A guide to doing it better in our CBVCT centres

Core practices in some European CBVCT centres

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Summary

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Why are we inviting you to read this document?

Access to health should be a reality, but every day we find examples contradicting this statement. Depending on the country, access to health is guaranteed to a greater or lesser extent according to the political, economical, historical and societal situation. HIV/AIDS has undoubtedly a crystallizing effect on the social inequalities impacting access to health and quality care. The present document focuses on a very specific health issue; HIV counselling and testing.

Epidemiological and other scientific data provide us with information showing that those who face vulnerability are most at risk of acquiring HIV (e.g. men who have sex with men, drug users, poor people, women and migrants) and do not receive the care a more just society should provide for them. Besides, sometimes access to data concerning these individuals are scarce or nonexistent because they do not even reach the health system, which prevents us from knowing to what extent they are affected by HIV, what their needs are, and the kind of care they could receive. Fear of stigma and discrimination is an additional barrier.

The implementation and improvement of community-based voluntary counselling and testing (CBVCT) services is a means of offering these so-called hard-to-reach or more-at-risk populations an opportunity to know their HIV status, receiving information and counselling, being linked to the health system if necessary and being treated in a non-judgmental way. The community-based approach will be the leitmotiv of this document, since CBVCT services target one or more communities and include community members in at least one part of the implementation process of the service.

The CBVCT approach can break down many barriers to HIV testing among most-at-risk populations through the social proximity of the staff to the target community. Promotion of quality implementation of CBVCT is necessary to guarantee and extend the valuable characteristics of the community-based approach.

The main objective of this document is to provide some ideas, but above all, some existing practices, on how CBVCT centers can implement and offer their services. Respecting the value of "learning by doing", some NGOs and other establishments already performing CBVCT have worked together in order to collect their experiences and inspire new practices. We believe that being aware of these different practices might inspire new ways of reaching the populations most affected by HIV infection as well as more varied and better ways of performing counselling and testing and, consequently, reducing HIV incidence.

To whom is this document addressed?

- To NGOs which are members of the HIV-COBATEST network. This document will provide a framework about how the various members manage their CBVCT centres.
- To NGOs which already conduct CBVCT or who wish to implement CBVCT in their establishments or in partnership with other establishments. This document will provide experiences of other NGOs and institutions which already conduct CBVCT and can provide insights when making enlightened decisions about the implementation and improvement of these services.
- To all health-related institutions and all those concerned about the quality of life of vulnerable groups. This document will help develop a better understanding of the reasons that justify the existence of this kind of service (e.g. within National AIDS Strategies), the difficulties in implementing it but also the advantages and the lessons that can be learnt from those conducting it. Other health services could be inspired by CBVCT in order to improve their ways of "doing" if they consider it necessary and possible.
- To all those institutions that can allocate funds to develop CBVCT services, since it will provide them with valuable information on the potential benefits of such services.

1. Definition, objectives and methodology of this guide

1.1. What is CBVCT? A definition.

Literature and evidence show us that the definition of community-based voluntary counseling and testing differs enormously from one national European context to the other. For this reason, and even if we are aware of this large range of CBVCT experiences, the HIV-COBATEST project proposes the following definition:

CBVCT is any program or service that offers HIV counselling and testing on a voluntary basis outside formal health facilities. It has been designed to target specific groups within the most-at-risk populations and is clearly adapted and accessible to those communities. Moreover, these services should ensure the active participation of the community with the involvement of community representatives either in planning or implementing HIV testing interventions and strategies.

Community-based HTC (HIV testing and counseling) services are expected to help build public trust, protect human rights and reduce stigma and discrimination (UNAIDS, 2010)[1]
In practice CBVCT, can be implemented in a variety of settings and with various approaches and use standard HIV testing or HIV rapid testing (HRT).

1.2. How this guide was created.

The current guide is derived from the "HIV community-based testing practices in Europe" (HIV-COBATEST) project (Grant Agreement N° 2009 12 11) co-funded by the Executive Agency for Health and Consumers (EAHC). More information can be found on the site www.cobatest.org.

This project aims to foster early HIV diagnosis and linkage to care through the implementation and improvement of CBVCT services and programs, which are capable of reaching vulnerable and most-at-risk populations who do not have access to other HIV testing settings. Thus, these populations could benefit from early diagnosis, which allows early treatment and enhancement of quality of life for those living with HIV/AIDS. Furthermore, the knowledge of one's serology is a way of adapting one's own behavior and avoiding HIV transmission.
For all these reasons, the HIV-COBATEST project aims to facilitate the implementation and improvement of CBVCT services on the basis of existing practices.

[1] Service delivery approaches to HIV testing and counselling (HTC): a strategic HTC policy framework. World Health Organization 2012

The main specific objectives of the HIV-COBATEST project are:

- To gain a thorough understanding of CBVCT programs and services in different countries.
- To identify and describe best practices regarding the implementation of CBVCT.
- To identify a core group of indicators that can be used to monitor and evaluate CBVCT.
- To establish a network of community-based VCT in which to perform operational research.
- To assess the acceptability, feasibility and impact of introducing oral rapid testing technologies at community-based VCT.

1.3. How this document should be used.

This collection of CBVCT practices **aims to**:

- Be an "inspiring" document, helping you to perform CBVCT in the best possible way in your current (social, economical, historical, and political) context.
- Guide your CBVCT initiatives by contrasting your experience with existing experiences.
- Be based on and promote the community-based approach, since this is a collection of exchanged community-based experiences.

This collection of CBVCT practices **does not aim to**:

- Provide "gold standards".
- Provide information about *how to conduct counselling and testing*. There is already vast literature regarding this issue (see references).
- Provide an evaluation of your service.

The objectives of this guide are:

- To identify and describe CBVCT practices in Europe.
- To facilitate implementation and development of CBVCT programs.
- To inspire organizational change.
- To provide a framework for collaborative partnerships.
- To inform about the development, implementation and evaluation of evidence-based programs and advocacy.
- To help monitor and improve the quality of CBVCT programs.

