to consider self-administered questionnaires.

When, where and how do I interview clients?

Conduct the interviews as patients leave the health centre and after they have collected their drugs. Interview clients of counselling services immediately after they have seen the counsellor. Each interview should take five minutes or less. Number the questionnaires in consecutive order each day (starting from 1) and note the date. Try and find a place that is quiet and away from the other patients and staff. Offer the patient somewhere to sit so that they feel comfortable during the interview.

- Ask the person if you may interview them.
- Explain briefly why you are interviewing them.
- Ask the questions exactly as they are written and only give further explanations if you feel they do not understand the question.
- Ask the questions very clearly and let the client decide their response. (Remember that it is the client's perception of the service that we are measuring and not what you think their perception is! Do not try to influence the client's answer.)

Your answers are strictly confidential and we thank you for your participation and honesty.

4.4 Observed practice – HIV testing and counselling

Date	DD/MM/YY	Site:		Counsellor		Supervisor	
PITC ☐ VCT ☐ ... Home-based ☐							

I am here to observe and support you. This will help us to see what you are doing well and which areas you may require some additional support. I will only observe you with the consent of the client, whose confidentiality I will maintain.

COUNSELLING SKILLS

1. **Provides warm reception**
   ☐ Yes ☐ No ☐ N/A
2. **Explains confidentiality**
   ☐ Yes ☐ No ☐ N/A
3. **Engages client in conversation**
   ☐ Yes ☐ No ☐ N/A
4. **Exhibits a non-judgemental attitude**
   ☐ Yes ☐ No ☐ N/A
5. **Listens effectively**
   ☐ Yes ☐ No ☐ N/A
6. **Avoids giving inappropriate advice**
   ☐ Yes ☐ No ☐ N/A
7. **Communicates at the client's level of understanding**
   ☐ Yes ☐ No ☐ N/A
8. **Provides relevant and correct information**
   ☐ Yes ☐ No ☐ N/A
9. **Seeks clarification where necessary**
   ☐ Yes ☐ No ☐ N/A
10. **Uses and responds to non-verbal communication**
    ☐ Yes ☐ No ☐ N/A
11. **Uses silence well to allow for self-expression**
    ☐ Yes ☐ No ☐ N/A
12. **Who is doing most of the talking?**
    ☐ Counsellor
    ☐ Client
    ☐ Both partners in a couple
    ☐ One partner in a couple

INDIVIDUAL PRE-TEST

1. **Assesses knowledge of HIV**
   ☐ Yes ☐ No ☐ N/A
2. **Assesses client motivation for testing**
   ☐ Yes ☐ No ☐ N/A
3. **Collaboratively develops risk reduction plan**
   ☐ Yes ☐ No ☐ N/A
4. **Demonstrates condom use**
   ☐ Yes ☐ No ☐ N/A
5. **Discusses disclosure with partner**
   ☐ Yes ☐ No ☐ N/A
6. **Obtains informed consent**
   ☐ Yes ☐ No ☐ N/A

COUPLES PRE-TEST

1. **Ensures that each member of the couple has given informed consent**
   ☐ Yes ☐ No ☐ N/A
2. **Ensures that each member of the couple is aware that s/he is expected to disclose their test result to their partner**
   ☐ Yes ☐ No ☐ N/A
3. **Performs risk assessment**
   ☐ Yes ☐ No ☐ N/A
4. **Demonstrates condom use**
   ☐ Yes ☐ No ☐ N/A
5. **Discusses possibility of serodiscordance**
   ☐ Yes ☐ No ☐ N/A
6. **Discusses impact of testing on each member of the couple**
   ☐ Yes ☐ No ☐ N/A

TESTING SKILLS

1. **Number of finger-pricks**
   ☐ 1 ☐ 2 ☐ more
1. **Follows standard operating procedures**
   ☐ Yes ☐ No ☐ N/A
1. **Fills out standard laboratory register**
   ☐ Yes ☐ No ☐ N/A

INDIVIDUAL POST-TEST

1. **Sensitively provides test result and assesses impact on client**
   ☐ Yes ☐ No ☐ N/A
2. **Addresses client reaction**
   ☐ Yes ☐ No ☐ N/A
3. **Makes collaborative risk reduction plan**
   ☐ Yes ☐ No ☐ N/A
4. **Discusses disclosure with partner**
   ☐ Yes ☐ No ☐ N/A
5. **Makes condoms available**
   ☐ Yes ☐ No ☐ N/A
6. **Makes appropriate referrals**
   ☐ Yes ☐ No ☐ N/A
7. **Clarifies need for retesting (if negative)**
   ☐ Yes ☐ No ☐ N/A
8. **Discusses medical benefits of treatment and care (if positive)**
   ☐ Yes ☐ No ☐ N/A

COUPLES POST-TEST

1. **Sensitively provides test result and assesses impact on both members**
   ☐ Yes ☐ No ☐ N/A
2. **Assists with disclosure**
   ☐ Yes ☐ No ☐ N/A
3. **Develops joint risk reduction plan**
   ☐ Yes ☐ No ☐ N/A
4. **Discusses family planning/fertility**
   ☐ Yes ☐ No ☐ N/A
5. **If serodiscordant, discusses facts, issues and risk reduction strategies**
   ☐ Yes ☐ No ☐ N/A
6. **Allows couple to raise questions**
   ☐ Yes ☐ No ☐ N/A

Guidelines for observing counsellor practice

The text boxes give some suggested phrases for conducting observed practice.

Rationale

With the consent of the client, a counsellor can request to be observed by an experienced counsellor while conducting a session. The value of observed practice is that it gives the counsellor instant feedback from a supportive senior counsellor or supervisor. The objective nature of the checklists help them to know whether they have conducted a client-centred session, remembered the key components of the pre- and post-test counselling protocols, and how well they dealt with the client's emotional reaction. Supervision by observation is intended as a continuation of the learning process and, as such, should be supportive and not aimed at finding fault. Where rapid testing is conducted in-room, observed practice serves as a useful tool to observe adherence to standard operating procedures for rapid testing as well. It is designed to be used in all approaches and settings where HTC is conducted, and for observing counselling sessions with couples as well as with individuals. The tool will require adaptation to local circumstances and protocols.

"I am here to observe you and support you. This will help us to see what you are doing well and which areas you may require some additional support.
I will only observe you with the consent of the client, whose confidentiality I will maintain."

When to use observed practice

Observed practice can be used at the end of training but before a trainee is certified as competent. National guidelines may stipulate the number of sessions that are required to be observed but a minimum of ten is recommended, which includes at least one session with a couple and at least one which involves giving a positive result.

Observed practice can also be used for ongoing professional development with the help of more experienced counsellors. Used regularly (twice a year), it is suitable where relationships are supportive and a culture of mentoring already exists, and when individual one-on-one support may be required.

"I plan to observe a number of sessions and some of the different situations that you might face. When I am observing, I will not interrupt the session unless absolutely necessary.
I will sit out of the way so that I do not intrude."

How to complete the tool

1. The observer should be familiar with the approach, counselling protocols and, where applicable, the standard operating procedures for rapid testing at the site where the observation is taking place.
2. Each client needs to be told that training is in process and their consent should be sought for having an observer attend the session.
3. Confidentiality should be maintained at all times by the observer. This creates an atmosphere where the participant can develop confidence and also learn by example about confidentiality from the observer.
4. Indicate the date and site, the counsellor's and your own name.
5. Tick which HTC approach is used as this determines the counselling protocol that is followed. For VCT sites co-located in health facilities, tick VCT if the session was client-initiated and PITC if the session was provider-initiated.
6. Fill in the column on counselling skills as you go along. If you observe a particular skill, then indicate this. At the end of the session, take a few moments to go back to this section and reflect on the counsellor's use of skills. This column applies to all approaches for HTC.
7. Some questions may not be appropriate to the approach (PITC, VCT or home-based). While there may be overlap, the PITC sessions are shorter and follow a shortened protocol with a slightly different focus. If this is the case and the skill or information is not part of the protocol, tick N/A (not applicable).
8. Fill in the protocol-specific sections according to the session that is being observed (individual or couples session).
9. In settings where in-room rapid testing is conducted, fill in the number of finger-pricks that were required and whether standard operating procedures were adhered to.

"Let me give you some feedback on the session I just observed. The aim of the feedback is to support you and to help you learn so I will focus on specific areas that you did well and areas where you might have done things differently."

4.5a. Infrastructure checklist for registering HTC sites

Example tool taken from: Site Readiness Assessment Tool, Namibia 2010

Name of facility:	District: Region:	Date of visit:
HTC approach	PITC / VCT / Home-based	
HTC site	Health facility / stand-alone / mobile / outreach / home-based	
Assessors: 1. **2.**	**Managing agency**	

Site opening hours	Mon-fri	Sat	Sun	Holidays

Staff profile: (attach copies of certificates)

Names	**Designation**	**Full time**	**Rapid HIV test certificate**	**Counselling certificate**
		Y/N	Y/N	Y/N
		Y/N	Y/N	Y/N
		Y/N	Y/N	Y/N
		Y/N	Y/N	Y/N
		Y/N	Y/N	Y/N

		Questions	Yes	No	N/A
1	**Personnel**				
	a	Are there adequate staff at the site at all opening times?			
	b	Are staff conducting HCT counselling certified in the approved curriculum?			
	c	Are staff performing HIV rapid testing trained according to the approved curriculum?			
2	**Space and furniture requirements**				
	a	Is adequate private room/space available?			
	b	Is there good ventilation?			
	c	Is bench space for the performance of HIV testing available?			
	d	Is there a wash basin near the testing space?			
	e	Is there a protective cover on working area, easy to clean and disinfect?			

		Questions	Yes	No	N/A
3	**Storage facilities**				
	a	Is the kit storage area kept under lock and key?			
	b	Are kits stored within the recommended temperature range?			
	c	Are specimens for proficiency testing stored in a temperature-controlled environment?			
	d	Are lockable cabinets used for storing documents?			
4	**Inventory and stocks**				
	a	Is there a system in place for obtaining supplies? Forecasting, etc.			
	b	Is the site supervisor assigned to look after the stock?			
	c	Are stock control measures in place and a written policy present?			
	d	Are there adequate stocks of condoms at the site today?			
5	**Safety and infection control**				
	a	Is there a waste container for general waste?			
	b	Is there a waste container for bio hazardous waste?			
	c	Are there containers for sharps disposal?			
	d	Does the rapid HIV test site have a post-exposure protocol?			
	e	Are gloves available?			
6	**Client privacy and confidentiality**				
	a	Does this site provide privacy for counselling and testing?			
	b	Is reporting of tests done confidentially?			
	c	Is the site suitable for various volumes of client flow?			

