

**ASSESSMENT OF THE QUALITY OF HIV
COUNSELING AND TESTING SERVICE DELIVERY
IN PRIVATE FOR PROFIT HEALTH UNITS IN
KAMPALA DISTRICT**

BY

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2012

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Declaration

I Rebecca Kivumbi Mayanja do hereby declare that this programmatic activity report entitled ‘ Assessment of the quality of HIV Counselling and Testing service delivery in private for profit health units in Kampala district’ has been prepared and submitted in fulfilment of the requirements of Mak SPH-CDC HIV/AIDS Fellowship program and has not been submitted for any academic qualifications.

Signed Date.....

Fellow

Signed Date.....

Host Mentor

Signed Date.....

Academic Mentor

Dedication

This work is dedicated to all Ugandans who have utilized services available to regularly have an HIV test done on them together with their partners and children under their care

Acknowledgement

I thank the Almighty God for granting me life, health, strength, wisdom and persistence to complete this Fellowship Program.

My sincere gratitude goes to my Host Mentors; Dr. Benson Tumwesigye, Dr Ario Riolexus and Dr Zainab Akol. They have given me clear guidance throughout the Fellowship program.

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I would like to thank all the health workers in Private for profit health facilities that carry out HIV counselling and testing for they are doing a great job out there.

I also take this opportunity to thank my research assistants; statistician and everybody who made this work a success. Thank you so much and God bless.

Last but not least I thank my Family for all the support they have given me during this fellowship program

Abstract

Assessment of the quality of HIV counselling and testing in private for profit health units in Kampala district Uganda

Introduction: Knowledge about the quality of HIV counselling and testing (HCT) in private for profit health units is limited yet the private sector is increasingly becoming an important source of health care.

Objective: To assess the quality of HIV counselling and testing in private for profit health facilities in the central division of Kampala district.

Methods: Quantitative data was collected using semi-structured questionnaires through descriptive cross-sectional study design. A facility assessment tool was used to inspect the physical environment. In each facility one laboratory personnel and one counsellor were interviewed. The data was entered in Epi info computer soft ware package and analysed using STATA.

Results: 102 PFP health facilities were assessed; each facility had 2 respondents totalling up to 102 counsellors and 102 laboratory personnel. Only 19 out 102 counsellors were qualified and 88 out of 102 were qualified laboratory personnel. The rest were clinicians and nurses. Only 50% health facilities had and ever used HCT guidelines and 72% HCT providers had ever received in service training in HCT. Standard operating procedures were available in only 39% of the health facilities. Only 39% of the counsellors had ever received supportive supervision from DHO/MOH or partners. Only 2 HCT service providers started their clients on cotrimoxazole. About 11% of the health facilities had IEC materials. Counselling rooms were available in up to 90% of the facilities however privacy was considered adequate in 77% of these rooms.

Conclusion: The quality of HIV counselling and testing in private for profit health facilities in Kampala district is far below the standards. This was confirmed by little or no in service training in HCT, minimal or no supervision from MOH/District, facilities lack standard operating procedures (SOPs) & guidelines for guidance, few qualified HCT service providers especially in the area of counselling, and inadequate privacy of counselling at the facilities.

List of Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral drug
CDC	Centres for Disease Control
FP	Family Planning
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
IEC	Information Education and Communication
MOH	Ministry of Health
MakSPH CDC	Makerere University School of Public Health Centres for Disease Control
PITC	Provider Initiated Testing and Counselling
PFP	Private-for-Profit
PMTCT	Prevention of Mother to Child Transmission
USAID	United States Agency for International Development
PNFP	Private-not-for-Profit
QA	Quality Assurance
SOPs	Standard Operating Procedures
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

Operational Definitions

Client: Refers to a person to whom HIV counselling and testing (HCT) professional services are rendered

Confidentiality: This refers to health workers not disclosing an individual's HIV status to any other person without specific permission from them/ client.

HIV counselling and testing (HCT): Process of one getting to know their HIV status through a blood test on them

Private-for-profit health units: Health facilities owned by individuals, groups where by clients have to pay for the services being offered and they make profits out of them.

Private not-for-profit health units: Health units in Kampala district that are faith based and offer services at a subsidized rate and do not aim at making profit

Public health units: Health units in Kampala district that are government owned and most of the services are free

Quality HIV testing and counselling: HIV counselling and testing services that are in line with national HCT policy guidelines.

Quality Assurance: This refers to set minimum HCT standards for good care in areas such as provider performance, infrastructure, and client satisfaction.

Technical competence: Refers to the ability of the HCT service provider to deliver HCT services according to the national HCT policy guidelines (standards).

INTRODUCTION AND BACKGROUND

HIV counselling and testing (HCT) remains a very important intervention in HIV/AIDS control as it is the entry point into prevention, care, treatment and support services¹. In Africa Uganda has achieved the most success in the fight against HIV/AIDS and has shown the greatest commitment to promoting HIV counselling and testing.

HIV counselling and testing (HCT) in Uganda started in 1990 with voluntary counselling and testing as the model of implementation. New innovations in HCT have evolved and currently the ministry of health is rolling out provider initiated HCT in hospitals.

While Uganda has put in place policies and guidelines to ensure high quality HCT services within the reach of every Ugandan^{2,3}, the quality of HCT in PFP health facilities is not known since most programs and projects target public health facilities and not private for profit (PFP) health facilities. Since the quality of HCT in PFP health facilities is not known most likely a knowledge gap exists in private for profit health facilities. The Ugandan HCT policy indicates that private for profit health units should adhere to the national HIV testing algorithm and have a quality control link with established reference laboratories³. The policy also recommends that the facility should have personnel, space for counselling and an HIV testing laboratory³. It should offer ongoing care and support for HIV/AIDS patients or should have an established referral system or links with other HIV/AIDS services³.

World health organization recommends that in all health-care settings, screening for HIV infection should be performed routinely for all patients aged 13-64 years⁴. Health-care providers should initiate screening unless prevalence of undiagnosed HIV infection in their patients has been documented to be <0.1%^{2,4}. The process of HIV counselling and testing (HCT) includes making a decision to be tested, accessing testing services, testing and counselling and waiting for the results.

Quality assurance ensures that HIV testing is of high quality by ensuring adherence to standard operating procedures (SOPs), use of test kits that are not past the expiry date, availability of laboratory internal quality control and regular calibration, monitoring

and maintenance of equipment. Quality assurance also ensures there is client satisfaction and test results are provided immediately to the client.

The Ministry of Health defines quality as 'doing the right thing right, the right away'. Therefore quality assurance can be defined as the process of ensuring that performance is done according to the set standards. These guidelines form the national standards for HCT services in Uganda³.

HCT service standards include competent counselling and laboratory personnel, appropriate infrastructure, appropriate test kits and protocols. A hospital may be well organized, ideally located and well equipped but it will fail in its responsibility to provide quality care if patient satisfaction is not of a high calibre⁵. The Ministry of Health and individual HCT sites must have ways of assuring that the services meet a minimum standard of quality.