Besides, this guide uses the same framework and objectives as the "Code of Good Practice for NGOs Responding to HIV/AIDS"[2] developed by non-governmental organizations (NGOs). This code, based on the knowledge and experience gained since the response to HIV began, sets out that practice and evidence are required in order to provide successful responses to HIV when we aim to:

- assist NGOs in improving the quality and cohesiveness of work and accountability to their partners and beneficiary communities
- foster greater collaboration between the variety of NGOs and institutional partners actively engaged in responding to the AIDS pandemic
- renew the 'voices' of NGOs responding to HIV by enabling them to commit to a shared vision of good practices in programming CBVCT and advocacy

In conclusion, this guide:

- Is not a theoretical document but an evidence-based guide stemming from various CBVCT practices.
- Is not a guideline to define or label CBVCT projects.
- Is not another guide on how to do quality "testing" but a source of information where community-based aspects are highlighted.
- Is a tool to understand better how CBVCT works, how it can be implemented and improved. It inspires rather than dictates.
- Is not a catalogue but a collection of key features that can be adapted according to local situations, targeted populations and CBVCT organizations.

[2] [http://www.hivcode.org/about-the-code/]

1.4. The methodology and sources of information used for creating this guide

The document has been drawn up using the data collection of various work packages of the HIV-COBATEST project and an analysis of existing literature.

Regarding the **HIV-COBATEST project**, we have used:

1. Information collected from a quantitative study conducted to gather data on National AIDS policies and on the way community-based voluntary counselling and testing services are run in practice. A survey was administrated to the HIV national and/or regional managers and to representatives of some CBVCT programs in each country, in order to have insights on the various national contexts. Thus, it was possible to have an overview of the HIV testing and counseling situation in general and from the point of view of the CBVCT programs and services. Special attention was given to the comparison between what is known by the National/Regional Focal Points (NFPs) and what is done/known concretely by CBVCT programs and services.

2. Information was collected from a qualitative study conducted in 8 participating countries (The Czech Republic, Denmark, France, Germany, Italy, Poland, Slovenia and Spain). Focus groups with CBVCT clients and semi-structured interviews with CBVCT coordinators were conducted by a core group of field-coordinators (one per participating country) which was set up in order to guarantee linkage with all these centers, to moderate the focus groups and to perform the interviews.

3. The document "Core indicators to monitor CBVCT for HIV: Guidelines for CBVTC services" defines a standardized approach to monitoring and evaluating (M&E) CBVCT activities. For some CBVCT services such M&E processes will provide valuable information in order to improve their services and to enable them to compare their performance with other similar services. Besides, M&E can also be a useful means for: a) advocating for broadening the offer of CBVCT services in addition to formal health care systems, b) providing evidence of their activities, c) demonstrating their value when seeking funding.

Thus, the data collected by the HIV-COBATEST project provide key elements on the way CBVCT services are run and on the national regulation and contexts in several European countries. This information has allowed us to portray the pros and cons of CBVCT: what works, what is appreciated by CBVCT clients, what is important to take into account in the implementation and improvement of CBVCT programs.

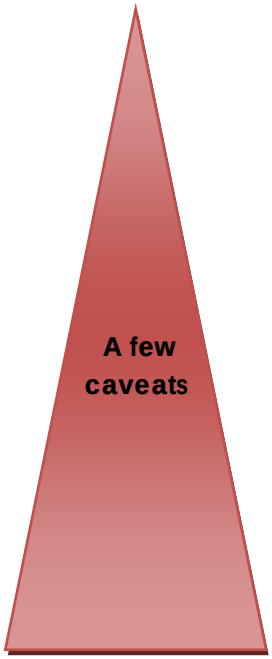
Since the objective of the HIV-COBATEST project is not to establish a theoretical guide but to gather concrete elements in order to provide stakeholders with some assistance for the successful implementation of CBVCT services or improving existing services, this document

focuses on those elements which appeared indispensable and crucial for successful implementation but, specially illustrates those issues that deserve special attention and that must be decided on according to the very particular context where the CBVCT is being conducted (target population, national or regional organization, medical staff or peer educators...).

To complete the data from the HIV-COBATEST project and to build this guide, a **review of existing European and non-European guidelines** was conducted.