General comments:

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DATE OF ASSESSEMENT	NAME OF ASSESSOR	SIGNATURE OF ASSESSOR

For Office use **Date received:** _____	**Signature:** _____
SITE ASSEMENT EVALUATION	

4.5b. National accreditation tool

Example tool taken from: VCT Site Accreditation Tool, Kenya 2003

For assessment of VCT sites

Accreditation is voluntary for sites providing VCT services. The accreditation assessment focuses on adequacy of existing structures (human resources, guidelines, infrastructure, safety issues and information systems), key processes and results in the delivery of VCT services.

Facility name:	**Date:**
Site code:	**Time started:**
Province: **District:**	**Time finished:**
Facility type: (please circle) **Stand-alone/Integrated**	**Managing agency:**
Assessors: **1.** **2.** **3.**	
Staff interviewed: **1.** **2.** **3.** **4.** **5.**	

Purpose: To ensure that continuous quality improvement systems are in place for assuring compliance with national VCT standards and guidelines

Objectives
1. Assess availability of staffing levels.
2. Assess adherence to protocols.
3. Assess availability of health education materials and condoms.
4. Assess availability and use of record-keeping formats.
5. Assess availability of test kits and medical consumables.
6. Assess adherence to staff roles and responsibilities.
7. Assess general aspects of site operations.

4.5.a Staff site profile

Please complete the table for each member of staff working on VCT in the facility.

Name	Position (supervisor, counsellor, lab technician, receptionist, etc.)	Completed training (certification, registration, license)	Full-time (F/T) Part-time (P/T) (on VCT services)	Employment status (permanent contract, paid volunteer, etc.)
1				
2				
3				
4				
5				
6				
7				
8				
9				

4.5.a Staff site profile

Days of week	Opening hours
Monday-Friday	
Saturday	
Sunday	
Public holidays	

4.5c Scoring system

Yes	**Minimum standard met**
No	**Minimum standard not met**

Critical criteria questions must score 100% (13/13) and all other questions ≥75%

	Critical criteria	YES	NO
1	Two VCT-trained counsellors available?		
2	Trained lab technician or counsellor able to do rapid tests available?		
3	Secure lockable cupboard for storing client records available (counsellor access only)?		
4	Kits within expiry date?		
5	Kits stored at an appropriate temperature (fridge required if above 30 degrees Celsius)?		
6	Protective clothing available and used for testing (gown and gloves)?		
7	Sharps container used for disposal of lancets and needles?		
8	Separate, lined bin in testing room for disposal of contaminated waste (gloves, cotton wool etc.)?		
9	Safe site storage of contaminated waste until disposal?		
10	Pit, incinerator or contractual arrangement in place for disposal of contaminated waste?		
11	Client register available and maintained daily?		
12	Laboratory log book available and maintained daily?		
13	For discrepant results, third test performed or referred to laboratory?		

I. Structure

1.	Leadership and supervision	YES	NO
1.1	Regular VCT site meetings taking place?		
1.2	Regular QA site meetings taking place?		
1.3	Named District VCT coordinator (DASCO) making regular supervisory visits?		
1.4	Trained counsellor–supervisor supervising counsellors?		
1.5	Trained laboratory supervisor supervising systems for testing?		

2.	Human resource management	YES	NO
2.1	List of VCT staff available including registration, qualifications, etc.?		
2.2	Job descriptions of VCT staff available?		
2.3	Receptionist or clerk oriented in VCT available?		
2.4	VCT site-manager or in-charge available?		

3.	Policy standards and guidelines	YES	NO
3.1	National VCT guidelines easily accessible?		
3.2	VCT counselling protocols available and on display?		
3.3	VCT testing protocols available and on display?		
3.4	Safety guidelines available and on display?		

4.	Infrastructure	YES	NO
4.1	Facility registered to provide VCT services?		
4.2	Adequate counselling room/s available (well lit, spacious, ventilated, private)?		
4.3	Room/s adequately equipped with three chairs, one table and separate testing area?		
4.4	Penile model available and on display?		
4.5	Room/s and waiting area well maintained and clean?		
4.6	Adequate waiting area (chairs and space)?		
4.7	Accessible clean toilets with handwashing facilities?		

5.	Supplies and storage	YES	NO
5.1	Uninterrupted and adequate supply of non-pharmaceuticals (gloves, lancets, condoms, spirit, cotton wool, chlorine, detergent, disposable syringes)?		
5.2	Uninterrupted and adequate supply of rapid test kits in stock?		

6.	Safety	YES	NO
6.1	All VCT staff received hepatitis B immunization?		
6.2	Running water available in testing room?		

7.	Referral system	YES	NO
7.1	Referral system in place and functioning?		
7.2	Referral directory/list available?		
7.3	Designated referral site for care and support?		
7.4	Post-test support available (post-test counselling, people living with HIV, etc.)?		

8.	Records and information system	YES	NO
8.1	Uninterrupted and adequate supply of VCT data forms and client cards?		
8.2	System for anonymous client coding in place and functioning?		
8.3	Easily retrievable copies of quarterly reports sent to DHMT available?		
8.4	Stock register available and up to date?		
8.5	Accident/incident book available and used?		
8.6	QC reports from certified labs easily accessible?		

9.	Information, education and communication (IEC) materials	YES	NO
9.1	Signboards, signs, labels and directions for VCT room/s?		
9.2	Opening hours prominently displayed?		
9.3	Door tags used for privacy (please enter/counselling in progress)?		
9.4	Uninterrupted and adequate supply of VCT leaflets and posters?		
9.5	VCT leaflets on display and available for clients?		
9.6	VCT posters prominently displayed?		
9.7	Adequate supply of condoms freely available and on display?		

10.	Financial management		YES	NO
10.1	Fee charges prominently displayed ? (if FREE skip 10.2 and 10.3, and circle N/As)			
10.2	Records of accounts available?	N/A		
10.3	Clear policy and measures in place for clients unable to pay?	N/A		

II. Process

11.	Adherence to guidelines/client–provider interaction	YES	NO
11.1	VCT services available on advertised days?		
11.2	Informed consent (signature) obtained before testing the client for HIV?		
11.3	Condoms supplied where appropriate?		
11.4	Same-day blood testing conducted on site?		
11.5	Correct testing algorithm used?		
11.6	All forms are checked for missing items at the end of each day?		
11.7	Community mobilization activities being conducted?		
11.8	All counsellors attending regular group supervision?		
11.9	All counsellors receiving individual or peer supervision?		
11.10	Counsellors working scheduled hours (not assigned to other non-VCT services)?		
11.11	Each counsellor sees <10 clients/day?		

12.	**Continuous quality improvement**	**YES**	**NO**
12.1	Regular monitoring and analysis of VCT data conducted (summary sheets, graphs)?		
12.2	QA tools used for systematically monitoring quality of service provision (client exit interviews, counsellor self-assessment or other alternatives)?		
12.3	QA meetings identify areas for improvement and plan accordingly?		
12.4	10% of blood samples sent for quality control to a certified laboratory?		
12.5	All discrepant results and filter papers sent to a certified laboratory?		

III. RESULTS

13.	**Performance** (Are the following indicators calculated on a quarterly basis?)	**YES**	**NO**
13.1	Breakdown of clients by age, sex and test result		
13.2	Average number of clients/counsellor/day		
13.3	% Clients given condoms		
13.4	% Counselled clients who take HIV test		
13.5	% Clients coming back for follow-up counselling		
13.6	% Test results given same day		
13.7	% Test results indeterminate		
13.8	Levels of concordance with reference laboratory		
13.9	Timely submission of monthly/quarterly reports		

14.	**Client**	**YES**	**NO**
14.1	Mechanisms for client feedback in place (exit interviews, suggestion box, complaints procedures, community meetings, etc.)?		
14.2	Client satisfaction improved over time?		

15.	**Provider**	**YES**	**NO**
15.1	VCT staff attitude, motivation, job satisfaction and professional improvement is assessed and monitored over time (annual appraisal)?		

Overall Remarks: (Please comment specifically on each item that has scored 'no')	

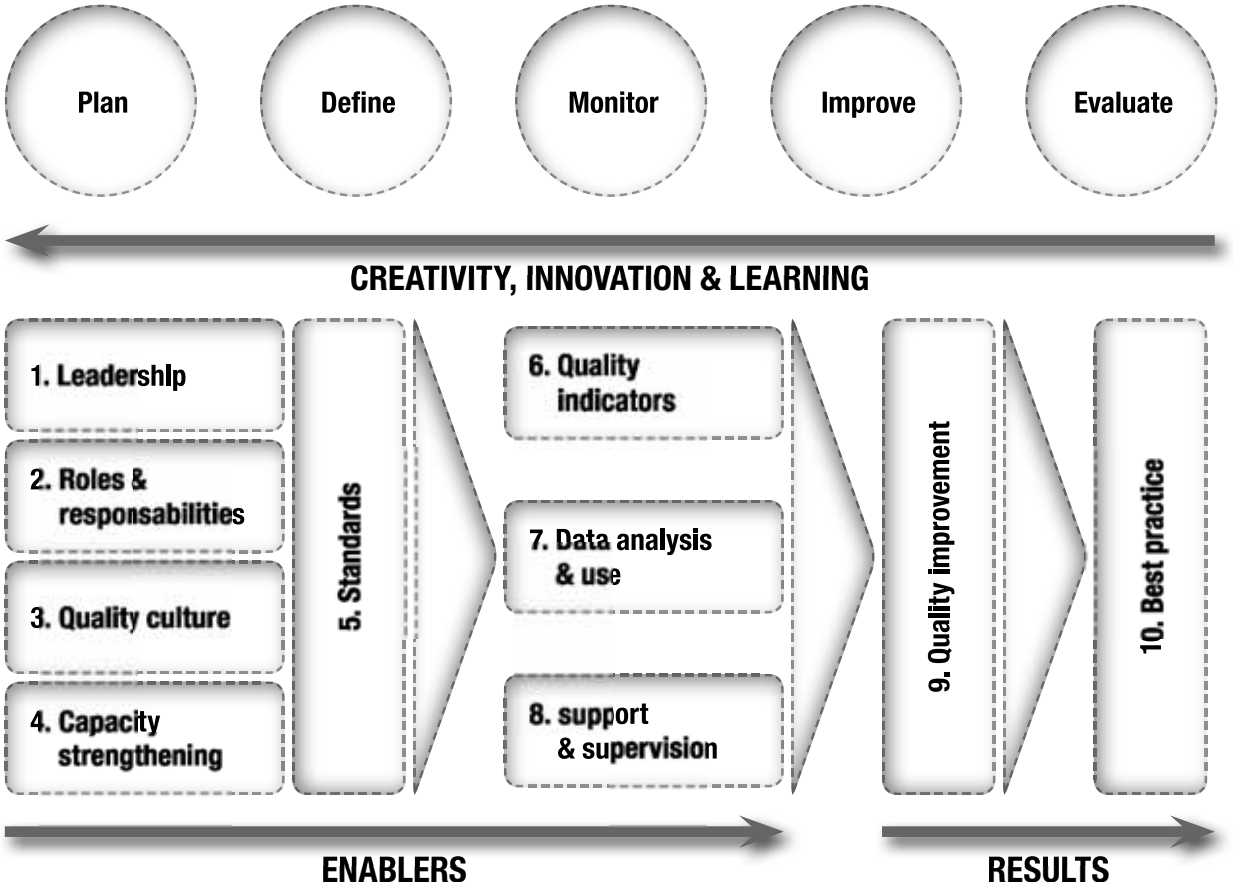
Critical criteria (Must score 100%)	**Total Yes**		**Total No**		**Score Y/(Y+N) x 100**	**%**
All other questions (Must score ≥75%)	**Total Yes**		**Total No**		**Score Y/(Y+N) x 100**	**%**
Recommendation for accreditation	**PASS**	**RE-ASSESSMENT WITHIN**			**MONTH/S**	**TEMPORARY CLOSURE**