One framework for measuring the quality of health services, developed by Donabedian, focuses on three main attributes: structure, process, and outcome^{6, 7}. Structural dimensions of quality examine the infrastructure and management systems in which care is delivered⁷. Process dimensions of quality identify the extent to which good medical practice has been applied, as well as the interpersonal characteristics and skills of providers⁷. Outcome dimensions of quality measure the impact of care on the overall health of patients.

Statement of the Problem:

Knowledge about the quality of HIV counselling and testing (HCT) in private for profit health units is limited.

It is not known what quality of HCT is being given to clients who carry out their HIV counselling and testing from PFP health facilities yet the private sector is increasingly becoming an important source of health care, filling gaps where no or little public health care is available. In Uganda the public seeks up to 90% of health care from the private sector for common ailments and HCT is expected to be performed routinely for all patients aged 13-64 years^{3,4}.

The Ugandan HCT policy indicates that private for profit health units should adhere to the national HIV testing algorithm and have a quality control link with established reference laboratories. The policy also recommends that the facility should have personnel, space for counselling and an HIV testing laboratory. However it is not also known whether PFP health facilities do follow the policies and guidelines on testing and quality control.

It is therefore important to study the quality of HIV counselling and testing service delivery so that gaps are identified and this will lead to important steps in improving HCT service delivery in PFP health units which will in turn influence client service utilization, behaviour change and satisfaction.

Justification:

Studies have attempted to describe the quality of HCT services in Uganda but none has adequately addressed quality of HCT in private for profit (PFP) facilities.

Since HCT is the entry point to accessing treatment and the PFP health facilities are the biggest providers of care, it is important that factors that compromise quality of counselling and testing are identified and addressed.

Private for profit HCT providers have missed out on services such as trainings⁸⁸⁸⁸, mentoring, supportive supervision and support with test kits. This may have compromised the quality of HIV counselling and testing offered to their clients.

Results of this study will help address the gaps in the quality of HCT and this will result in improved health benefits to their clients.

Conceptual frame work:

Assess adherence to counselling & testing standards

Confidentiality, consent, pre and in-service training, supportive supervision in the last 6 months from MOH/District, waiting time, linkage to care, availability and utilization of HCT policy/guidelines,



Quality HCT



Health facility factors

Availability & number of counselling rooms

Availability of laboratory

Amenities (IEC, cleanliness of place)

Presence of Waiting room

Privacy in the counselling rooms

Supplies and logistics (storage, availability)

Documentation (availability of registers & client cards)

LITERATURE REVIEW

Time management

In Zambia a study showed that waiting times were an important component of overall VCT quality. Long waiting times, particularly while waiting for a HIV test result, deterred clients from learning their HIV status⁹. In the same study the NGO sector recorded the shortest waiting time (15 minutes) while clients in the mission sector waited the longest (42.5 minutes). There were no significant differences between sectors in the median amount of time spent by clients in their pre-test or post-test counselling sessions, or in waiting for a HIV test result⁹. There were relatively low wait times for HIV test results after testing, and post-test counselling sessions were substantially shorter than pre-test counselling sessions⁹.

Clients' perception of VCT services in Uganda reported that female counsellors were preferred compared to male counsellors and the average time was 1 hour and 7 minutes¹⁰.

In South Africa¹⁰ a study on VCT in the public sector found that counsellors spent an average of 25 minutes on pre testing and 20 in post testing and counselling. The absence of doctors and mismanagement of time for post-test counselling were the main reasons why women did not receive test results¹¹ in the Burkina study.

Provider adherence to standards

A study done in Kenya assessed the implication of quality assurance of VCT in by observing client-provider interaction in 20 VCT centres. The study found that overall VCT providers did a good job on counselling about HIV transmission and prevention. However counselling about condom use to prevent STIs and unwanted pregnancy was less common and condom distribution was low¹².

Another study showed that nurses were generally positive about PITC, but expressed the need for more training and managerial support. Health system constraints (lack of staff, lack of space) meant that nurses did not always have time to provide adequate

counselling. Nurses were particularly stressed by breaking bad news and handling ethical dilemmas¹³.

In Mulago hospital, Mungerera et al found that Hospital-based health workers were missing important opportunities for AIDS prevention education with their patients, 26% of health workers had never referred patients for HIV counselling and 31% had never advised patients suspected of HIV infection to be tested. Frequent explanations for not providing AIDS prevention education included time constraints and/or lack of related knowledge or skills¹⁴.

However the Tanzanian study showed that 60% of counsellors did not meet standards of preventive counselling skills, while most counsellors reported good counselling practice on self assessment¹⁵.

In Burkina a study showed that the quality of pre-test counselling was very poor as 42% did not understand the process¹¹.

Other studies have shown that counsellors were competent and confidential; a community health survey on HIV/AIDS-related knowledge, attitudes and practices of health care workers in Tamatave (Madagascar) showed that 61% of the health-workers reported never having advised patients to be tested while only 10% mentioned correct counselling precautions¹⁶. workers were favoured as the preferred provider of HIV CT services¹⁷.

Health care workers from two states in southern Nigeria showed a fair level of knowledge with doctors scoring the highest while laboratory workers scored lowest¹⁸. There was a significant gender difference in the level of knowledge but the data suggested that knowledge did not differ by hospital settings. There were generally negative feelings and views about the care of HIV/AIDS patients among the professionals, these views being worst at the community health centers and best at the government hospital. The greatest source of information for the majority of professionals was health talks/seminars¹⁸.

In the Zambian study to assess 'who goes where and why for HIV counselling and testing', it was observed that counsellor answered questions with enough detail"; the

NGO sector had the highest rates, although the private sector also performed well on this indicator. Counsellors also provided clear explanation of the HIV test result," the private sector performed the best; the vast majority of clients across all sectors felt they received a clear explanation of their HIV test result⁹.

Obiajulu Anthony of the University of Limpopo South Africa in his MMed thesis found very high level of knowledge, a moderately supportive attitude and a moderately high level of practice of VCT amongst health care providers¹⁹. He observed that divorced/separated respondents to this study had more supportive attitude towards VCT than their single colleagues. Age was found to have a very weak but positive correlation to attitude score. There was no significant difference in knowledge and attitude scores between those who practiced VCT and those who did not. And he concluded that health professionals understand the importance of VCT as an HIV preventive behaviour but there remains some VCT knowledge, attitude and practice concerns together with other determinants of VCT behaviour that needs to be addressed¹⁹.

In a cross-sectional survey carried out by UNAIDS, twenty-two nurse counsellors and six community volunteers were interviewed²⁰. Twenty-four counselling sessions were observed and 24 client exit interviews were conducted. Although nine of the 22 nurse counsellors had only in-service rather than formal training for HIV counselling whereas all community volunteers had been formally trained, nurse counsellors demonstrated better interpersonal skills than did community volunteers. Both clients and counsellors identified fear of a positive result as a major barrier to HIV testing. Clients also raised concerns about confidentiality. The study identified areas where training needs to be strengthened and suggested ways of improving the services²⁰.