- *Quality Assurance Standards for HIV Counseling, Testing, and Referral Data*, Developed by Program Evaluation Branch Division of HIV/AIDS Prevention Centers for Disease Control and Prevention, 2009
- *Let's talk about HIV counselling and testing*, *Facilitators' guide*, Tools to build NGO/CBO capacity to mobilize communities for HIV counselling and testing; International HIV/AIDS Alliance, 2006
- *HIV testing: increasing uptake and effectiveness in the European Union*. European Centre for Disease Prevention and Control. Stockholm: ECDC, 2010
- *Service delivery approaches to HIV testing and counselling (HTC): a strategic HTC policy framework. World Health Organization 2012*
- *Revised recommendations for HIV testing of adults, adolescents, and pregnant women in health care settings*: CDC 2006
- *Quality Assurance Guidelines for Testing Using Rapid HIV Antibody Tests, CDC 2007*
- *HIV Counseling, Testing, and Linkage Protocols, Procedures, and Continuous Quality Improvement Plan* , Template, San Francisco Department of Public Health, 2010
- *Community models of HIV testing for men who have sex with men (MSM): Systematic Review 2011.* Pedrana A., Guy R., Bowring A., Hellard M. & Stoove M., Report commissioned by ACON, 2011
- *The NGO HIV/AIDS Code of Good Practice Project, Renewing our voice*, 2004. The code of Good Practice for NGOs Responding to HIV/AIDS, 2004
- *Scaling up HIV testing and counselling in the WHO European Region as an essential component of efforts to achieve universal access to HIV prevention, treatment, care and support*. WHO EUROPE, 2010
- *Planning for the sustainability of community-based health programs: conceptual frameworks and future directions for research, practice and policy, Mona C. Shediac-Rizkallah and Lee R. Bone, Health education research, Theory & Practice, Vol.13 no. l 1998, Pages 87-108*
- *Rapid HIV Tests: Guidelines for use in HIV Testing and counseling services in resource-constrained settings. WHO. 2004 Geneva.*
- *Good practice update community based HIV testing and HIV treatment as prevention*, 2008. International HIV/AIDS Alliance, International Secretariat, June 2009.
- *Developing sexual health programmes: A framework for action* - WHO/RHR/HRP/10.22 © World Health Organization 2010
- *European Quality Instrument for Health Promotion (EQUIHP), User manual*. Project: Getting evidence into practice. September 2005
- *Defining equity in health, P Braveman, S Gruskin J Epidemiol Community Health, 2003;57, p254-258*
- *Ottawa Charter for Health Promotion, 1986 - http://www.who.int/healthpromotion/ - 2012*
- *Developing sexual health programmes: A framework for action* - WHO/RHR/HRP/10.22 © World Health Organization 2010
- *- Access to earl yHIV and STI diagnostics for vulnerable groups. Self-assessment of the voluntary counseling and testing services.* Bordenet Work 2012.
- *Core Indicators to monitor community based voluntary counselling and testing (CBVCT) for HIV. Guidelines for CBVCT services.* Field-test version. HIV-COBATEST. July 2012. Available on: www.cobatest.org
- *Implementation of CBVCT programs and services. Qualitative Study Report.* HIV-COBATEST. September 2012. Available on: www.cobatest.org
- *Cross-national survey on the implementation of community based voluntary counselling and testing (CBVCT) programmes – Quantitative Report.* HIV-COBATEST. October 2012. Available on: www.cobatest.org.

We can state that this document was created from existing experiences in European CBVCT centers and from international recommendations.



✸ The current document is partially based on the HIV-COBATEST deliverables, which is a limited source of information. Besides, there are some methodological limits (for more details, see the deliverables on www.cobatest.org).

✸ Most of the experiences described in this guide come from CBVCT targeting men who have sex with men (MSM). This is not surprising, since the MSM community has been very active in the fight against AIDS since the beginning of the epidemic. Nevertheless, other communities might express other needs or might prefer other ways of performing CBVCT.

✸ This guide is not a "final" but a dynamic document, since input from future experiences should be a key element for its evolution. Just in the same way that the HIV epidemic, national contexts, and HIV screening regulations also evolve and develop.

2. Theoretical framework regarding the implementation of CBVCT

During the last ten years, scientific and practical evidence have largely demonstrated the impact of structural and non-structural components of community-based counselling and testing in the implementation, development and success of this kind of service.

Now, even if the technical aspects of VCT practices are really important, it is essential to also highlight the theoretical aspects of the "community-based" approach to VCT. In this way, we can state that the success of implementing and improving CBVCT services depends on their consistency with health promotion and community-based approaches.

In the following sections we will briefly present various theoretical approaches that embrace different steps or aspects of community-based voluntary counselling and testing. Thus, we will present an approach to sexual health promotion which covers the whole VCT process as well as the quality assurance approach, which corresponds more precisely to the evaluative aspect of CBVCT. It has been decided to present all the theoretical approaches at the same time in order to dedicate the third part of this document to core VCT practices

2.1 Health & Sexual health promotion approaches

CBVCT services are, first and foremost, an important example of what health promotion can do to improve the lives of those who are most at risk of HIV and who face difficulties in taking care of their health and being cared for. For this reason, we believe that the internationally recognized concept of health promotion is crucial when reflecting on the implementation and improvement of CBVCT. As for health promotion, the World Health Organization (WHO) provides the following definition:

What is Health Promotion?

- Process of enabling people to increase control over, and to improve, their health.
- Health is a resource for everyday life.
- Health is a positive concept emphasizing social and personal resources, and physical capacities.
- Health promotion focuses on achieving equity in health.

"Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as

well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being"[3].

Community action is one of the cornerstones of health promotion. What does this mean? It means that the communities are actors of their own health and can take steps in leading changes in the health determinants of their members (legislation, organizations, institutional networks, services offered, infrastructures etc).

Thus, health promotion focuses on achieving equity (for a definition see table below) in health. Regarding the issue at hand, HIV testing and care, it seems obvious that the health promotion approach is the most adequate to reach our main goal, i.e. ensuring access to health for the most-at-risk populations. As described in the Ottawa charter, "health promotion actions aim to reduce differences in current health status and ensure equal opportunities and resources to enable all people to achieve their fullest health potential. This includes a secure foundation in a supportive environment, access to information, life skills and opportunities for making healthy choices"[4]. People cannot achieve their fullest health potential unless they are able to take control of those things which determine their health. This must apply equally to women, men and transsexuals.

"**Equity** in health can be defined as the absence of disparities in health (and in its key social determinants) that are systematically associated with social advantage/disadvantage. Health inequities systematically put populations who are already socially disadvantaged (for example, by virtue of being poor, female, or members of a disenfranchised racial, ethnic, or religious group) at a further disadvantage with respect to their health.

Equity in health means equal opportunity to be healthy, for all population groups. Equity in health thus implies that resources are distributed and processes are designed in ways most likely to move toward equalising the health outcomes of disadvantaged social groups with the outcomes of their more advantaged counterparts. This refers to the distribution and design not only of health care resources and programs, but of all resources, policies, and programs that play an important part in shaping health, many of which are outside the immediate control of the health sector."

P Braveman, S Gruskin "Defining equity in health", *J Epidemiol Community Health,* 2003;57, p254-258

When speaking about health promotion, we obviously include sexual health. We must emphasize this since sexuality and sexual health are quite often dealt with from a negative or pathological point of view. Because most-at-risk populations include men who have sex with men, transsexuals and sex workers, we believe that it is worth keeping in mind what WHO says about sexuality and sexual health.