ASSESSORS	
Name: **Signature:**	**Name:** **Signature:**

5. APPLYING THE FRAMEWORK AT THE SERVICE DELIVERY LEVEL: ILLUSTRATIVE EXAMPLES

The QA cycle and QI framework described in sections one and two of this handbook can be used to guide activities for applying the QI framework shown in Figure 5 at the service delivery level. We strongly suggest a team approach, focusing on practical examples and action planning. Team work and the ethos created will have additional positive outcomes in the facility, such as improved motivation of staff. The tools provided here can be used by facilities with little or no previous experience in QI to identify and work on their quality problems. Once the facility team have gained confidence in monitoring, improving and evaluating quality on a routine basis, other QI tools can be developed, adapted and used.

Figure 5. Quality improvement framework for HTC



Planning for quality assurance at the service delivery level

The four building blocks of planning (leadership, roles and responsibilities, quality culture and capacity strengthening) will ultimately define the success of facility efforts to improve quality. Determining the scope of the QI effort is extremely important and facilities should guard against being overambitious. A simple, well-focused approach is far more likely to succeed than trying to tackle all quality problems at once. Interdisciplinary teams provide the best mechanism for driving the process, and at least some of the team members should have managerial responsibility to take decisions that can directly influence service quality. The QI team should be responsible for implementing QA and should be representative of those involved in the provision of HTC.

Defining quality: Good standards are realistic, reliable, valid, clear and measurable. Facilities should state the standards that they expect. Standardization covers two distinct aspects: the use of agreed guidelines for practice (standard operating procedures [SOPs]) and the standardization of services, staffing levels, equipment and supplies across health facilities. All providers should be familiar with national guidance documents and be able to use and adhere to them in their daily work. Facilities should be working according to national guidelines on HTC, which should always be available on site. Staff will have also received orientation as part of their initial training in HTC.

Monitoring the quality of services: While we all have personal views on the level of quality that we provide and receive, the only way we can estimate this is through measurement. We have to be clear on:

- what it is that we want to monitor – selection of indicators
- where we can find this information – client, health centre registers, etc.
- how we can collect the required information – through use of questionnaires, checklists, etc.

No one method can capture all the information we need. It is sensible to collect data from various sources and then analyse and interpret the findings as a team. In this handbook, examples are given of how collection of routine data, counsellor self-reflection tools and exit interviews, among other sources, can be used for monitoring quality and for QI of both HTC and curative services. Completing Table 5 might help you decide how you may want to start.

Table 6: Strengths and weaknesses of different methods for monitoring quality

Data collection method	Inexpensive	Quick	Ease of collection	Ease of analysis	Represents service users views	Represents the community opinions	Bias
Observation (check-list)							
Self-assessment							
Peer supervision							
Supervision							
Focus group discussion							
Community meeting							
Household survey							
Suggestion box							
Exit interview (short questionnaire)							
Data from routine HMIS							
Mystery client exercise							

The level of support that facility-based teams receive from the district and regional levels will also determine the success that they achieve in improving the quality of HTC provision.

Team action for quality improvement: QI is an important component of the QA cycle. Team members should be encouraged to work together to understand client needs and expectations, analyse how processes and systems work, and develop, test and implement solutions to improve performance. The most important step is for the QI team at facility level is to have a picture of quality through the routine monitoring of HTC services and undertake improvement through analysing and using data to identify problems and implement local solutions. As confidence and skills increase in the use of the QI methodology, the scope of and ambition for QI increase. All teams, whether working on localized problems and local solutions, or as part of a larger QI effort, should be guided by a step-wise approach:

Step 1: Identify, prioritize and define the problem.

Step 2: Analyse and try to understand what is causing the problem.

Step 3: Develop solutions to overcome the problem.

Step 4: Decide on and implement the solution.

Evaluating actions: Once the solution has been implemented, the team should evaluate whether it has been implemented correctly and whether it has resolved the problem it was designed to address. The team can check this by reviewing the monitoring mechanisms described in the action plan for the problem solution and checking whether the agreed target was attained. Once the solution has proved to be effective, new problems can be identified through monitoring data derived from conducting client exit interviews, self-assessment, etc. and so the cycle is completed. Feedback is a part of evaluation and at the facility level this includes feedback to the community as well as to other facility staff and supervisors.

Knowing where to start can be hard

QI can be simple, practical and easy. You do not have to tackle every quality problem at once and you do not need many additional resources to get started. Just choose one area of local concern and use any one of the tools or methods provided in this handbook to start on the road to QI.

Use of a standardized logbook for monitoring the quality of rapid testing: a case study from Country X

The rapid testing logbook was customized, translated into French and piloted at 10 HTC sites in Country X. The customized version included critical information such as individual test kit name, lot #, expiry date and page totals. The pre-printed logbook was distributed to 10 sites that had been trained to use the logbook. Logbooks from all sites were reviewed at the end of one week to collect and assess the page total data. Analysis of page total data demonstrated that nine sites had excellent concordance between test-1 and test-2 but one site had poor concordance between the two tests used in the algorithm, suggesting a site-specific problem in conducting HIV rapid testing. Further investigation found that the testing personnel at that site did not follow the assay procedure correctly and read the results of rapid tests after only a few minutes rather than waiting for the full 15 minutes required by the standard operating procedure. Additional training and timers were provided to the individuals at the site, resulting in improvement of operator proficiency and accuracy of test results at that site. The results demonstrated that routine testing data, if collected and evaluated in a timely manner, can be used to monitor and improve the quality of HIV testing at testing sites.

5.1. Quality improvement through the use of a standardized laboratory logbook

We can monitor the quality of service provision through the collection and analysis of routine data. A sample laboratory tool and instructions on its use in HTC services is given in section four. By recording all the steps in the testing process, we can analyse these data to provide useful information in relation to client flow, gender, age, positive and negative test results, invalid results, false-positive results, and participation in QA. First, look at the logbook and the instructions on how to use it. If you already use a similar logbook in your facility, then continue to the steps below. If you do not use a logbook you may wish to consider altering how, when and where you collect data. In either case, you will need to adapt the example below to suit the setting and logbooks that you have in your HTC site. The steps below outline how to use the routine laboratory logbook data for QI.

Step 1: Identify, prioritize and define the problem: use results from QA monitoring

Identify the problem

For results from the laboratory logbooks we recommend that you use the summary boxes at the bottom of each page of the register. You may want to combine data by adding several pages. Sites should routinely fill in a monthly summary sheet; it can be convenient to use this to identify the QI problem. If client flow at the site is low you may want to aggregate data from several months. Using summarized data will help you to see quickly and easily how you are performing in relation to the results expected for your area. Going from left to right along the columns you will come across:

a. Age: Some sites are better at attracting youth or older people and it is good to see how you perform in relation to others.

b. Gender: Some sites are better at attracting men or women.

c. Page totals – check that the total positive, negative and invalid results add up to the total number of people tested with each individual test.

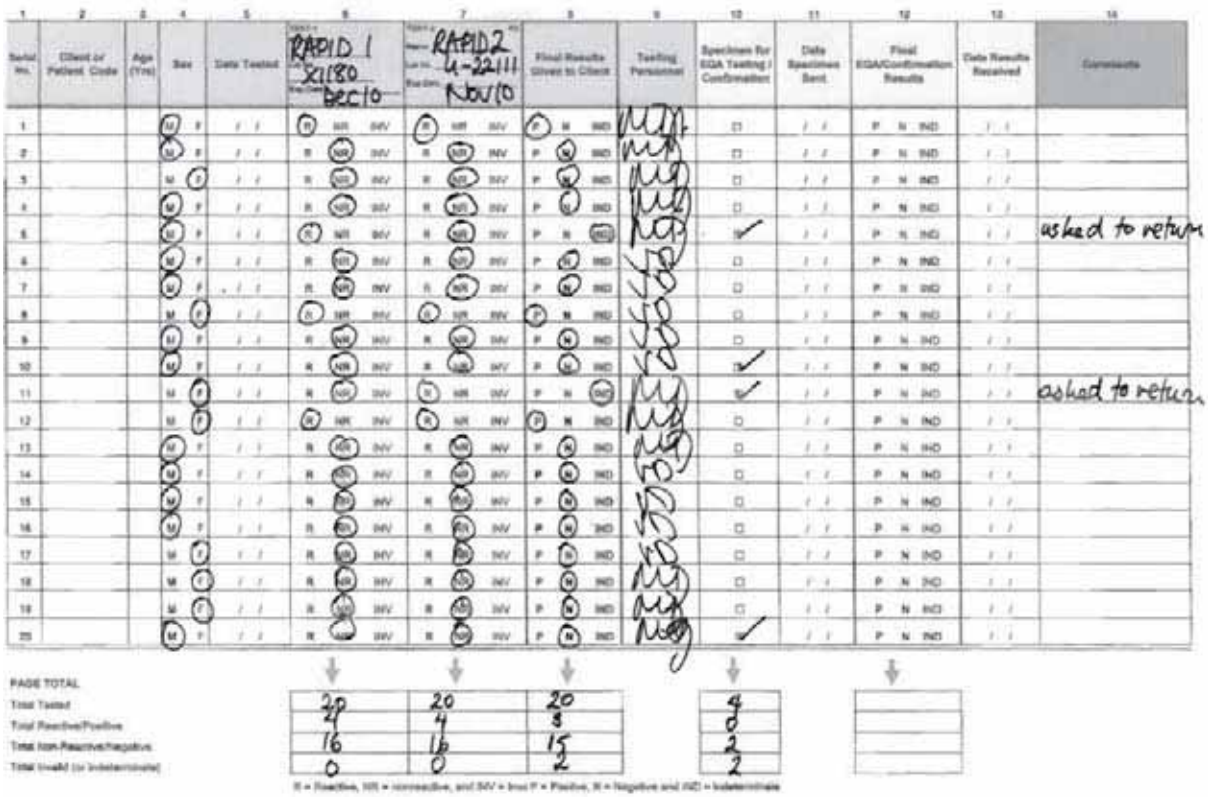
d. Check that the data make sense. There should be high rates of concordance between the first and second tests. If the results are discordant, the client should be asked to return after two weeks for retesting and the final result given should be based on the testing algorithm. You can expect the HIV positivity rates to reflect the HIV prevalence rates in your area.

e. Invalid: Invalid results for individual tests should be rare. If the number of invalid results observed is excessive, this requires further investigation into areas such as quality of the kit or testing procedure.

f. Indeterminate (or discrepant) final results: This should occur at a low frequency. Again, a high rate of indeterminate results may indicate a problem. This will require further investigation and here it is important

to compare operators, sites, and lot number and expiry dates of kits. Discrepant results may also indicate seroconversion.