Infrastructure

In 3 districts of rural Uganda the quality of care was assessed basing on the existing infrastructures, trained staff, quality of equipment and good clinical skills of provider²¹. The quality of care for all public and private not for profit (PNFP) facilities was found to be good or satisfactory. Most private for profit (PFP) units were also found to have

satisfactory quality of care but some few, especially clinics or drug shops that were manned by persons that were not fully trained, were assessed to have unsatisfactory quality of care^{21, 22}. This is because many of them were short of space, lacked the basic diagnostic equipments like thermometer or blood pressure machine and failed the clinical competence tests. The assessment tool scored the informal units very low because none of them had basic equipment²¹.

In Uganda a research to assess the private for profit (PFP) HIV care in Uganda found that although nearly 60% of the PFPs surveyed offered voluntary counselling for HIV and distributed condoms, only 29% had facilities for HIV testing²³. The quality of services in these facilities had not been assessed, and little was known about the quality of HIV care in PFPs²⁴. Service quality was thought to likely vary from one PFP to another, depending on available resources invested. It was also thought that PFPs might be missing out on support available from the Government and its partners, since PFPs are not integrated with the public health system²⁴.

In the Zambian study there are very few significant differences between sectors in the physical environment for VCT. The only significant difference between sectors relate to the mean percentage of VCT rooms with lancets: the mission sector has the highest percentage (86 percent) and the public sector the lowest (41 percent). The private sector has the highest number of rooms available for VCT, with an average of 2 VCT rooms. Other studies on assessing quality care of VCT concluded that quality of care could be improved by: increasing accessibility; expanding the buildings to promote privacy and maintain confidentiality; reducing cost for test; increasing awareness and reducing stigma.

The Horizon project ²⁵in Kenya and Uganda found a wide range of configurations of testing and counselling offered. Some facilities provided only testing and no counselling. Other facilities provided only counselling, but were sending clients to another venue for testing. The researcher concluded that periodic satisfaction studies are very important tools for evaluating services delivery.

Monitoring the quality of counselling remains a challenge for most VCT program; good quality of services is not only reflected by client attendance, but it is also important to ensure effective strategies that facilitate changes adoption.

In many low and middle income countries, the private sector is increasingly becoming an important source of health care, filling gaps where no or little public health care is available. Uganda has 4,639 health facilities of which 2,154 (46%) are privately owned. Government has accredited 36 private for profit to provide care and treatment to people with HIV /AIDS. The conclusion of the review is that research is needed to examine both clients' and counsellor's expectations, experiences and satisfaction with HIV test counselling. Like many other countries Uganda is at the stage of promoting and even formalizing linkages between public and private health care systems with the aim of improving access to health care. However, knowledge on the private sector providers in terms of HIV/AIDS is limited and this makes it difficult to include them in health care planning²⁶.

Client satisfaction

Patient's satisfaction is a major indicator of the quality care and quality of service can be assessed by mapping out patient satisfaction with care providers. Furthermore, clients' views on delivering VCT services in South Africa concluded that 63% of clients reported to be satisfied with counselling session²⁷. Clients felt that those providing counselling should work full time on counselling and need to be trained in counselling. However, qualitative studies on public interest towards VCT in Malawi and Uganda reported that community members valued VCT; counsellors gave them enough time to ask questions and others said counsellor are competent and confidential^{17, 28}. Some studies showed that clients preferred that counsellors do not come from the same community^{17, 28}. The Malawi Demographic and Health Survey in 2004 showed that people from the urban areas are more likely to report HIV testing than those from the rural areas, similarly those with higher primary school education levels and those in higher wealth quartiles are more likely to test for HIV than those in the lower wealth quintiles.

In 2007 WHO/UNAIDS issued new HIV testing guidelines recommending 'provider-initiated HIV testing and counselling' (PITC)⁴. Key concerns were whether/how informed consent, privacy and confidentiality would be upheld in overstretched health

care settings, and whether appropriate post-test counselling, treatment and support could be provided¹³.

Different protocols from different parts of the world specify the same elements of quality as outlined below^{3, 9, 29-31}.

Key Elements of Quality for HIV Counselling

- The client must make the decision him/herself to receive VCT services, and consent must always be obtained and documented before testing occurs. Additionally, confidentiality must be maintained throughout the process.
- Counselling should be adapted to the client's needs, and approaches may include individual and couple sessions. Pre-test counselling should be centred on the client's: personal history and risk of exposure to HIV, understanding of HIV/AIDS and experience in dealing with crisis situations, previous attempts at reducing risk, understanding of the HIV test and decision whether to take it.
- The counsellor should discuss with the client: basic facts about HIV/AIDS prevention, treatment, the meaning of the HIV test, a personal risk assessment, the client's readiness and intentions after learning his/her status, ways to cope with an HIV-positive result, ways of staying uninfected if the test results are negative, family planning (FP) methods, potential support from friends and family, consent; and any other concerns the client might have.
- The counsellor should be able to explain the procedures (including wait time) and offer educational materials about VCT and HIV in the waiting rooms.
- The results should be given in the same day, in a private setting, and the client may request to have a supportive person accompany him/her. Clients who test negative should be encouraged to return within three months to ensure that they are truly uninfected. Regardless of the result, the client should be counselled on leading a healthy lifestyle and developing a personalized risk-reduction plan. HIV-positive clients should be referred to appropriate treatment services. Other referrals (regardless of the result) include medical, social, legal, economical, spiritual, and psychological support.

- If a client requests only testing, the counsellor should explain that VCT services are a package and should encourage the client to come when s/he has enough time to undergo both procedures.
- A client may request only counselling services, and should not be pressured or coerced into being tested.

Key Elements of Quality for HCT Infrastructure

- Does the HCT room have good lighting, adequate space, and well-ventilated?
- Does the HCT room provide privacy and confidentiality for the client?
- Is there water available for hand-washing in the VCT room?
- Availability of information, education and communication (IEC) materials on HIV/AIDS
- Availability of a waiting area with chairs/benches for VCT clients
- Availability of furniture, supplies and test kits including: Screening test, confirmation test, and tie-breaker test,
- Gloves, Alcohol/methylated spirit, Cotton, Lancets, Safety box for disposal of needles/lancets
- At least 1 desk, 3 chairs, and a 1 lockable cabinet

STUDY OBJECTIVES

General objective

To assess quality of HIV counselling and testing in private for profit health units in order to improve HCT services in Kampala district.

Specific objective

1. To determine the level of adherence to counselling and testing guidelines by the HCT service providers in private for profit health facilities in Kampala district.
2. To establish the health facility infrastructure factors that affect quality of HCT service delivery in private for profit health facilities in Kampala district.

Research questions

1. What is the quality of counselling and testing being offered to clients who receive HCT services in the PFP health units?
2. What are the infrastructure factors affecting the quality of HCT service provision in PFP health units?