[3] Ottawa Charter for Health Promotion, 1986 - http://www.who.int/healthpromotion/ - 2012
[4] *Ibid.*

According to WHO[5], definitions of sexuality and sexual health emphasize these positive aspects: "Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of pleasurable and safe sexual experiences, free of coercion, discrimination and violence".

Sexual Health

➔ Promotion to sexual health needs to take physical, psychological, cognitive, socio-cultural, religious, legal, political and economic factors into consideration.

The objective of CBVCT is not only about providing people with an HIV test but, respecting this positive approach, the main activity will be to help those most at risk to integrate this result into their lives and promote better sexual health. Thus, the work carried out in CBVCT centres will be far from giving a medical response to sexual health as defined below.

"Typically, a medical response to sexual (ill-) health tends to identify 'sexual and reproductive dysfunctions'. This term is problematic as it suggests individual problems, whereas the definition of sexual health suggests that problems of sexual ill-health might be better labeled 'social dysfunction'. Sexual health is directly affected by a range of physical, psychological, cognitive, socio-cultural, religious, legal, political and economic factors, some of which the individual has little or no control over. Standards of sexual health depend on a complex interaction of many of these factors, which must therefore be taken into account in the measurement and promotion of sexual health"[6].

Given the importance of this issue, CBVCT centres that offer several services for comprehensive sexual health care will generally be very attractive to clients who need more than HIV VCT. That is why more attention is being paid these days, in several countries, to creating "one-stop-shop services" or "sexual health centers".

2.2 Community-based approach – Community health

Among the numerous existing definitions, we believe that the definition which suits our topic best is the one that defines a community as "a group of people with diverse characteristics who are linked by social ties, share common perspectives, and engage in joint action in geographical locations or settings" [7].

[5] WHO, *Developing sexual health programmes : A framework for action, 2010*
[6] WHO, *Measuring sexual health: conceptual and practical considerations and related indicators*, 2010
[7] K. M. MacQueen *et al.* "What Is Community? An Evidence-Based Definition for Participatory Public Health", *Am J Public Health,* 2001 December

Within the CBVCT framework, the notion of community only makes sense in relation to "pre-existing action" and long-standing communities are not necessarily ready to launch a community-based programme. Most of the time, a community is created when individuals or groups are able to mobilize themselves towards a commonly identified goal. This mobilization is based on shared interests and implies the participation of the community throughout the project. Thus, the proof that a community exists is the capacity of its members to act cooperatively. In order to launch a community dynamic that can truly bring social openness, a collective responsibility to deal with common preoccupations based on a willingness to take care of oneself must exist. Furthermore, this approach is not compatible with a purely epidemiological approach which works with clearly labeled population categories. Our definition of "community" aims to avoid classifying populations with labels that might be perceived by the community as strict and simplistic, and which could prevent people from self-identifying as belonging to such a category.

Community-based approach

- Community is *a group of people with diverse characteristics who are linked by social ties, share common perspectives, and engage in joint action in geographical locations or settings.*
- This approach emphasizes the capacity of the community's members to act cooperatively.

The European Community Health Practices Network (ECHPN)[8]- in agreement with the World Health Organization – underlines the role of "Community Health" as one of the strategies of Health Promotion implementation as defined in the Ottawa Charter. According to the ECHPN, community health approaches share the following main characteristics:

- A collective base (a group of residents, a group gathered for a problem, a situation of dependence or an objective for an action or actions to develop).
- A collective identification of problems, needs and resources (a community analysis).
- All stakeholders can participate: users, specialists, professionals (from the most diverse fields), administrations and politicians, which means the implication of the population in identifying the problem, to mobilize their capacities, for their participation in the whole process, and professional de-compartmentalization.

"Community development draws on existing human and material resources in the community to enhance self-help and social support, and to develop flexible systems for strengthening in public participation and direction of health matters. This requires full and

[8] Convention of the Community Practices of Health 1999 – SEPSAC http://www.sepsac.org/index.php?id=20

continuous access to information, learning opportunities for health, as well as funding support"[9].

2.3 CBVCT in scaling up strategies

When speaking about CBVCT we cannot avoid dealing with the issue of *scaling up*. In fact, from the moment CBVCT services start to perform HIV tests, the question of adapting their response to the estimated population that might need these services arises. Even if some CBVCT programmes and services are launched in a more "local" context or with a "modest" objective, the issue of scaling up appears at some point.

Thus, "it has been estimated that in the European Union around a third of those infected are not aware of their serostatus, while in some countries in Eastern Europe and Central Asia, more than 60% of people with HIV remain undiagnosed. Lack of knowledge of HIV status is a key issue for both individuals and society. One of the main challenges in tackling the HIV epidemic is increasing the number of people who have access to HIV Testing and Counselling (HTC) and decreasing the number of people who are unaware of being infected"[10].

- On an individual level, HIV Testing and Counselling (HTC) "can provide an opportunity for timely access to appropriate treatment, care and support; late presenters suffer greater morbidity and mortality than those diagnosed early"[11].
- On a community/collective level, "Quality HTC can help prevent HIV infection through counseling to discourage high-risk behavior and support protective behavior. People who learn that they are HIV-infected can take steps to decrease the risk of transmitting HIV to injecting and sexual partners. The importance of this for HIV prevention is enhanced in settings where antiretroviral treatment (ART) is available and accessible to all who need it, given its value in reducing viral load and the amount of virus circulating in the community".

WHO EUROPE's Policy Framework emphasizes the need to increase efforts to scale up access to HIV testing and counseling services. "It must be considered as a public health and human rights imperative but is not the ultimate goal. HTC programs must be linked to broader efforts to achieve universal access to comprehensive, evidence-based HIV prevention, treatment, care and support"[12].