Figure 6. Example of a completed laboratory logbook



Ongoing review of concordance rates between test-1 and test-2 can help identify problems at the early stages, which may be site-specific, operator-specific or related to a specific test kit. Standardized logbooks can assist in a quick review of sites during supervisory visits and further provide comparison of testing quality with retesting data when these are available. Review of concordance rates can be used for the following:

- Monitor the quality of testing at a specific site over time
- Compare multiple sites to identify sites with poor performance
- Compare the performance of testing personnel to help identify personnel needing additional training
- Conduct an ongoing assessment of the testing algorithm and test kit performance.

Additionally, page totals can help identify problems with an individual kit, a kit lot or a large number of invalid results. Concordance between the final results and EQA retesting (if and when done) can further validate the testing algorithm and quality of testing. Page total data from sites within a region/ province or country can be added and reviewed periodically to

When you are reviewing logbooks, remember to check:

- that the correct algorithm is being followed
- that expired test kits are not being used
- that there are high levels of concordant results between test-1 and test-2
- that feedback from final QA is entered
- concordance of individual operators with QA results.

assess the overall quality of testing as well as monitor the HIV prevalence over time. A major variation in prevalence should cause a review of the sites unless it can be explained by variation in the population being tested.

Using these rules, we can identify a high number of discordant results from the example in Figure 6.

Prioritize the problem

The problem is serious and needs addressing.

Define the problem

10% of rapid test-1 and rapid test-2 results were discordant.

Remember when analysing a problem using a fish bone:

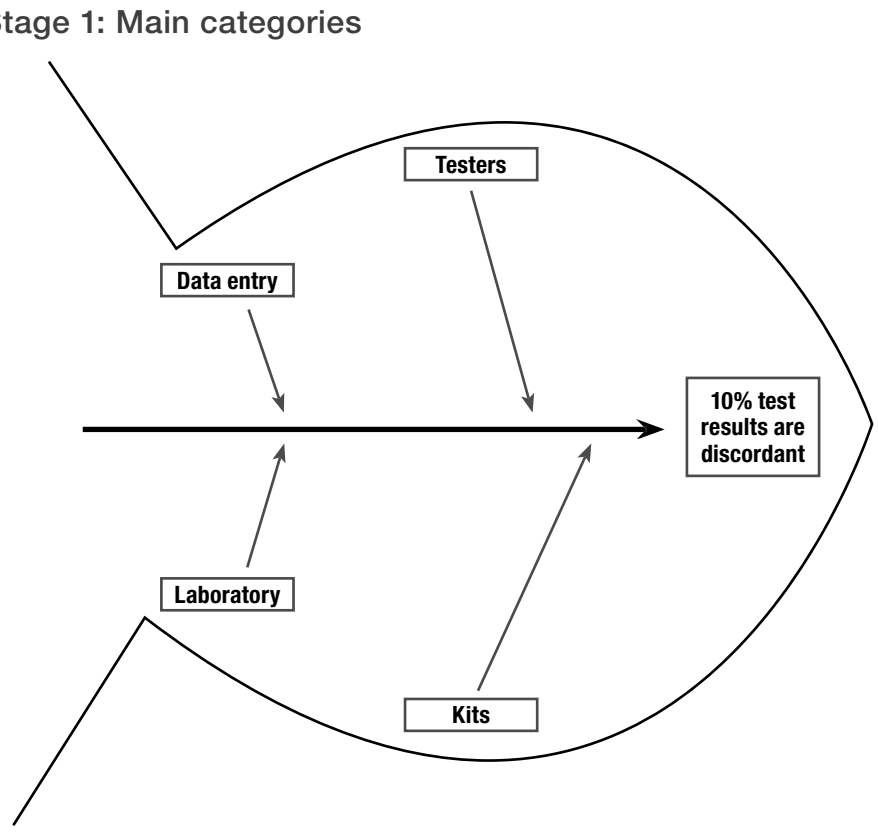
- Be honest.
- Identify the main categories.
- Brainstorm possible causes.
- Ensure that each cause has a direct relationship to the layer above.
- Make sure the causes are amenable to action.

Step 2: Analyse and try to understand what is causing the problem

There may be a number of reasons why one HIV rapid test might be positive and one negative. The kits may have expired or been stored or transported incorrectly. Staff may be too busy to wait until the read time specified by the manufacturers, may lack timers or may be unaware of the read time due to a lack of standard operating procedure manuals or of proper training. Figure 7 is an example of a fish bone which is a simple guide of how to use this technique.

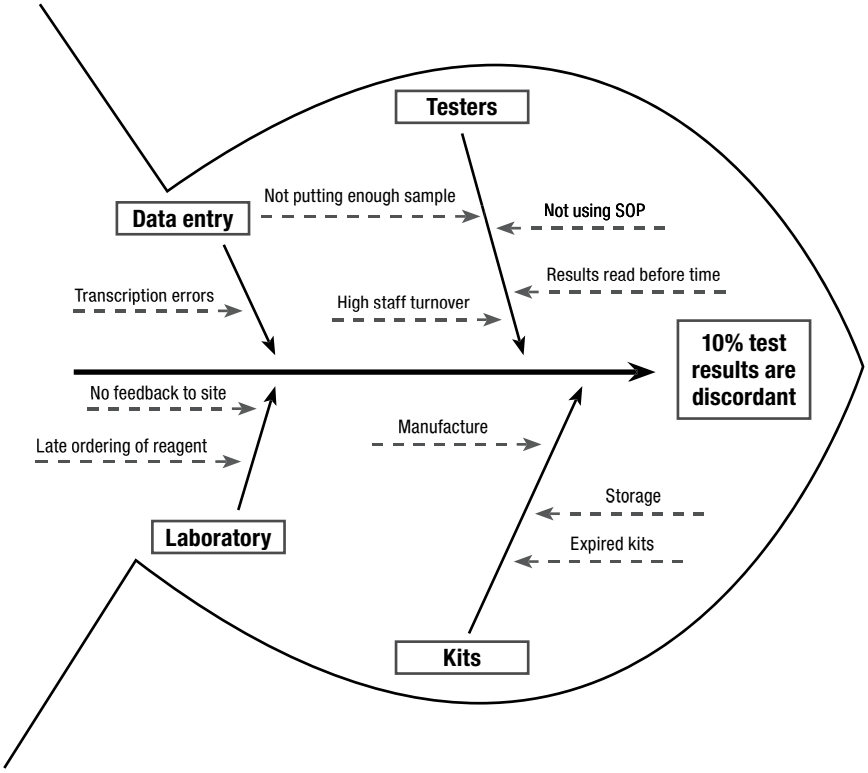
To fill in a fish bone, start with writing the problem you identified in the box at the nose of the fish. In a group, brainstorm the two or three main reasons that you feel may be the possible causes or may contribute to the problem. Write them in the spines as clearly and simply as possible.

Figure 7. Example fish bone diagram

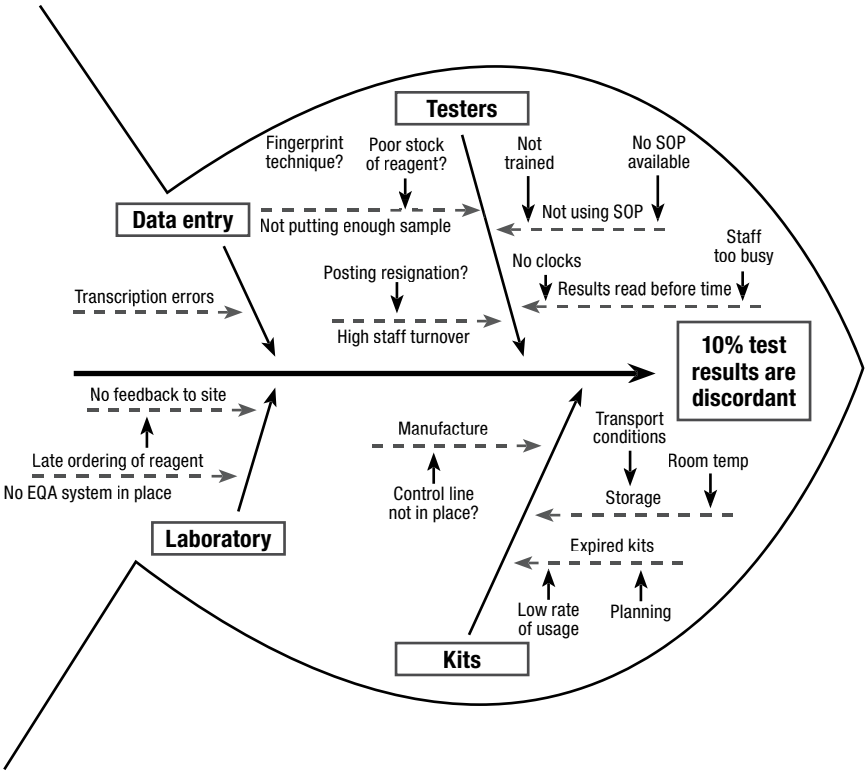


Now examine each of these spines in turn asking yourself "but why" until you are not able to go further down. Build up the fishbone in stages so that each spine has lateral spines and these in turn have smaller spines.