METHODOLOGY

Study sites

The study was carried out in private for profit health facilities in Kampala district. Kampala district is divided into 5 divisions' namely Central division, Kawempe division, Makindye division, Nakawa division, and Rubaga division. And has a total of 766 private health facilities registered with private practioners' association. The study was conducted in only 1 randomly selected division i.e. Central division. Central division has 141 health units.

Study population

The study participants comprised of HCT counsellors and laboratory personnel from private for profit health units that carry out HCT. In the counselling unit and the laboratory section only one counsellor and one laboratory personnel was selected from each health facility. The counsellor and laboratory personnel who were at the facility at the time of the interview were the ones interviewed and all carried out HCT services. The health facility factors that affect HCT were established in this study.

Study design:

A cross sectional study design was used to assess the quality of HCT in private for profit health units. Quantitative methods of data collection were used to collect the data through structured questionnaires to answer the research questions. A facility assessment tool was used to inspect the infrastructure.

Sample size estimation

Using Levy, SP and Leme show, S.1991 formula for sampling of populations:

The sample size was 103 health facilities in Central division in Kampala district.

Sampling

$$n = \frac{N \cdot z^2 \cdot pq}{(N - 1) \cdot d^2 + Z^2 \cdot pq}$$

z	d	p	N	n	
1.96	0.05	0.5	141	103	108

$$\approx \frac{z^2 \cdot pq}{d^2}$$

n= estimated sample size

z= value on standardised normal distribution curve corresponding to a level of significance. Ie 5% and the corresponding z value is 1.96

pq= q=1-p

p= probability of outcome interest

N= number of private for profit health facilities in central division

d= acceptable error

Sampling procedure

Simple random sampling technique was used to select private health facilities providing HCT services in the central division of Kampala district. A few facilities were however purposively selected. This was to enable us to have a fair representation of all types of health facilities serving different populations. And in each health facility only one laboratory personnel and one counsellor present at the time of interview was interviewed bringing to a total of 204 respondents.

Study variables

Dependent variable

Dependent variable included quality of HIV counseling and testing.

Independent variables

Adherence to HCT policy guidelines, Pre and in-service training, supportive supervision in the last 6 months from MOH, waiting time, confidentiality, quality counselling and testing, linkage to care, number of staff present at any one time,

Factors that affect quality HCT delivery assessed included availability & number of counselling rooms, availability of laboratory, amenities (IEC, cleanliness of place), presence of Waiting room, privacy in the counselling rooms, supplies and logistics

Inclusion criteria

- HCT service providers at the private health facilities i.e. counsellors and laboratory personnel who were be on duty at the time of the interview and who consented for the study.

- Private for profit health facilities in central division of Kampala district that provide HCT services.
- Private for profit health facilities in central division that registered with Kampala city council.

Exclusion criteria:

HCT service providers who did not consent for the study.

Data collection tools

Pre-tested and standardized questionnaires written in English were used. For each health unit there were two questionnaires i.e. one for interviewing health workers and the other was for facility assessment. The principle investigator or the research assistant did administer these questionnaires.

Training of research assistants

Five research assistants were recruited and trained for three days. Selection of research assistants was based on previous experience in research work. All the recruited research assistants received 3 days of training on the aim of the study, research methods and data collection procedures. The training also focused on obtaining consent, privacy issues, personal relation and ethics.

Data collection methods and procedures

Data was collected from in December 2012. A program detailing the purpose and the schedule for the visits by the research team was communicated to all the health unit managers of the private health facilities that were visited.

Research assistants together with the principle investigator then proceeded to the health units for data collection. The interviewer explained the purpose of the study and obtained a written informed consent from the participants. Each person was interviewed separately and the interview took about 30 minutes. After the interviews the research assistants then inspected the physical environment.

Pre-testing

The data collection tools were pre-tested from 12 health units in Wakiso district. This was to ensure that the questionnaire is appropriate prior to conducting the study. The tool was then appropriately corrected.

Field editing of data

The principal investigator did supervise the research assistants in the field and checked the questions to ensure completion, consistency and uniformity. The principle investigator also performed field editing of the completed data collection forms. Error and missing data was corrected in consultation with the research assistants. The research team held daily review meetings at the end of each day during which experiences, lessons learnt, challenges and way forward for the next day were discussed and shared.

Data management and analysis

All data was double entered into EPI-info, verified and cleaned. Stata version 10 was used for all data analysis. Descriptive data was first analysed and presented in frequency tables of numbers and proportions at the health facility level. This was categorised as either having or not of the following: HCT policy manuals, IEC materials, availability of a counselling room, privacy during counselling, use of MOH registers,

adequate lab space, availability of lab SOPs, PEP and kits storage space, safe biohazard waste disposal and number of weekdays of HCT. All data at the individual level was categorised as gender, qualification, duration of experience in counselling, confidentiality, supportive supervision and linkage to care. This was also presented in a frequency as numbers and percentages. The proportion of health worker participants who attended HCT training was presented as a bar graph and a one way ANOVA was used to assess significance in differences between these health worker categories. A two-sided *P*-value of ≤ 0.05 was considered as statistically significant.

Ethical Considerations

Institutional consent was sought from MakSPH-CDC Fellowship program, MakSPH institutional review board, Uganda National Council for Science and Technology and from the President's Office.

Informed consent was obtained from health unit managers, laboratory assistants and counsellors.

The HCT service providers were free to withdraw from the study at any level of interview

Quality control

Questionnaires were pre tested and standardized

Research assistants were trained before data collection

The questionnaires were cross checked to ensure completeness before the investigator or research assistant left the study site and were stored securely.

Study limitation

There was a possibility of service providers improving their performance at the time of interview and not giving the correct information.

Being private for profit health facilities some questions were spared especially ones to do with finances as they were not comfortable answering them.