[9] Ottawa Charter for Health Promotion, 1986 - http://www.who.int/healthpromotion/ - 2012
[10] WHO EUROPE , *Scaling up HIV testing and counselling in the WHO European Region as an essential component of efforts to achieve universal access to HIV prevention, treatment, care and support,* 2010.
[11] *Ibid.*
[12] *Scaling up HIV testing and counselling in the WHO European Region as an essential component of efforts to achieve universal access to HIV prevention, treatment, care and support*. WHO EUROPE, 2010

A policy framework listing the ten main principles to scale up HIV testing and counseling in member states was elaborated by WHO Europe (see appendix 1).

2.4 Quality assurance approach

Finally, we would like to dedicate some lines to the qualitative assurance approach. No matter what kind of health services we are managing, the issue of evaluation quickly comes up if we have the intention, the necessity and/or the obligation of describing our results accurately and if improvement is possible and/or desired.

Quality assurance is a "broad concept that can be defined as the methodology to secure quality, focusing on planning of projects and activities. Quality assurance involves measuring and evaluating quality, but also covers other activities to prevent poor quality and ensure high quality.

Quality assurance in health promotion has four main advantages:

- the avoidance of the use of ineffective health promotion strategies;
- the promotion of evidence-based health promotion;
- a consideration of the limited resources in health promotion practice;
- the integration of the needs and wishes of the target group."[13]

Obviously quality assurance is not only a monitoring and evaluating process (M&E) but it includes the data provided by M&E.

Several common standard tools or guidelines have been written, carried out by institutions and/or associations, some at a national level, and others within national frameworks. They offer comparative criteria that enable evaluation and quality improvement. The use of these criteria should depend on how relevant the theoretical approaches and values are for the actions developed by the organization, for the financial means and human resources available, and for local public health or financial policies.

Quality assurance

- ➔ Quality assurance is the methodology to secure quality, focusing on planning of projects and activities.
- ➔ Quality assurance involves measuring and evaluating quality, but also covers other activities to prevent poor quality and ensure high quality.
- ➔ The European Quality Instrument for Health Promotion has been used to build this guide.

[13] *Ibid.*

As stated by Bollars et al., "Health promotion interventions are complex and multi-sectorial processes, the outcomes of which are not always visible in the short term; the concept of quality assurance cannot be simply transferred to health promotion. Furthermore, the basic orientation of health promotion is emancipative, and its values are rooted in fundamental human rights. Quality assurance in health promotion should reflect these fundamental and ethical values, which means that the existing quality frameworks and instruments need to be expanded to include the contextual, multidimensional, emancipatory and ethical aspects of health promotion"[14].

The European Quality Instrument for Health Promotion (EQUIHP), used in this document, has been developed as a European consensus tool facilitating the assessment and improvement of quality in health promotion and was supported by the European Commission. It relies on a unique collaboration between a consortium of health promotion agencies and institutes from nearly all EU member states.

"The conceptual basis of EQUIHP is a model derived from practical experience in health promotion. It identifies four areas that are essential in achieving quality in health promotion interventions. These areas are:

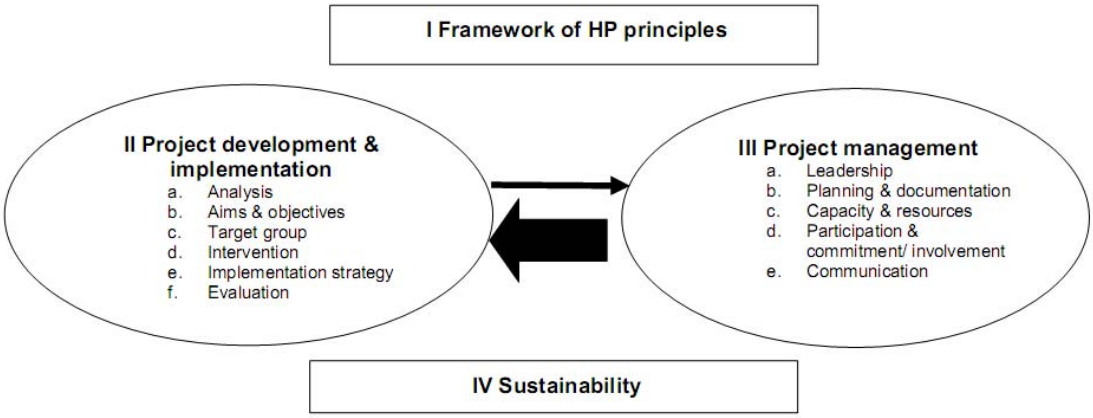
- the framework of health promotion principles
- project development and implementation
- project management
- sustainability

For each of these areas or 'clusters', a number of criteria have been formulated, as well as indicators to measure these criteria. The connection and interrelation between the clusters are shown in the figure below" [15].

[14] C. Bollars *et al.*, *European Quality Instrument for Health Promotion (EQUIHP), User manual.* "Project: Getting Evidence Into Practice Project", 2005
[15] *Ibid.*

Figure 1 - Dynamics of health promotion projects

Model taken from C. Bollars *et al.*, *European Quality Instrument for Health Promotion (EQUIHP), User manual*. "Project: Getting Evidence Into Practice Project", 2005



3. CBVCT Key issues

3.1 The community-based approach in CBVCT services.

"Community-based HTC services are expected to help build public trust, protect human rights and reduce stigma and discrimination (UNAIDS, 2010). They are also expected to remove structural, logistic and social barriers to HTC, including—in the case of home-based and mobile or outreach HTC—costs associated with transportation to facility-based services"[16]

CBCVT is addressed to those communities who have been historically rejected and stigmatized: MSM, migrants from high HIV endemic countries and intravenous drug users (IDU) among others. These communities usually prefer to get tested in their own "territory" (e.g. community-based organizations) and not in the institutions which participate in this discrimination unwittingly or not (e.g. health centres). As expressed by a majority of the MSM participating in the COBATEST qualitative study, it is quite important for this population to have a place of their own, a place for them.