Stage 2: Main causes in each category



Stage 3: Potential underlying causes



Step 3: Develop solutions to overcome the problem

At this stage, the problem-solving team should be ready to suggest possible solutions. Some solutions may be straightforward; such as reminding staff about standard operating procedures, checking the expiry dates of test kits and storage conditions. Individual staff may require some refresher training. Some may be more difficult to solve (for example, staff being "too busy" to wait for the prescribed read time) or involve things beyond the control of the team. If a problem with the manufacture of the test kit is suspected, then the regional and laboratory supervisor should be made aware.

Remember when preparing your action plan

- Specify clearly the roles and responsibilities for each activity.
- Do not always assign all activities to the same person/s, decide on who is/are the most appropriate.
- Plan within the limits of your resources and do not attempt to tackle problem areas which are outside your control.
- Make allowances for unexpected activities so plans are realistic yet flexible.

Step 4: Decide on and implement the solution

Once the team has chosen the solution, implementing it requires careful planning, and must be written into a change plan. Taking into account your selected problem, you should set a target for what you are aiming for – by how much you expect to improve the situation. It is important to be realistic when setting targets – failure to meet overambitious targets can lead to disappointment and disillusionment. The next step will involve identifying the principal activities you will need to conduct to implement your chosen solution. You must be clear about the resource requirements and realistic about the timescale for conducting each activity. Assign responsibility for each activity and set out exactly how those responsible will monitor (evidence) that the activity has been completed. Once you have agreed on the change plan with the rest of the health centre staff, you are ready to implement it!

Example Change plan

Problem identified: 10% of persons tested in July 2010 had discordant results.				
Target: Less than 1% of persons tested have discordant results.				
Activities (towards the solution)	**Resources needed**	**Timing (dates)**	**Evidence that activity is completed (monitoring mechanism)**	**Persons responsible**
Distribute standard operating procedures (SOPs)	Printing and lamination	20 August	Laminated SOPs in testing areas	Laboratory supervisors
Ensure all test kits are within the expiry date	Staff time	20 August	Test kits within expiry date	Counsellors
Update list of who is qualified to test and conduct refresher training	Staff time	28 August	List or spreadsheet with names and dates of training	Laboratory supervisors, AIDS coordinator
Distribute timers	Timers	28 August	Timers available in test room	Supervisor

5.2. Quality improvement through counsellor self-reflection

We can also work on quality through self-reflection. A sample self-reflection tool and instructions on its use are given in section four. Counsellor self-assessment is a process aimed at:

- assisting counsellors in understanding how well they are doing in their work
- allowing counsellors to get a better idea of what impact they are having on the people who receive counselling
- identifying areas that need improvement.

The same basic steps of QI can be applied but due to the nature of self-reflection, a different methodology may be used.

Step 1: Identify, prioritize and define the problem: use results from QA monitoring

The information can be used to help you reflect on your performance. For example, you can see how many times you have rated your counselling performance as excellent, good, fair or poor. If a number of interviews are combined, you would be able to find more about how you respond to members of a particular group (e.g. women, men, young persons, older persons). For example, a counsellor could look at the last 30 self-assessment forms they filled out and note that they have self-rated themselves as "excellent" 60% of the time when counselling women, but 80% of the time when counselling men. In addition,, a counsellor, their supervisor or an administrator could review the self-assessment data for an individual counsellor or for all counsellors. For example, it might be important to note that a number of counsellors self-assessed their performance as strongly agree or agree only 30% of the time on the item, "I was able to help the client fully understand their test results". This would reveal a real problem in the quality of counselling provided at a health facility. Overall, the kind of information that becomes available when counsellors fill out the self-assessment tool is intended to help in planning training, supervision and, importantly, recognition of problem areas in counselling quality.

Step 2: Analyse and try to understand what is causing the problem

Rather than using numerical quantification, self-reflection forms are best shared with a supervisor, friend or peers. Formal supervision groups are one venue where this analysis may take place.

Use of counsellor self-reflection in an NGO in Kenya

An NGO providing mobile VCT services in Kenya asked counsellors to fill in one self reflection form a day after seeing clients. Counsellors were encouraged to choose a session that they feel went particularly well or that was particularly challenging for them.

The form included question such as: Did I perform a risk assessment? Did I discuss the meaning of the results? Did I feel comfortable giving the results? Did I conduct a client-centred session? How well did I deal with the clients/my own emotional reactions? The NGO decided to instigate peer supervision sessions to enable the counsellors to get personal support and professional development. Sessions were conducted in small groups of counsellors and in the presence of a trained supervisor.

During feedback the counsellors reported that they felt encouraged by the support they got in supervision. They were keen to correct small errors. They also found that they were harsher on themselves than their clients were on them. During the same period a mystery client exercise and client exit interviews both revealed that the clients rated the experience much higher than the counsellors. Clients ranked counsellors highly in compassion dedication, interest and sensitivity.

Step 3: Develop solutions to overcome the problem

Since solutions may be very personal, they are best formulated personally. There may be a number of reasons for certain behaviours. Things that may have happened in your life may affect the way you handle certain clients. Your own HIV status and how you handle this or the way you handle your own emotional reactions may affect how you handle clients.

Step 4: Decide on and implement the solution

Skilled group supervisors can help you to focus your thinking, challenge your values and attitudes while providing support and unconditional regard for you. They can also use this forum to improve knowledge and practice skills such as helping clients to develop risk reduction plans.

5.3. Quality improvement through the use of client exit interviews

It is of vital importance that our services are tailored towards the needs of our clients. Client exit interviews can be used to measure client perception and satisfaction with particular aspects of the service or the service in general. A satisfied client is more likely to listen, comply with treatment and/or advice, and provide complete and accurate information in relation to their concerns and/or sickness. Exit interviews are a rapid way of assessing client perceptions of our services on a routine basis. The community can be involved in administering the questionnaires. Clients are more likely to describe how they really feel about the services to a community volunteer rather than to a member of the staff. Client exit interview tools and instructions on how to use the tools are described in section four.

Step 1: Identify, prioritize and define the problem

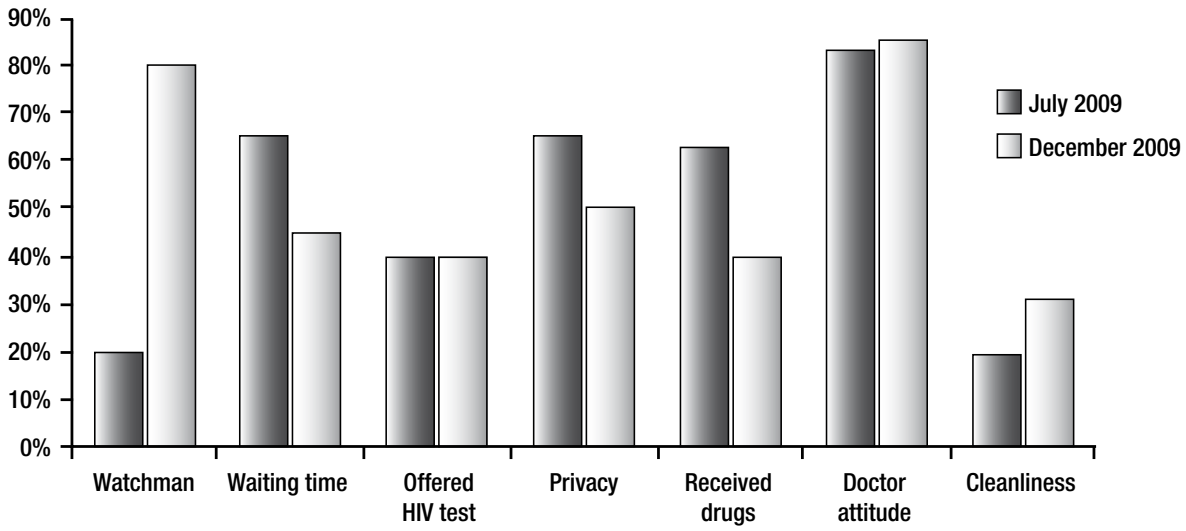
We recommend that you use bar charts to display the results from client exit interviews. This will help you to see quickly and easily how you are performing in relation to client satisfaction. If some of the percentages are very low, it suggests that these are priority areas that should be addressed to understand why they received such low scores. If the scores have decreased over time, it should be a cause for concern. You may also find that the percentages have remained the same, though you were expecting an improvement or that, in some cases, things have improved, but not enough. Figure 8 shows selected results from client exit interviews on STI treatment.

Involving community health centre committees in client exit interviews at a primary health-care centre

In rural Kenya, many primary health-care centres have health centre committees comprising community members. Committee members take decisions regarding the local health centre and have access to some of the cost-sharing funds collected at the health centre. These are used to improve the local facility. Health centre QA teams found that working with this health centre committee was an ideal way of giving feedback and implementing change plans. After agreeing on areas for inclusion in a satisfaction survey, they approached the committee for support in providing volunteers to conduct client exit interviews. Volunteers were given lunch and training on how to administer a basic survey – often conducted under a tree near the entrance to the facility. Examples of how the results from the client exit interviews have helped health centre committees in rural Kenya make local improvements are:

- hiring of a gardener with the health centre committee funds to improve waste disposal, cleanliness at the entrance and plant flowers around the health centre
- sacking of a watchman whose attitude to VCT clients was inquisitive and off-putting
- provision of a bench for those waiting and furniture for a counselling room from cost-sharing funds.

Figure 8. Results of exit interviews from STI clients



For analysis of routine data, you may find that a tabular format helps you to analyse client throughput and outcomes as shown in Table 6.

Table 7. Example of problem identification

Aspects of service being assessed	July 2009 (%)	December 2009 (%)
1. Watchman treated them well	20%	80%
2. Waiting less than 60 minutes to see clinician	65%	45%
3. Offered HIV test	40%	40%
4. Privacy	65%	50%
5. Received all drugs/injections	63%	40%
6. Attitude of doctor (very good)	83%	85%
7. Cleanliness (very clean)	95%	99%

Using the above rules you would probably identify the three most important problems as:
- Waiting time – (decreased by 20%)
- Offered HIV test – (score has remained the same and is low)
- Received drugs (low and decreased by 23%)

Priority-setting example

We use priority-setting so that we tackle the most important problem first. For the three selected problem areas, we now have to decide which is the most important (the problem we will tackle first). For this we can use a matrix and the criteria for priority-setting. Each individual writes a score in each column for each problem as is illustrated in the problem matrix.

Matrix for priority-setting

	How serious? Very serious = 3 Quite serious = 2 Not serious = 1	How many resources? Few resources = 3 Average resources = 2 A lot of resources = 1	How easy? Very easy =3 Quite easy = 2 Not easy =1	Total
Waiting time	1	2	2	5
Offered HIV test	3	2	2	7
Drug availability	3	1	1	4

Sum up the score for each problem and identify the problem with the highest score.
Top priority is: offering an HIV test.