Dissemination of results

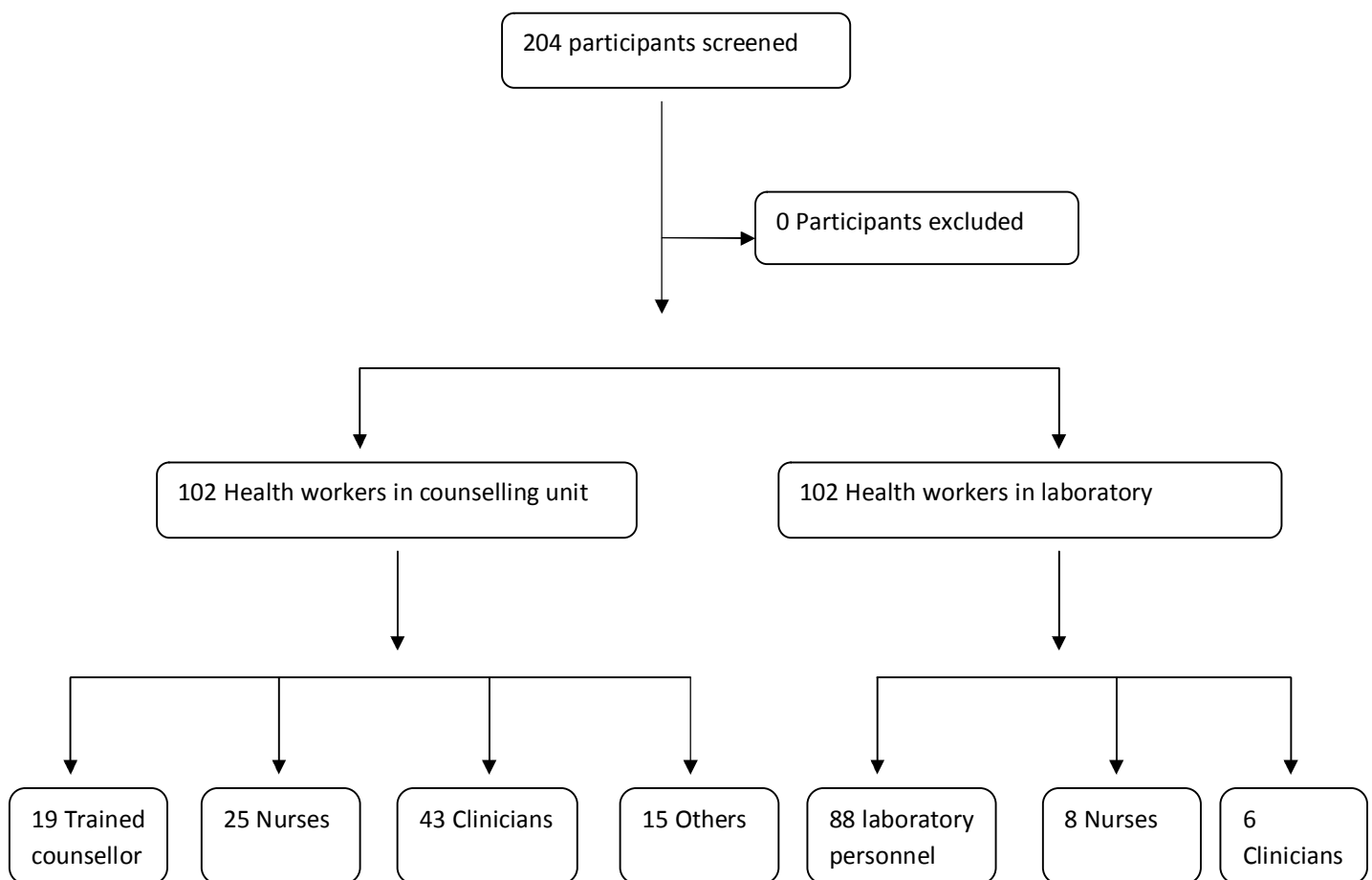
The results of the study were submitted to MakSPH CDC Fellowship program as partial fulfilment of the requirements for CDC Fellowship award. The results were also availed to, MakSPH, Ministry of Health, Uganda, and Uganda society for health scientists.

RESULTS

The study was carried out in 102 private for profit health facilities in the central division of Kampala district during the month of December 2011. Overall 204 health workers were interviewed; half of them working in the counselling unit and the other half in the laboratory.

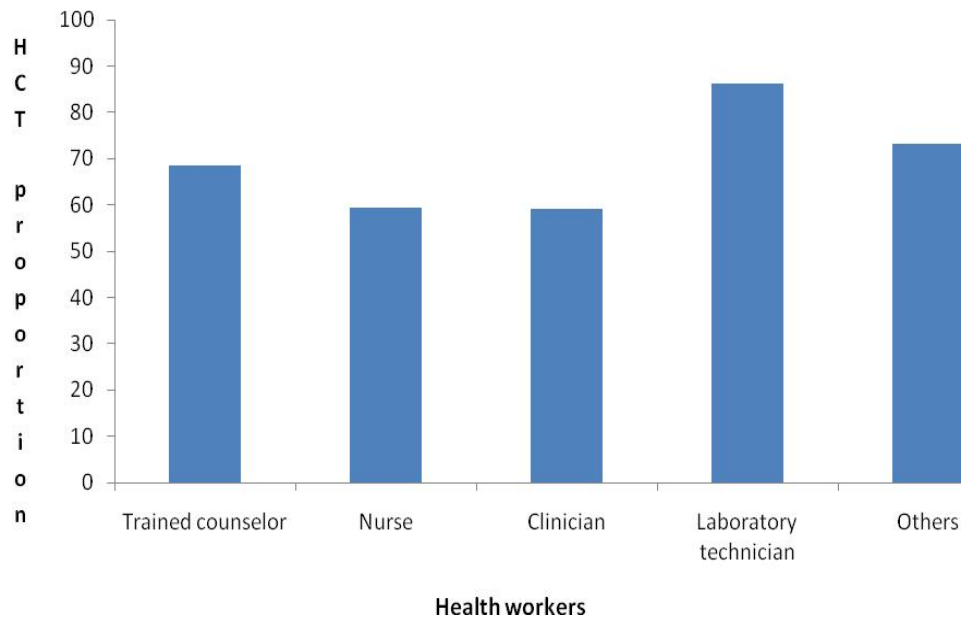
In the counselling unit there were 19 qualified counsellors, 25 nurses, 43 clinicians while the remaining 15 had other qualifications. In the laboratory 88 were qualified laboratory personnel, others were nurses and clinicians. Of the 204 respondents 93 (45.59%) were males while the rest were females. *See figure below.*

Figure 1: Individual level study profile



Below is a graph showing proportion of health workers carrying out HIV counselling and testing;

Figure 2: Graph showing proportions of health workers carrying out HCT



About one third had experience in HCT of less than 1 year; another 1/3 had experience of 1-2 years while the other 1/3 had experience of more than 5 years.

The study showed that 87 (85%) of the health workers obtained only verbal consent while the remaining 15 (15%) obtained both verbal and written consent before carrying out an HIV test on their clients.

To ensure clients confidentiality, all the health workers maintained confidentiality either through use of lockable cupboards (10%), computer password (2%), information remaining between counsellor and client (84%), and only 4% did all the above.

After a positive test, 88 (86%) health workers referred their clients for chronic care, however only 2% health workers started their positive clients on contrimoxazole prophylaxis. At least 98 (97%) out of the 102 counsellors reported their clients to have gotten results on the same day of testing. Ninety two (90%) of the health workers did

give post test counselling to all who test while 10(9.8%) gave it to only those whose HIV results turn out positive.

Only 40(39%) counsellors have ever been supervised by DHO's office/MOH or partners. Of the 40 who had received supportive supervision, 21 (52%) was from MOH, 12 (30%) from district health officer's office and 7(17%) from partners. Of those supervised, 17 were being supervised every 3 months, 15 every 6 months, and 4 once a year.

In terms of training 148(73%) health workers had ever received in service training in HCT while the remaining 55 (27%) had never received in service training in HCT.