Community based VCT can have an impact on three levels:

- ***Individual:*** health benefits for each individual
- ***Collective:*** benefits for the community (reduce or stop the spread of the epidemic within one's community through treatment and positive prevention)
- ***Professional, institutional, political & environmental***: impacts health systems by adapting itself to the needs of hard-to-reach populations.

Better and equal access to counseling and testing

➲ Easier access to testing by taking the needs of hard-to-reach populations into account.

In most cases, community-based health services are particularly developed in contexts where specific community's needs are not being fulfilled and where there is unequal access to public or private health services. It is not only about improving the health of the population, but about reducing gaps in health status among population subgroups (Ottawa Charter, OMS, 1986).

[16] Service delivery approaches to HIV testing and counselling (HTC): a strategic HTC policy framework. World Health Organization 2012

In the European countries participating in the COBATEST project, most-at-risk populations are: MSM, migrants, transgender people, sex-workers and IDU. Hard-to-reach populations are mainly homeless people, undocumented people, migrants who do not speak the national language, people who do not/cannot benefit from health and social coverage, IDU, MSM and ethnic groups among MSM.

As stated before, most of the CBVCT programs participating in the COBATEST project, even if diverse in "nature" and quantity, and even if they all target "most-at-risk" populations, MSM is still the main targeted population.

Community-based staff and a community-based steering committee in CBVCT programs are necessary to create and develop adapted programs for most-at-risk and hard-to-reach populations. Indeed, they know the needs of the community and thus, can adapt the programs to the needs identified by the people at stake.

Specific, community-based communication as well as community-friendly organizations are favorable elements to ensure better access to HIV voluntary counselling and testing. A more varied VCT offer increases the likelihood of reaching more and different people.

To foster CBVT accessibility for most-at-risk and hard- to-reach populations, we should:

- ➔ Have community-based staff and steering committees in order to adapt the programs to the needs identified by the people at stake.
- ➔ Take the culture of the individuals, minorities and communities into account, and be sensitive to gender and the different requirements according to the period of life.
- ➔ Foster specific, community-based communication and develop partnerships with community friendly organizations.
- ➔ Launch community-based research programs: data and in-depth understanding are needed.
- ➔ Provide a more diverse offer in order to increase the likelihood of reaching "hard-to-reach groups".

➲Access to testing which is facilitated by an appropriate offer

Even if wide HIV testing availability is observed in Europe, this "availability" does not necessarily correspond to people's daily lives. Whatever the context is, service models should try to take easiness of access into account: the location should be accessible and/or there

should be outreach programs in the communities' neighborhoods. CBVCT should provide services that are either free or affordable, and offer flexible opening hours outside working hours. Several programs and guidelines affirm that rapid testing is acceptable and preferred over standard HIV testing among clients. This is mainly due to the fact that rapid tests reduce the time between the realization of the test and the provision of results. This shorter waiting period increases the number of tested clients receiving their HIV test results. Rapid testing also eliminates the need for a second appointment for the majority of clients who receive a negative test result (for more information on rapid test vs. traditional tests, see Figure 2).

Literature describes several barriers and facilitators regarding the implementation and success of rapid HIV testing. Nevertheless, most barriers are overcome by some advantages of rapid tests, such as the comfort of undertaking the test in a community environment and receiving the results the same day. These advantages highlight the importance of developing client-friendly services and a supportive testing environment, but also the importance of service promotion. In this sense, it is important that clients are aware of testing protocols and of pre and post-test counselling procedures.

To be compatible with people's daily lives, CBVCT should:

- Be located at easily accessible areas.
- Create a comfortable and friendly environment.
- Offer mobile services and outreach activities in order to reach those that wouldn't (or couldn't) go to CBVCT centers, or those doing the test because they have the opportunity.
- Provide free-of-charge or very low-cost services.
- Choose opening hours or provide testing outside working hours (evenings, weekends).

➲A positive and comprehensive approach to health and sexual health.

Most people attending CBVCT programs only request a HIV test. However, during the pre and post-test counseling, the risk of exposure to HIV and other STIs (including hepatitis) as well as other aspects of the client's sexual life should be explored. Sexual health issues as a whole need to be addressed.

Carrying out the test is often a way of getting a "foot in the door", and discussing other sexual health needs which could be discussed at another time with another staff member or in another place (e.g. partnerships). Effective screening and treatment for sexually transmitted

infections needs to be intensified, other STI tests (syphilis, hepatitis) can be conducted at the CBVCT center, if the means to do them are available, or they can be referred to other services that support your project. The same can be done regarding other needs, such as contraception, pleasure, sexual well-being and support for those facing sexual violence.

In order to ensure a comprehensive approach to sexual health, good training in this field is needed for medical staff and all other health providers (e.g. community-based stakeholders). This training is also needed for those stakeholders with whom strong partnerships exist.

Finally, since advocacy for a better sexual life at individual and community level is a major objective of CBVCT, information about individual and collective/social unfavorable situations impacting sexual health (gender violence, sexual discrimination etc) should be gathered.

For a positive and comprehensive approach to health and sexual health, we need:

- To integrate testing and counselling in conjunction with vaccination and screening for hepatitis and other STIs (added value: follow-up).
- To integrate testing and counselling in conjunction with other sexual health services (e.g. contraception).
- Good training for the staff.
- Interdisciplinary staff and/or strong partnerships.
- To gather information about individual and social unfavorable situations for better sexual health.
- To advocate for a better sexual life.
- Work to improve the health coverage in the public health system by the development of partnerships with prevention and care services.

Sustainability

Planning for sustainability requires, first of all, a clear understanding of the concept of sustainability and operational indicators that may be used for its monitoring over time. Important categories of indicators include: maintenance of health benefits achieved through an initial program, level of institutionalization of a program within an organization and measures of capacity-building in the recipient community.