Define the problem

Often, problem statements are poorly defined and Table 7 describes poor and well-defined problem statements. In this example, the problem statement can be defined as:

Problem statement: *60% of patients presenting for treatment of an STI are not offered an HIV test during their visit.*

Table 8. Example problem statements

Poor problem statement	Weakness in problem statement	Well-defined problem statement
Client flow	• This is not a problem • No quantification	Client flow for HTC services has dropped by 20% over the past four months
Queue jumping	• Statement contains a cause • No quantification • Imprecise	25% of clients experienced an unnecessary delay when waiting for curative services
We need more staff	• This is a premature solution • Imprecise • Not quantified	50% of HTC clients wait for more than 2 hours before seeing the counsellor
Staff are rude	• Imprecise • Not quantified	80% of HTC clients feel that the watchman has a very poor attitude
Poor condom distribution	• Imprecise • Not quantified	Only 15% of all HTC clients are given condoms by the counsellor
Too many interruptions	• Statement contains a cause • Imprecise • Not quantified	20% of HTC clients did not have privacy during the counselling session
Poor communication	• Statement contains a cause • Imprecise • Not quantified	25% of TB patients do not know whether they need to return for a follow-up visit
We need more drugs	• This is a premature solution • Imprecise • Not quantified	40% of STI patients did not receive all the prescribed drugs

Step 2: Analyse and try to understand the problem

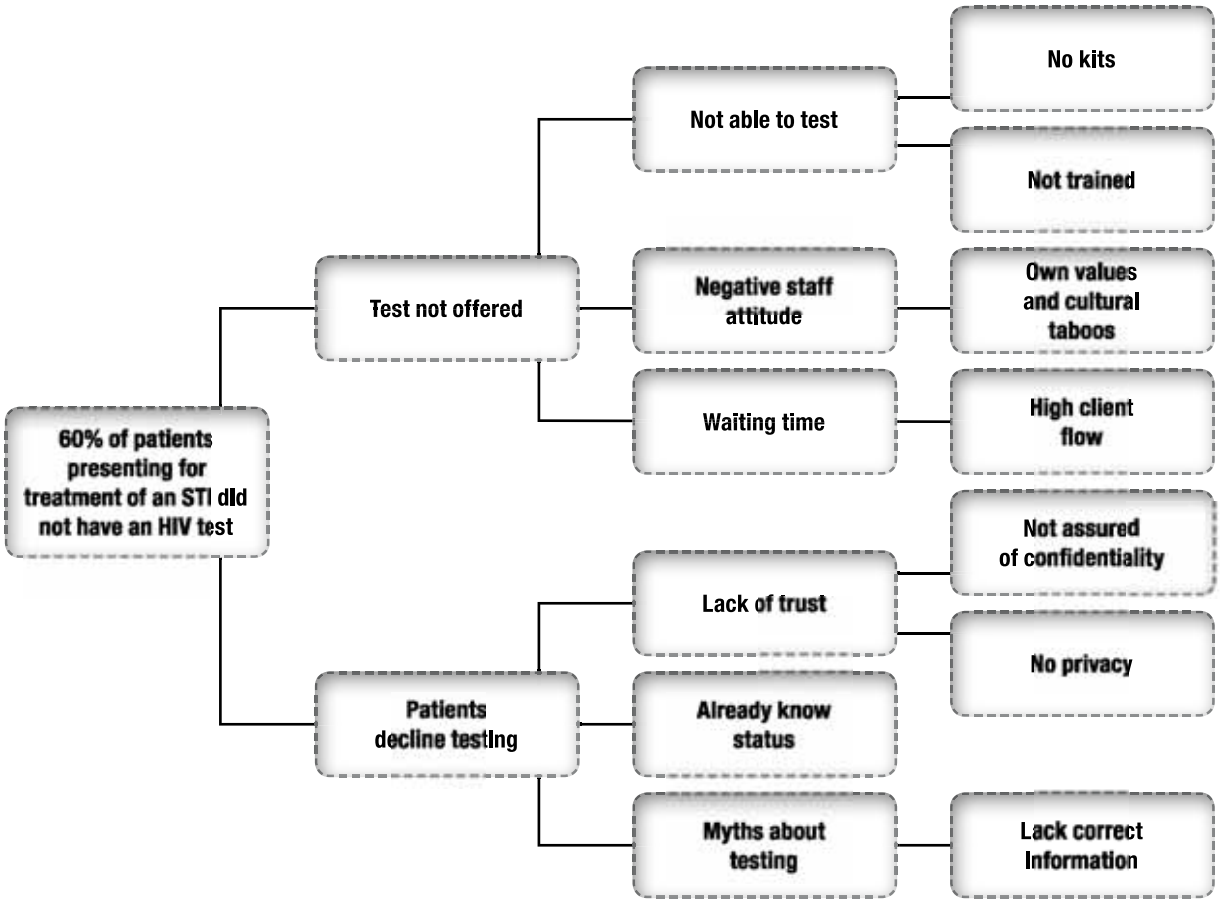
Identify who will work on improving the routine offer of HIV testing in STI clinics

A multidisciplinary group of people working on the problem might include clinician prescribers, HTC counsellors working in other areas of the facility, outpatient nurses and laboratory staff.

Analyse and study why HIV testing is not being done for 60% of patients

There may be a number of reasons why HIV rapid testing is not offered routinely in STI clinics. The policy may not have been disseminated to clinical staff, who may be busy, overworked, have a long queue waiting, or lack training or confidence. It may be as simple as a lack of availability of test kits or logbooks. Figure 9 provides an example of a problem tree as a method for identifying root causes. Keep asking "but why?" until you reach the root causes of the problem.

Figure 9. Example problem tree for low testing rates among STI clients



Step 3: Develop solutions to overcome the problem

At this stage, the problem-solving team should be ready to suggest ways of increasing the number of HIV tests offered. Some solutions may be straightforward; such as reminding staff about clinical guidelines on PITC through in-service training. Other problems may be more difficult to solve because it might involve changing procedures such as patient flow through the health centre to allow for more privacy during the

consultation process. In the short term, a lay counsellor might provide support to the clinician for HIV testing while health-care workers are trained in HIV rapid testing.

Remember that the choice of solution or solutions depends on:

- Is it affordable (resources available)?
- Is it feasible (practical)?
- Does it address the root cause?
- Is there community support?
- Is there management support?

Step 4: Decide on and implement the solution

The choice of solution must depend on the resources available and what is practical. Once the team has chosen the solution, implementing it requires careful planning, and must be written into a change plan. First, take into account your selected problem. You should set a target for what you are aiming for – by how much you expect to improve the situation. Remember to be realistic when setting targets; overambitious targets that are not met will only discourage and disappoint people. The next step will involve identifying the principal activities you will need to conduct to implement your chosen solution. For each activity, you must be clear of the resource requirements and realistic about the timescale for conducting each activity. Assign persons who will be responsible for each activity and set out exactly how they will monitor (evidence) that the activity has been completed. Once you have agreed on the change plan with the rest of the health centre staff, you are ready to implement it!

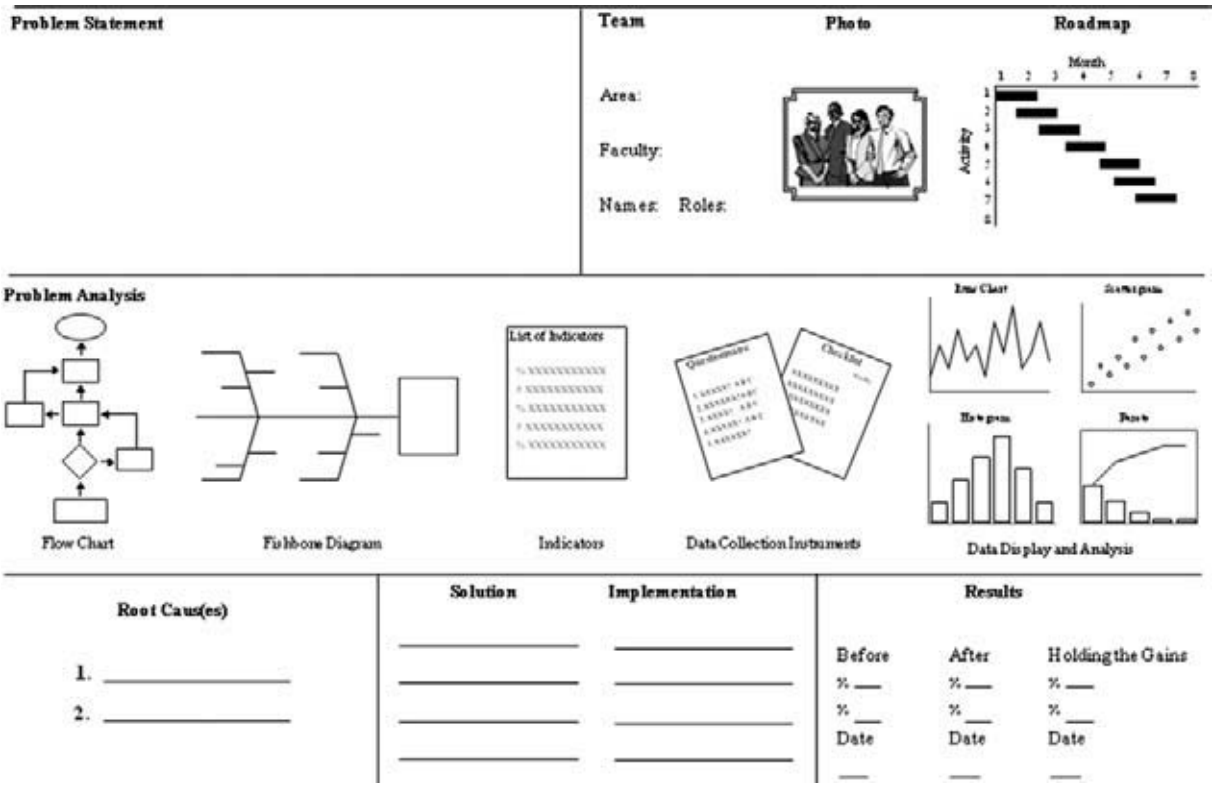
Example Change plan

Problem identified: 60% of STI clients are not offered HIV testing.
Target: 80% of STI clients are offered an HIV test

Activities (towards the solution)	Resources needed	Timing (dates)	Evidence that activity is completed	Persons responsible
Community meetings / mobilization to clarify myths and misconceptions about HIV testing	• Staff time • Transport	20 April	Reports of the meetings attended / conducted	Counsellor Other staff Community health volunteers
HIV rapid testing posters in the STI room and office cubicles	• Staff time • Posters	23 April	Poster on display in the counselling room and in the office (cubicles)	Counsellor
Rapid tests kits available in STI treatment room	• HIV test kits and reagents • Clinician time	23 April	Kits and logbooks available in treatment room	Laboratory technician
Deal with clinician values through supervision and group meetings	• Clinician time • Counsellor supervisor time • Self-assessment forms	25 April	Record of clinicians' attendance at meeting	Counsellor and supervisor

Using storyboards is an effective way of providing feedback to other staff and users on the systematic approach used in QI, such that the level of effort, approaches used and results of QI efforts are fully described to all stakeholders.