About 50% health facilities had and used HCT guidelines. Of the 44 available guidelines mentioned, 32 (72.73%) were MOH, 2 (4.56%) were WHO while 10 (22.73%) were from partners.

On self assessment 19(19%) health workers rated their health facility HCT services as very good, 68(66%) as good while 15 (15%) rated their services to be fair. *See summary in the table below.*

Table 2: Baseline characteristics plus HCT service delivery

Characteristic	Number (N=204)	Percentage
Gender		
1. Male	93	45.59
2. Female	111	54.41
Service provider		
1. Trained counsellor	19	09.31
2. Clinician	49	24.02
3. Nurse	33	16.18
4. Lab techs	88	43.14
5. Others	15	07.35
Duration of counselling experience*	37	36.27
1. <1 year	31	30.39
2. 1-2 years	34	33.33
3. > 2years		
Mode of informed consent*		
1. Verbal	87	85.29
2. Written	15	15.71
Confidentiality*		
1. Lockable cupboards	10	09.90
2. Computer password	2	01.98
3. Between counsellor and client	85 4	84.16 03.96
4. All the above		
Patient waiting time in minutes*		
1. < 30	41	40.20
2. 30-60	54	52.94
3. >60	7	06.86
Patient referral*		

1. Specialized clinic	97	95.10
2. General clinic	1	00.98
3. Not referred	4	03.92
Support Supervision*		
1. Yes	40	39.22
2. No	61	59.80
3. Missing	1	00.98
Training in HCT		
1. Yes	148	72.55
2. No	55	26.96
3. Not specified	1	00.49
Availability of National guidelines		
1. Yes	102	50.00
2. No	100	49.02
3. Missing	2	00.98
Available types of test kits¥		
1. All the three	95	93.14
2. Only two	2	01.96
3. Only one	5	04.90
DBS for children¥		
1. Yes	3	02.94
2. No	99	97.06

*Only includes the 102 health workers in the counselling unit

¥Only includes the 102 health workers in the laboratory

Health facility infrastructure

All the 102 health facilities assessed had waiting areas where clients sit as they wait for HCT services. These waiting areas however doubled as reception area for all patients.

Information, education and communication (IEC) materials were available in only 11 (11%) of all the health facilities. The counselling rooms were also available in up to 90% of the facilities however privacy was only adequate in 77% of these rooms.

Very few (13%) health facilities had Ministry of health registers and only 56 (55%) had adequate laboratory space. Standard operating procedures (SOPs) were available in only 39% of the health facilities and Post exposure prophylaxis was only in 23(22%) of the facilities.

There was not enough space for storage of kits in 34% of the facilities. However all the 102 laboratories had protective gear available for health workers' use. Safe biohazard waste disposal was adequate in 89% of all the health facilities.

The results are summarized in the table below

Table 1: Health facility level baseline characteristics

Characteristic	Number (N=102)	Percentage
Availability of HCT policy manual	26	25.49
1. Yes	76	74.51
2. No		
Availability of HCT IEC materials	11	10.78
1. Yes	91	89.22
2. No		
Availability of counselling room	92	90.20
1. Yes	10	09.80
2. No		
Privacy during counselling		
1. Yes	78	76.47

2. No	24	23.53
Use of MOH registers		
1. Yes	13	12.75
2. No	89	87.25
Adequate laboratory space		
1. Yes	56	54.90
2. No	46	45.10
Availability of laboratory SOPs		
1. Yes	40	39.22
2. No	62	60.78
Availability of PEP		
1. Yes	23	22.55
2. No	79	77.45
Adequate Kits storage space		
1. Yes	67	65.69
2. No	35	34.31
Safe biohazard waste disposal		
1. Yes	91	89.22
2. No	11	10.78
Number of HCT weekdays		
1. < 7 days	39	38.24
2. 7 days	63	61.76

DISCUSSION

The results of this study have clearly demonstrated that the quality of HIV counselling and testing is way below the recommended standards (HCT guidelines & policies): there were few HCT service providers who had ever undergone in service training in HCT. There was minimal supportive supervision from MOH/District or partners. Facilities lacked standard operating procedures (SOPs) & guidelines for guidance and there were few qualified HCT service providers especially in the area of counselling. Privacy was also present in a few of the facilities.

These results are comparable to other studies that showed the quality of service delivery in private for profit facilities to be low when compared to public and PNFP facilities^{21,32}. There were few qualified counsellors (19/102) yet the policy recommends that HCT should be carried out by qualified personnel³. This could have compromised on the quality of counselling and testing in that the clinicians and nurses could not commit enough time to HCT as they had their core duties in the health facilities. This is evidenced by the waiting time which was either too long or too short.

Privacy was adequate in only 76% of the counselling rooms and all health workers practiced some form of confidentiality such as information remaining between client and health worker (84%), using lockable cupboards (10%), computer pass word (2%) or all the above (4%). The policy recommends 100% privacy and confidentiality and if there is any gap in privacy then the quality is compromised³.

Written consent was obtained by only 15.7% of health workers and the rest obtained verbal consent. The guidelines recommend written/documented consent for privacy purposes however written consent contributes to continued stigma and discrimination. Some policy makers think HIV test should be like any other test where one does not need a written consent.

Only 86% of health workers referred their positive clients for chronic care and only 2% started their clients on cotrimoxazole. This is the main aim of HIV counselling and testing; linking positive clients to care. If all health workers are not linking their positive clients to chronic care then the quality of HCT is being compromised. This also shows a gap in knowledge and skills in HCT service providers.

Results demonstrated that health facilities are not receiving supportive supervision, a few have trained in HIV counselling and testing and even few guidelines have been availed to these health facilities. This is putting the level of adherence to guidelines low which is highly compromising on the quality of HIV counselling and testing. The policy states that HCT services shall be standardised nationwide and shall be authorized, supervised, supported and regulated by MOH².

On self assessment 67% described quality of HCT in their facilities to be good. This can be explained by the fact that there were some qualified counsellors and laboratory personnel and in addition 73% had undergone in service training in HCT.

Other studies have also shown that on self assessment HCT service providers reported good counselling practice¹⁵. However this need to be proved further by interviewing clients, in the same study clients rated them poor as they did not meet standards for preventive counselling¹⁵.

Health facility infrastructure

HIV counselling and testing guidelines were present in only 25% of the health facilities. And standard operating procedures were present in only 39% health facilities. Both these materials are important for HCT service provider use as they provide guidance as they carry out HCT. Lack of the policies, guidelines and standard operation procedures compromised greatly on the quality of HCT as they did not have any reference to make to in case they needed to do so.

Waiting area was present in almost all the health facilities and this was the same waiting area for clients with other conditions. This was excellent quality as it reduced stigma and discrimination. However Information, Education and communication materials were present in only 11% health facilities. Waiting areas should have HCT IEC materials for all patients to read and get more information on HIV; this was lacking in almost all the facilities.