Secondly, planning for sustainability requires the use of programmatic approaches and strategies that favor long-term programme maintenance. We suggest that the potential influences on sustainability may be derived from three major groups of factors: project design and implementation, factors within the organizational setting, and factors in the broader community environment[17].

State authorities should not use the communities' mobilization as a pretext for not acting at their own level. CBVCT must be included as part of a global plan and as a tool to reach most-at-risk populations. Using either community services or institutional health services must be a personal decision.

To guarantee sustainability, CBVCT services need to:

- Secure financial resources and benefits from a supportive social and political environment.
- Be based on efficient project design and implementation factors.
- Stay relevant to the needs using a flexible approach: decisions have to be evidence-based and include epidemiological, social & behavioral research.
- Use the programs' evaluation findings to maintain health benefits for beneficiaries.
- Use quality process programmes.
- Continue to involve affected communities in participatory assessments and work on capacity to strengthen appropriation.

For wider national or regional scaling up of the HIV testing offer, the most forward thinking CBVCT services or programmes may support other organizations that cover different locations or work with other communities by sharing their best practices. Nonetheless, given the financial fragility of most NGOs and complex national contexts, such capacity building/sharing is not always possible and unfortunately not often supported by institutional funders.

[17] *Planning for the sustainability of community-based health programs: conceptual frameworks and future directions for research, practice and policy*, Mona C. Shediac-Rizkallah and Lee R. Bone, Health education research, Theory & Practice, Vol.13 no.l 1998, Pages 87-108

3.2 CBVCT implementation among and with populations

➲ CVBCT promotion and participation of communities in program development

Social and community mobilization is necessary in order to guarantee the acceptance, the appropriateness to needs and the implementation of community-based testing. This mobilization could be created through dialogue with relevant stakeholders, community organizations and key community leaders on multiple topics:

- Individual and collective benefits of testing[18].
- Response to community needs by existing testing offers and the consideration of needs by public health policies.
- Identification and emphasis of existing community knowledge and resources.
- The capacity of the community to use CBVCT programs as a way to fight against stigma.
- The possibility and the desire to participate in a direct way in the planning, implementation and evaluation of CBVCT projects.

Before implementing the programme, it could be interesting to build a network and/or a collaborative platform with community leaders and institutional, local and regional, partners. The aim would be to create a synergy and a partnership to support CBVCT programmes. Different forms of participation and commitment are possible, for example, as members of the steering committee or the community advisory board.

Community involvement would be helpful to identify the potential opponents and obstacles of the project, to analyze health needs and to have a better knowledge of the context in which CBVCT services will be implemented. The community must be associated to assess the adequacy of the implementation strategy (particularly regarding communication) and to evaluate the effects and the quality of the program. Finally, community involvement includes the participation of peer educators.

[18] Information about the individual and collective benefits of testing must not lead to any (moral) pressure to get tested and/or treated. CBVCTs are committed to non-judgemental, non-stigmatizing and client-centered approaches in counseling and testing. Therefore CBVCTs support the right of (potential) clients' to make a free and individual choice of getting tested (and if necessary of starting treatment)

Promotion of the service by community stakeholders is an important factor of CBVCT's success. Thus, community stakeholders will ensure their presence in the community and will increase acceptance from community members (e.g. gay bar owners are sometimes helpful, allowing the dissemination of leaflets and encouraging outreach activities).

➲ Intervention venues: locations (healthcare settings/community spaces) and outreach areas.

As stated above, the CBVCT offer will have to adapt itself to the context, to the diversity of places and to the targeted public by taking the specificities of most-at-risk/hard-to-reach populations into account. One of the most important keys for CBVCT's success is the physical proximity of these centers to the most-at-risk populations. Furthermore, the strategies have to be linked with national and CBVCT contexts.

Thus, the places depend on the type of tests that are performed and on the target population. For instance, in some countries blood tests or rapid tests are not allowed outside CBVCT sites and must be performed by medical staff.

The testing offer could be proposed on sites already used for prevention services (meeting places, bus terminals, pharmacies, market places, commercial centres, associations, etc.) or specific healthcare services or in areas where these populations live (e.g. vaccination centres, community health centres) or in new places adapted to the needs of the concerned population.

Counseling and testing can be performed in different places according to the choices and the human and financial resources of CBVCT, as well as the capacity to ensure a confidential environment.

Two possible strategies can be developed:

- A "sedentary strategy": tests are offered in the CBVCT setting.
- A "mobile strategy": tests are offered in community partners' facilities, in gay venues (clubs, saunas), in market places, hairdressing salons, pharmacies, etc. Mobile units (vans) offer the flexibility of changing their location and can be used near a community's fixed

place when there are not adequate conditions for carrying out the test; confidentiality, safety and hygiene.

Most CBVCT services chose to combine the above strategies in order to increase access to people who cannot go to CBVCT centres (distance, lack of public transport, and opening hours) or who would be afraid of attending the CBVCT centre because of stigma. This last issue deserves particular attention. CBVCT centres should have a neutral location in terms of visibility, in order to avoid "outing" the clients attending the centre. Besides, CBVCT centres should be welcoming and easily accessible (near public transport).

In fact, a non medical environment may facilitate access to testing. It is important to create a pleasant and non-judgmental physical environment which allows the possibility of receiving more personalised care, of feeling comfortable to speak openly about sexuality.

Venues must be adapted to carrying out counseling and testing: for example a quiet place, guaranteeing strict confidentiality, with a minimum standard of hygiene and ensuring biohazard safety precautions.

Finally, receiving a result from a member of the community (CBVCT) or in a service that shares the same location as the community could have consequences for some people, for instance, fear of anonymity/confidentiality breaches. Thus, it is important to anticipate and talk about this issue before testing.

Fixed or mobile CBVCT programmes should consider:

- Country context: laws, authorizations, etc.
- The preservation of a friendly non-medical environment.
- Neutral and easily accessible location.
- Appropriate procedures and practices for testing and counseling: confidentiality, hygiene, security.
- Communication adapted to the different strategies.