Example format for storyboard



5.4 Quality improvement through observed practice

Direct observation of HTC sessions can be particularly useful in identifying quality problems that would not be obvious from the records. It allows for immediate feedback from supervisors, project managers or trainers. If done in a supportive manner, this allows for on-the-job mentoring or coaching. Observation allows the whole HTC protocol to be observed and incorporates the counselling as well as testing components of HTC. If the results are aggregated across several service providers, data from observed practice can identify common problems and gaps in training. With the consent of the counsellor and the client, observed practice may also be done through video recordings of counselling sessions.

An observed practice session provides a snapshot in time of the performance of one particular counsellor in one particular session. It is not intended as a systematic approach to monitoring quality. Rather, it is intended as a way of maintaining standards, adhering to national protocols and professional development.

Step 1: Identify, prioritize and define the problem

The information from observed practice can be used to assess the quality of counselling through a focus on counselling skills. For example, an observer watching HTC sessions in a busy PITC or PMTCT setting may note that the counsellor rushes through the session, interrupts the client frequently, does not make eye contact and does not give the client time to ask questions. Based on this, they might conclude that the session was not client focused and of poor quality even though every item in the PITC (or PMTCT) protocol was covered according to the checklist. The observer might notice that the implications of testing were not

explained prior to conducting an HIV test and might conclude that the consent was not adequately "informed" and thus the client's human rights were not respected.

Identify the problem: the session was not client-centred and informed consent was not obtained.

Prioritize the problem: both are serious problems that need to be addressed.

Define the problem: informed consent was not obtained during the session.

Step 2: Analyse and try to understand what is causing the problem

A counsellor in a busy clinic may feel that they do not have the time or staffing resources to provide a client-centred session. They may be experiencing burnout or may simply need to talk to someone about the challenges they face. Their issues may be personal or common to a number of counsellors. They may also feel that they are out of date or lack knowledge in a particular area.

Step 3: Develop solutions to overcome the problem

Solutions must be jointly developed and agreed upon between the supervisor and counsellor who was observed. Supervisors should also be cognizant of problems that are not just at the individual level, but are observed across more than one provider. In this case, solutions should be developed for the team as opposed to the personal development of an individual counsellor.

Step 4: Decide on and implement the solution

Refresher training and supervisors' support can help counsellors to grow professionally and provide a better quality of counselling. They can also use this forum to improve their knowledge and skills.

6. RESOURCES

6.1 Recommended core resources

A modern paradigm for improving healthcare quality describes quality improvement (QI) approaches along a continuum of increasing complexity. The four approaches, which vary in the intensity of resources and time they require, are individual problem-solving, rapid team problem-solving, systematic team problem-solving and performance improvement. Activities/tools: systems view, evidence-based medicine, hierarchy of evidence, hypothesis testing, interpreting data variation, four steps to QI, continuous QI, Shewart's cycle for learning and improvement (Plan, Do, Study, Act), matrix of QI tools, descriptions of 21 QI tools and activities with advice on when and how to use each.

Massoud, R. Askov, A. Reinke, J et al. 2001. A modern paradigm for improving healthcare quality. *QA Monograph*. Bethesda, MD: Published for the US Agency for International Development (USAID) by the Quality Assurance Project. (http://www.qaproject.org/pubs/PDFs/improhq601bk.pdf)

Guidelines for assuring the accuracy and reliability of HIV testing: a quality system approach establishes guidelines for applying the essentials of a quality system to HIV rapid testing. It is intended to provide assistance to all persons involved in policy development, planning and implementation of HIV rapid testing. The document should be useful for government health officials, those responsible for HIV/AIDS programmes and for managing VCT sites. It also provides information useful for testing personnel, both trained laboratory technologists and those with no laboratory training.

WHO, CDC. *Guidelines for assuring the accuracy and reliability of HIV testing: a quality system approach*. Geneva, WHO, 2005. (http://whqlibdoc.who.int/publications/2005/9241593563_eng.pdf)

Guidance on provider-initiated HIV testing and counselling in health facilities responds to a growing need at country level for basic operational guidance on provider-initiated HIV testing and counselling in health facilities. It is intended for a wide audience including policy-makers, HIV/AIDS programme planners and coordinators, health-care providers, NGOs providing HIV/AIDS services and civil society groups.

WHO, UNAIDS. *Guidance on provider-initiated HIV testing and counselling in health facilities*. Geneva, World Health Organization, 2007. (http://whqlibdoc.who.int/publications/2007/9789241595568_eng.pdf)

Operations manual for delivery of HIV prevention, care and treatment primary health centres in high-prevalence and resource constrained settings provides guidance on planning and delivering HIV prevention, care and treatment services at health centres in countries with a high HIV prevalence. It provides an operational framework to ensure that HIV services can be provided in an integrated, efficient and quality-assured manner.

WHO. *Operations manual for delivery of HIV prevention, care and treatment primary health centres in high-prevalence and resource constrained settings*. Geneva, WHO, 2008. (http://www.who.int/hiv/pub/imai/operations_manual/en/index.html)

Draft Guide for monitoring and evaluating national HIV testing and counselling reviews basic M&E concepts in the context of HTC programmes, including a suggested logic model for HTC programmes. It describes a set of indicators that can be used by national AIDS programmes to monitor and evaluate their HTC services.

Guide for monitoring and evaluating national HIV testing and counselling (HTC) programmes. Geneva, World Health Organization (under development).

6.2 Additional resources

Ashton J. *Taxonomy of health systems standards. Project Report*. Bethesda, MD, Center for Human Services, Quality Assurance Project, 2001. (http://www.qaproject.org/pubs/PDFs/taxhlthsybook.pdf)

Ashton J. *Monitoring the quality of hospital care. Health manager's guide*. Bethesda, MD, Center for Human Services, Quality Assurance Project, 2001. (http://www.qaproject.org/pubs/pubsmonographs.html)

Bouchet B. *Monitoring the quality of primary care. Health manager's guide*. Bethesda, MD, Center for Human Services, Quality Assurance Project, 2000. (http://www.qaproject.org/pubs/pubsmonographs.html)

CDC. *Couples HIV counseling and testing intervention and training curriculum*. Atlanta, Centers for Disease Control and Prevention, 2007. (http://www.cdc.gov/globalaids/CHCTintervention/)

Donabedian A. The effectiveness of quality assurance. *International Journal for Quality in Health Care*, 1996, 8:401–407. (http://intqhc.oxfordjournals.org/cgi/reprint/8/4/401.pdf)

USAID, Family Health International. *Clinical facility and services assessment field guide. Quality assurance (QA) and quality improvement (QI).* Family Health International, 2007. (http://www.fhi.org/en/HIVAIDS/pub/guide/res_QAQI_Field_Guide_ClinicalServices.htm).

Gruskin S, Ahmed S, Ferguson L. Provider-initiated HIV testing and counselling in health facilities – what does this mean for the health and human rights of pregnant women? *Developing World Bioethics*, 2008, 8:23–32. (http://www.hsph.harvard.edu/pihhr/files/Gruskin_PITC.pdf)

Human Rights Watch. *A testing challenge. The experience of Lesotho's universal HIV counselling and testing campaign*. USA, Human Rights Watch, 2008. (http://www.hrw.org/en/reports/2008/11/18/testing-challenge)

Miller Franco L et al. *Achieving quality through problem solving and process improvement*. Bethesda, MD, Center for Human Services, Quality Assurance Project, 1997..

Miller Franco L et al. *Sustaining quality of health care: institutionalization of quality assurance*. Bethesda, MD, Center for Human Services, Quality Assurance Project, 2002. (http://www.qaproject.org/pubs/pubsmonographs.html)

Nemes M et al. The variability and predictors of quality of AIDS care services in Brazil. *BioMed Central Health Services Research* 2009, 9:51. (http://www.biomedcentral.com/1472-6963/9/51)

New York State Department. *HIVQUAL workbook: guide for quality improvement in HIV care*. New York, New York State Department of Health AIDS Institute, 2006. (http://www.ihi.org/IHI/Topics/HIVAIDS/HIVDiseaseGeneral/Tools/HIVQUALWorkbookGuideforQualityImprovementinHIVCare.htm)

Ovretveit J. *Health service quality: an introduction to quality methods for health services*. Oxford, Blackwell Scientific Publications, 1992.

Parekh BS et al. Dried tube specimens: a simple and cost-effective method for preparation of HIV proficiency testing panels and quality control materials for use in resource-limited settings. *Journal of Virological Methods*, 2009, doi:10.1016/j.jviromet.2009.10.013.

Republic of Kenya, Ministry of Health. *National quality assurance strategy for voluntary counselling and testing*. Nairobi, National AIDS and STI Control Programme (NASCOP), 2005.

Roemer M, Montoya-Aguilar C. *Quality assessment and assurance in primary health care*. Geneva, World Health Organization, 1988 (WHO Offset Publication 105). (http://whqlibdoc.who.int/offset/WHO_OFFSET_105.pdf)

Rooney A, van Ostenberg P. *Licensure, accreditation, and certification: approaches to health services quality*. Bethesda, MD, Center for Human Services, Quality Assurance Project, 1999. (http://www.qaproject.org/pubs/pubsmonographs.html)

Taegtmeyer M, Doyle V. *Quality assurance resource pack for voluntary counselling and testing service providers*. Liverpool HTC and Care Kenya, 2003. Nairobi, LVCT Kenya.

UNAIDS, WHO. *UNAIDS/WHO policy statement on HIV testing*. Geneva, UNAIDS/WHO, 2004. (http://www.who.int/hiv/pub/vct/en/hivtestingpolicy04.pdf).

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UNICEF, WHO, FHI. *HIV counselling resource package for the Asia Pacific*. 2009. (http://www.fhi.org/en/HIVAIDS/pub/guide/res_VCT_APRO_trainingpackage.htm)

United Republic of Tanzania, Ministry of Health. *Tanzania quality improvement framework. "Delivering quality health services".* Dar es Salaam, Ministry of Health, 2004.