The policy stipulates that MOH registers should be used in all the health facilities. MOH has also gone ahead to harmonise with partners so that the information collected is relevant and can be incorporated in the health management information system of the MOH. But in private health facilities assessed the MOH registers were present in only

13% health facilities. Meaning that HCT data is not being reported to the ministry of health and so is not being reported in national statistics leading to under reporting of HCT data.

For purposes of infection control, the laboratory should have adequate space, adequate storage facilities, and safe ways of waste disposal and should also have post exposure prophylaxis. All these were present in some facilities and absent in many of the health facilities and lead to the quality of HCT to be below standards.

CONCLUSION

The quality of HIV counselling and testing in private for profit health facilities in Kampala district is far below the standards. This is evidenced by the fact that there was little or no in service training in HCT, minimal supportive supervision from MOH/District and partners, Facilities lacked standard operating procedures (SOPs) & guidelines for guidance, few qualified HCT service providers especially in the area of counselling and privacy was only present in a few of the facilities.

RECOMMENDATIONS:

From the results of this study the following recommendations if put in place will contribute to the improvement in the quality of HIV counselling and testing in private for profit health facilities;

- In service trainings for all the HCT service providers in HIV Counselling and Testing
- Private for profit health facilities should be included in the support supervision schedule for MOH, DHO's office and partners.
- Guidelines, policies, IEC materials and standard operating procedures should be availed to private health facilities.
- HCT tools such as registers, referral forms, and consent forms should also be availed to private health facilities.

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Appendices

Counsellor Consent Form:

Title of study:

Assessment of the quality of HIV counselling and testing service delivery in private for profit health units in Kampala districts, the provider aspect;

Introduction:

I am Dr. Kivumbi Rebecca from Makerere university school of public health CDC fellowship program I'm the principle investigator in this study that entails assessing the quality of HCT in private health units.

Purpose of the study:

The study aims to determine the quality of HIV counselling and testing in private for profit health units in Kampala district. We want to assess the provider knowledge attitude, work environment and skills in HCT in order to improve HCT services.

Study procedures:

A few questions will be asked about your health facility for which you will be requested to answer. We shall then go on to inspect the facility looking at the infrastructure, equipment, test kits, and records.

Risk, benefits and confidentiality:

There are no risk factors; all information will be kept confidential however a feedback will be given to you for your own benefit.

Questions:

In case of further queries contact me on telephone number 077429849 or MUSPH CDC fellowship program.

Statement of Consent:

The purpose and nature of study has been explained to me and I understand that my participation in the study is voluntary and no consequences will result if I refuse to participate. I am free to withdraw at any time. I have the right to know the findings of the study.

Signature of HCT service provider.....dates.....

Name of investigator..... signature..... dates.....

Name of witness..... signature..... date.....

Laboratory personnel Consent Form

Title of study:

Assessment of the quality of HIV counselling and testing service delivery in private for profit health units in Kampala districts, the provider aspect;

Introduction:

I am Dr. Kivumbi Rebecca from Makerere university school of public health CDC fellowship program I'm the principle investigator in this study that entails assessing the quality of HCT in private health units.

Purpose of the study:

The study aims to determine the quality of HIV counselling and testing in private for profit health units in Kampala district. We want to assess the provider knowledge attitude, work environment and skills in HCT in order to improve HCT services.

Study procedures:

A few questions will be asked about your health facility for which you will be requested to answer. We shall then go on to inspect the facility looking at the infrastructure, equipment, test kits, and records.

Risk, benefits and confidentiality:

There are no risk factors; all information will be kept confidential however a feedback will be given to you for your own benefit.

Questions:

In case of further queries contact me on telephone number 077429849 or MUSPH CDC fellowship program.

Statement of Consent:

The purpose and nature of study has been explained to me and I understand that my participation in the study is voluntary and no consequences will result if I refuse to participate. I am free to withdraw at any time. I have the right to know the findings of the study.

Signature of HCT service provider.....dates.....

Name of investigator..... signature..... dates.....

Name of witness..... signature..... date.....

Counsellor's Questionnaire

Assessment of the quality of HIV counselling and testing service delivery in private for profit health units in Kampala districts

Please help us improve our program by answering some questions about the HIV counselling and testing services you offer in this health facility. We are interested in your honest answers, whether they are positive or negative. Please answer all of the questions.

Social Demographics

1. Name of Health Facility _____
2. Position of service provider
Trained Counsellor []
Nurse []
Clinician []
Other (please specify).....
3. Gender of service provider
Male []
Female []
4. For how long have you worked as a counsellor in the area of HCT?
<1 year []
1-2 yrs []
>2 years []

Adherence to Counselling and testing standards

5. How many days in a week do you offer HCT?
1 day.....
2-5 days.....
7 days.....
6. How many staffs are conducting HIV counselling in this health facility? []
7. On average, how many clients do you counsel in a week? []

8. When clients come for HCT what steps do you take as a counsellor (*looking for pre & post counselling*)?

.....
.....
.....

9. How do you obtain consent from the clients?

- 1. Verbally []
- 2. Written []
- 3. Others (Specify).....

12. How do you ensure clients' information/confidentiality?

- 1. Use of lockable cardboards []
- 2. Computer with password []
- 3. Information shared remains between clients and counsellor []
- 4. All the above []

13. When do clients receive their results?

- Same day []
- Not same day []

14. On average how long does it take for a client to receive their results from the time of entry into the health unit?

- < 30 min []
- 30-45min []
- >1hour []
- Other (Specify).....

15. Do you offer post-test counselling?

- Yes [] No []

16. If yes to the above question, to whom do you offer post-test counselling?

- 1. All who test []
 - 2. Only the positive []
17. What happens during post test counselling?.....
.....
18. When a client tests positive what is the next step?
- Refer []
 - Start client on Septrin []
 - Don't refer []
 - Two of the above []
19. Where would you refer a patient who test positive for HIV?
- Specialised HIV clinic []
 - Don't refer []
 - No specific clinic []
20. Do you have referral forms you use in this facility?
- Yes [] No []
21. Have you ever had any training in offering HCT services?
- Yes []
 - No []
22. If yes who trained you?
- MOH []
 - DHT []
 - Other partners []
23. If no would you like to receive training in HCT?
- Yes []
 - No []
24. Have you ever received refresher training on HCT in the past 1 year?
- Yes [] No []
25. Do you receive support supervision? Yes [] No []
26. If yes to the above question, from where?

- 1. MOH []
- 2. District []
- 3. Others (specify).....

27. If yes to the above question, how often are you supervised?

- 1. Every three months []
- 2. Every six months []
- 3. Once a year [] Never []

28. Do you have any guidelines you follow when conducting HIV counselling? Yes []
No []

29. If yes to the above question, which guidelines?

- 1. MOH policies and guidelines on HCT []
- 2. WHO guidelines []
- 3. Others (Specify).....

30. Over all, how do you rate the quality of HIV counselling in this facility?

- Very good []
- Good []
- Fair []
- Poor []
- Very poor []

31. In your opinion what factors influence/affect the quality of HCT services provided
in _____ this
facility?.....
.....
.....