United Republic of Tanzania, Ministry of Health and Social Welfare. National guideline for quality improvement in HIV and AIDS services. Dar es Salaam, National AIDS Control Program, 2009 (draft).

USAID Health Care Improvement Project. *The Improvement Collaborative: an approach to rapidly improve health care and scale up of quality services*. Published by the USAID Health Care Improvement Project. Bethesda, MD, University Research Co., LLC (URC), 2008. (http://www.hciproject.org/sites/default/files/The_Improvement_Collaborative.June08.pdf)

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WHO. *HIV rapid test training package*. Geneva, World Health Organization, 2005. (http://www.who.int/diagnostics_laboratory/documents/guidance/hivrttraining_overview/en/index.html)

WHO. *Testing and counselling for prevention of mother-to-child transmission of HIV support tools*. Geneva, World Health Organization, 2006. (http://www.who.int/hiv/pub/vct/tc/en/index.html)

WHO. *Consultation on technical and operational recommendations for clinical laboratory testing harmonization and standardization. Helping to expand sustainable quality testing to improve the care and treatment of people infected with and affected by HIV/AIDS, TB and malaria*. Geneva, World Health Organization, 2008. (http://www.who.int/hiv/amds/amds_cons_tech_oper_lab_test.pdf)

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WHO. *An approach to rapid scale up using HIV/AIDS treatment and care as an example*. Geneva, World Health Organization, 2004 (WHO/HIV/SPO/04.01). (http://www.who.int/hiv/pub/prev_care/en/rapidscale_up.pdf)

UNODC, WHO, UNAIDS. *Testing and counselling in prisons and other closed settings*. Geneva, World Health Organization, 2009. (http://www.who.int/hiv/pub/idu/tc_prisons/en/index.html)

WHO- SEARO/WPRO. *Guidance on testing and counselling for HIV in settings attended by people who inject drugs: improving access to treatment, care and prevention*. New Delhi, Manila, World Health Organization, 2009. (http://www.who.int/hiv/pub/idu/searo_wpro_tc/en/index.html)

World Bank. *Development in practice. Better health in Africa: experiences and lessons learnt*. Washington DC, World Bank, 1995.

Useful web sites

While there are a substantial number of web sites to choose from, the following web sites have useful materials and reports that can be downloaded free of charge

HTC documentation

www.cdc.gov

www.fhi.org

www.hivinsite.ucsf.edu/

www.liverpoolvct.org

www.popcouncil.org

www.psi.org

www.unaids.org

www.who.int

QI approaches, strategies and tools

www.hciproject.org

www.hivqual.org

www.qaproject.org

www.isqua.net.au

7. GLOSSARY

Accessibility
Ability of client or population to utilize the needed services, unrestricted by geographical, economic, social, cultural, organizational or linguistic barriers

Algorithm
Recommended patient management strategies designed to direct decision-making, such as a structured flow chart

Best practice
A method of conducting a process that is considered to be superior to all other known methods

Client
Denotes a participant in care, who in some settings may be referred to as service user, patient or customer

Coaching
Providing guidance, feedback and direction to ensure successful performance

Effectiveness
The extent to which something achieves its aim

Efficiency
The relationship of outputs to inputs (delivering maximum services with minimum expenditure of resources)

Equity
Ensuring fairness, impartiality and lack of discrimination in access to health services

Evidence-based medicine
The practice of medicine or the use of health interventions guided by or based on supportive scientific evidence

Guideline
A set of systematically developed statements, usually based on scientific evidence, to assist managers, practitioners and patient decision-making about appropriate interventions for a given service

Health services
All services designed to improve health and well-being

Health outcome
The effect on health status of the performance of one or more processes or activities carried out by health-care providers. Health outcomes include morbidity, mortality, physical, social and mental functioning; nutritional status and quality of life.

Indicator
A measurable variable (characteristic of service) that can be used to determine the degree of adherence to a standard or level of quality achieved

Measure
A number assigned to an object or event

Monitoring
Observation and recording of events over time

Multidisciplinary team
A group of individuals from different professions working together with a shared common goal and joint responsibility for achieving it

Outcome
Results of a process, including outputs, effects and impacts

Output
The direct result of the interaction of inputs and processes in the system

Patient
Recipient of care, who may also be referred to as client or service user

Patient satisfaction
Extent to which a patient expresses positive or negative attitudes to the health services in general

Performance
The actual output and quality of work performed

Policy
A formal statement or document outlining a course of action adopted by an organization. This includes decisions, usually developed by government policy-makers, for determining present and future objectives in response to health needs, available resources and other political pressures pertaining to the health system.

Problem-solving
A quality improvement approach that involves objectively identifying the causes of a problem and proposing potential, often creative solutions to the problem, which are agreeable to multiple parties or individuals

Process
A series of actions or activities that transforms inputs or resources into a desired product, service or outcome

Proficiency testing
Used to assess the ability of a laboratory or testing service to provide the correct testing results for a set of known specimens

Protocol
A detailed plan, or set of steps to be followed in a study, an investigation, or an intervention, as in the management of a specific medical condition

Quality
The totality of features and other characteristics of a product or service with the ability to satisfy stated or implied needs

Quality assessment
Determination of how processes and services correspond to current standards, as well as a patient's satisfaction with the care received

Quality assurance
A systematic and planned approach to assessing, monitoring and improving the quality of health services on a continuous basis within available resources

Quality control
An assessment of product compliance with stated requirements

Quality improvement
An approach to the study and improvement of the processes of providing health-care services to meet client needs

Quality improvement tools
The means by which quantitative and qualitative data are collected and analysed to help understand the situation where a quality problem exists and to develop and test/implement solutions. Examples include data collection tools, brainstorming techniques, problem analysis tools, flow charts, statistical and data presentation tools, benchmarking, QA story boards, etc.

Quality indicator
An agreed-upon process or outcome measure that is used to determine the level of quality achieved. A measurable variable (or characteristic) that can be used to determine the degree of adherence to a standard or achievement of quality goals

Quality management
An ongoing effort to provide services that meet or exceed customer expectations through a structured, systematic process for creating organizational participation in planning and implementing quality improvements

Quality monitoring
The collection and analysis of data for selected indicators which enable managers to determine whether key standards are being achieved as planned and are having the expected effect on the target population

Quality system
Defining the roles, responsibilities and procedures within an organization in order to ensure that staff are able to and do carry out quality assurance

Reliability
The extent to which the same result is achieved when a measure is repeatedly applied to the same group

Repeat testing
When additional testing is performed for an individual immediately following a first test during the same testing visit due to inconclusive or discordant test results; the same assays are used and, where possible, the same specimen

Retesting
When additional testing is performed for an individual after a defined period of time for explicit reasons, such as possible HIV exposure within the past three months, or ongoing risk of HIV exposure (sharing injecting equipment). Retesting is always performed with a new specimen and may or may not use the same assays (tests) as at the initial testing visit.

Sensitivity
A measure of the reliability of a screening test based on the proportion of people with a specific disease who react positively to the test. The higher the sensitivity, the fewer the false-negative results.

Specification
An explicit statement of the required characteristics for an input used in the health-care system. The requirements are usually related to supplies, equipment and physical structures used in the delivery of health services.

Specificity
The proportion of people free from a disease who react negatively to the test. The higher the specificity, the fewer the false-positive results.

Standard
An explicit statement of expected quality. Standards represent performance specifications which, if attained, will lead to the highest possible quality in the system.

Standard operating procedures
Management processes that describe chronological steps to be followed and decisions to be made in carrying out a specific task or function

Strategy
The means by which objectives are consciously and systematically pursued and obtained over time

System
The arrangement of organizations, people, materials and procedures associated with a particular function or outcome. A system is usually made up of inputs, processes and outcomes.

User
Denotes a participant in care, who in some settings may be referred to as client, patient or customer

Validity
The degree to which an indicator accurately measures what it is intended to measure

Variation
Differences in the output of a process resulting from the influences of people, equipment, materials and/or methods

Annex I - Feedback form

Handbook for improving HIV testing and counselling services – Consultation edition
Please take your time to answer the following questions about your experiences in using and adapting this handbook to your own country context. This is a living handbook and we therefore value your feedback to ensure that it is as user-friendly and practical as possible. We will post updates to the handbook on the WHO web site and include new tools that you have developed or would like to have included as well as case studies of your experiences in scaling-up quality HTC services in different settings. Please email this to hivtc@who.int
Chapter 1: Introduction
Is the scope of the handbook clear?
Is it clear who should use this handbook?
Is it clear how the handbook should be used?
Are the definitions for quality HTC appropriate to your context?
Chapter 2: Building blocks of the quality improvement framework
How useful and relevant are the building blocks to your own country context?
Did the way forward section guide you in implementing the handbook at national and subnational levels?
Chapter 3: Example quality indicators
How useful was the process map and flow chart for describing how to develop HTC indicators?
Did you monitor any of the example indicators?
Did you develop any additional indicators for monitoring the quality of HTC services?

Chapter 4: Example tools and instruction guides
Which tools did you use?
Did you develop any tools of your own?
Are there any other tools you would like to have included?
Chapter 5: Illustrative examples
How useful is it to include practical examples of quality improvement?
Are there any other examples you would like to see included?
Chapter 6: Resources
Is the annotated bibliography useful?
Are there any other resource documents you would like to see included?
Chapter 7: Glossary
How useful was the glossary?
Are there any other terms you would like to see included?
General comments/Suggestions
Do you have any other comments or suggestions regarding content, layout and language?

Annex II – Case study guide

Handbook for improving HIV testing and counselling services – Consultation edition
We would like to document different country experiences in implementing and adapting the handbook for improving HTC services, highlighting what went well and what went wrong. It is particularly important to give examples of QI and resulting best practice to inspire policy-makers, programme managers and providers of HTC on what can be achieved in various settings and at different levels. We welcome case studies describing programme-level QI efforts and those which may focus on the subnational level (district or subdistrict level) as well as examples on trying to improve specific aspects of HTC services or those focusing on specific aspects of the building blocks of the QI framework. We will post these case studies of your experiences in scaling-up quality HTC services in different settings on the WHO web site to allow exchange of experiences and ideas. Please email this to hivtc@who.int
Example structure (should be no more than two pages)
Aim: Describe the scope of the QI project.
Quality challenges/Problems: Describe the problem/s you attempted to tackle.
Approaches/Methods: Describe how you went about trying to improve quality.
Findings/Outcomes: Use data (graphics and tables) with clear evidence of improvements in selected quality indicators.
Enablers and inhibitors: Describe what factors helped you improve the quality and what inhibited you or slowed you down.