Thank you for answering these questions.

Lab personnel questionnaire

Assessment of the quality of HIV counselling and testing service delivery in private for profit health units in Kampala districts;

Please help us improve our program by answering some questions about the HIV counselling and testing services you offer in this health facility. We are interested in your honest answers, whether they are positive or negative. Please answer all of the questions.

Social Demographics

1. Name of Health Facility_____
2. Position of service provider
Laboratory personnel []

Nurse []

Clinician []

Other (please specify).....
3. Gender of service provider
Male []

Female []

Adherence to HCT standards

4. Do you have any HIV testing guidelines? Yes [] No []
5. If Yes which guidelines do you have

MOH

WHO

Others (specify)
6. How do you test for HIV in this facility?
Rapid tests []
Elisa []
PCR []
Others []

7. Have you ever been trained in HIV rapid testing? Yes [] No []
8. Please outline how you carry out an HIV test after you have withdrawn blood from the client
-
-
-
-

9. Which type of test kits do you have and use in this lab

Determine

Startpak

Uningold

10. Have the staffs conducting HIV testing been trained to do so? Yes [] No []

11. On average how many tests does this lab carry out in a week? []

12. Do you prepare DBS for the infants below 18months? Yes [] No []

13. How is your waste management done in the lab?

1. Waste bins []
2. Bio hazard bags []
3. Biohazard bags then into waste bins []
4. Others (Specify).....

14. Are the following standard documents available at the health facility?

Lab Register []

Lab Request Forms []

HCT register []

15. Are the Standard operating procedures (SOPs) available and in use in health facility?

1. No SOPs []
2. SOPs available but not in use []

3. SOP available and in use []
16. Do you test QC samples for HIV testing?
Yes []
No []
17. Does the health facility have enough test kits in stock?
No test kits at all (stocked out) []
Not enough test kits in stock (kits will last days) []
Enough test kits in stock (kits will last month's/_Weeks)
18. Are the laboratory log book and HCT register updated daily?
Yes []
No []
19. Are you provided with protective gear?
Yes []
No []
20. Over all, how would you rate the quality of HIV testing in this facility in the last one year?
Very good []
Good []
Fair []
Poor []
Very poor []

Thank you for answering these questions

FACILITY OBSERVATION TOOL:

Name of Facility-----

		Yes	No	Comments
Organisation	Availability of HCT policy manual			
	Presence of waiting area			
Counselling	Availability of a counselling room			
	How many counselling rooms are present?			
	Privacy in the counselling rooms			
	Availability of HCT IEC Materials hung on the walls for clients to read			
	Are counsellors welcoming (<i>what is their attitude towards the interview</i>)			
Laboratory	Availability of enough space in the lab			
	Ventilation and lighting systems in the lab			
	Availability and Use of MOH registers			
	Lab SOPs in place			
	Presence of hand washing supplies and facilities in a convenient area?			
	Availability of protective gear			
	Cleanliness and disinfection of the Lab			
	Are specimens appropriately labelled?			
	Availability of safe biohazard waste disposal			
	Adequate space for storage of kits			
	Is storage space for test kits adequate and clean			
	Availability of PEP			

Time frame

Activity	Feb-May 2011	July- August 2011	September - October 2011	November – December 2011	Jan- March 2012
Proposal Development and defence					
Pre testing of tools					
Data collection					
Data Analysis and Dissertation write up					
Submission of Dissertation					
Defence of the dissertation					

**ASSESSMENT OF THE QUALITY OF HIV COUNSELLING AND TESTING SERVICE
DELIVERY IN PRIVATE FOR PROFIT HEALTH FACILITIES IN KAMPALA DISTRICT:
BUDGET:**

	ACTIVITY	Item	Rate	Quantity	Days/Pages	Cost
1	IRB APPROVAL					
		MUSPH IRB	600,000	1	1	600,000
		UNCST	120,000	1	1	120,000
2	PROPOSAL DEVELOPMENT					
		Printing	500	3	40	60,000
		Photocopying	100	5	40	20,000
3	Develop data collection tools					
		Photocopying	100	208	10	208,000
		file folders	12,000	8	1	96,000
4	Training of research assistants					
		Facilitator Allowances and Transport				
		Transport Fuel refund	103,000	2	1	206,000
		Per-diem	100,000	2	3	600,000
		Facilitators' fees	80,000	2	3	480,000

		Participants per diem	100,000	5	3	1,500,000
		Participants transport refund	35,000	5	2	350,000
		coordination of workshop	150,000	1	1	150,000
		Hall hire	100,000	1	3	300,000
		Stationery (note book, pen, folder)	8,000	1	5	40,000
		flip chart/marker	30,000	1	1	30,000

	ACTIVITY	ITEM	RATE	NUMBER	NO. DAYS	COST
5	Pre testing of Questionnaires	Allowance for research assistants/PI	200,000	6	2	2,400,000
6	Data collection					
		Allowance for research assistants/PI	200,000	6	6	7,200,000
		allowance for respondents	10,000	103	1	1,030,000
7	Analysis	Data entry	500	206	1	103,000
		Data analysis	400,000	1	1	400,000
8	Report writing					
		Photocopying	100	5	60	30,000

		Binding	10,000	5	1	50,000
9	coordination					
		fuel	3,900	1	40	156,000
		telephone expenses	150,000	1	1	150,000
		District personell	80,000	1	6	480,000
10	Grand Total					16,759,000

Justification for the Budget

IRB & UNCST fee: Standard fees that are to be paid to both boards

- **Proposal development:** A total of 80,000/= was spent in terms of printing and photocopying. About 3 copies were printed during the proposal development for mentors to read through. Then 5 copies each 40 pages photocopied and handed in to the IRB.
- **Development of data collection tools:** Each health facility will have a structured questionnaire for lab personnel and counsellor and will also have a facility assessment tool implying that each facility will use up to ten pages of questionnaire.
- **Training of research assistants:** This we plan to move out of Kampala to allow for concentration and avoid unnecessary movement of participants. Five research assistants will be trained for 3 days
- Pre testing of questionnaires will be also out of Kampala. 200,000 as a allowance for the activities is broken down into 100,000 per diem, 80,000 allowance and 20,000 for transport.
- **Data collection:** The assessment will be carried out in Kampala district, I plan to give an honorarium to the research assistants of up to 200,000/= per day. This will include their allowances, lunch and transportation to the health facilities. Break down of 200,000/= is 100,000 per Diem (some research assistants do not stay in Kampala), 80,000/= facilitation allowance and 20,000/= for transport by public means to the health facilities. This is in agreement with MOH rates.
- **Coordination:** 150,000 will be used for telephone call to the research assistants and DHO's office, and then 40 litres of fuel will be used to move around by the PI during data collection.
- **District personnel** will assist with mapping out the health units and will be our guide throughout data collection and so will be given a facilitation allowance for the days we shall spend in the field.
- **Report writing:** Data entry, analysis, photocopying and binding will cost that amount of money and it is standard.