CBVCT communication

The involvement of the community regarding CBVCT communication can help the success of this kind of experience. CBVCT programs can try to use all possible means to advertise their services. As declared by CBVCT clients, most of them become aware of CBVCT through their social network; friends, boyfriends, and associations; the Internet, and adverts; posters and

flyers in bars, nightclubs and schools. Finally, they also declare finding out about these services via CBVCT outreach activities performed in community places (e.g. a van in a cruising area).

Mainstream media could also be used, but according to most CBVCT experiences it is not the most appropriate way to reach vulnerable populations. However, it could be interesting to involve them when advocating for better sexual health and communicating about the benefits of these services to tackle the HIV epidemic.

CBVCT promotion and communication, some keys points:

What

- Individual and collective benefits of testing.
- Appropriateness to identified needs, formulated by the communities: « A place for us and by us»
- Proposed services and how to use them.

Who

- Community members, "ambassadors": clients, community leaders, community venue tenants, CBVCT staff, steering committee members.
- Health professionals, health authorities.
- Communication officers in CBVCT services.

Where

- Community media and occasionally mainstream media.
- Social networks (word of mouth, internet)/professional networks.
- Community stores, bars, clubs.
- Follow the potential clients.

How

- Leaflets, posters, films.
- Street promotion.

When

- At the launch of the project.
- During actions.
- At key community events (e.g. gay pride).

3.3 Staff and people involved in CBVCT programmes.

Also critical to programmatic success is the involvement of well-trained and trusted staff members, including counselors, clinicians, community-health workers, peer educators, nurses and other advocates of this service. The deliberate use of allied health care workers or non-clinical staff is a main feature of most CBVCT services. This alliance can become a strong facilitator in the clients' access to CBVCT services, since it seems more culturally appropriate and friendly. Besides it reduces the number of physicians needed and consequently the testing costs in comparison to standard testing. Some CBVCT centres insist on involving PLHIV and ensuring gender equity among staff as an element that enhances the coherence of the offer.

People involved in CBVT activities can differ a lot from one experience to another. This variability can be explained by two factors; the legal framework regarding the kind of test allowed by the law and the kind of CBVCT service (fixed, mobile or mixed).

Thus, a whole range of possibilities exists regarding greater or lesser presence of medical CBVCT staff. Nevertheless, we must be aware that giving preference to medical staff (nurses, practitioners, medical officers, and laboratories) or to non-medical staff (social workers, volunteers, peer/outreach workers, counselors) should be decided according to:

- The desired degree of closeness to the people. Staff must thoroughly understand and know the targeted community, even if they do not necessary belong to the community.
- The type of test used: traditional or rapid test.
- The types of services provided: holistic, other STIs and so on.

Various skills: counseling, testing, and coordination

On the whole, CBVCT staff need skills in the following:

- ➔ Recruitment and education.
- ➔ Providing adequate pre and post-test counseling and risk-reduction information.
- ➔ Performing the HIV test and notifying test results.
- ➔ Providing adequate support and referrals.
- ➔ Assuring quality process and evaluation.
- ➔ Ensuring confidentiality.

Non-stigmatizing staff able to provide counseling and accurate preventive information is a key factor for guaranteeing CBVCT's success.

As stated by the "Technical report of the European CDC"[19], barriers to increasing HIV testing at the healthcare provider level consist primarily of discomfort when approaching the subject of HIV, lack of training to increase healthcare providers' ability to conduct HIV testing, lack of knowledge on the part of healthcare providers about local HIV prevalence, symptoms of undiagnosed HIV infection and local guidance and policy on HIV testing. Finally, logistic barriers also appeared, such as cost and time constraints and cumbersome consent procedures.

On the other hand, the COBATEST qualitative study[20] reported that one of the major issues associated with high levels of satisfaction with CBVCT services is having friendly community staff which belong to or are close to the community. This study concludes that reliance on staff like this has two major advantages:

1. People do not fear being stigmatized "not being confronted to prejudices, to stigma and/or guilt because of sexuality and/or sexual behavior when requesting a HIV test". The potential reception of "bad news" is anticipated in a better way if the client feels that the person in front of him/her is really concerned about the result and the effects on the person receiving the result.
2. People experience the CBVCT environment as an open space, where they are free to talk: "they take the time to listen to the client and to give detailed answers, a time that staff in traditional HIV testing centers usually do not have", "Staff are able to pay more attention to the client and to offer improved understanding because of a better knowledge of the people attending".

These two circumstances create a favorable climate to establish a good relationship between the person who is performing the test and the person getting tested, a relationship that ensures the provision of adequate counseling.

After appropriate training and with supervision, health-care workers with little or no previous laboratory experience can perform most rapid tests. The use of non-laboratory staff facilitates access to testing and counseling in small communities, rural sites and outreach programmes where professional laboratory personnel are often unavailable. If non-laboratory personnel

[19] HIV Testing: Increasing uptake and effectiveness in the Eurpean Union. Evidence synthesis for Guidance on HIV testing. European Centre for Disease Prevention and Control, 2010.
[20] Rojas D, Quatremere G and Le Gall JM, Agusti C, Fernandez L, Casabona J and the HIV-COBATEST project study group. Implementation of Community-Based Voluntary Counseling and Testing (CBVCT) Programs and Services. Qualitative Study Report. HIV-COBATEST; 2012. [Cited 2012 Nov 16]. Available from: http://www.cobatest.org/documents.php?group=00000010

are able to perform rapid tests, initial training, continuing supervision and periodic assessment of proficiency should be provided in order to ensure that the quality of testing is maintained. In some countries it is necessary to take legal restrictions into account concerning the qualifications of people who perform blood tests: persons lacking the required qualifications should work under the authority of people who possess such qualifications[21].

➲ Initial and continuous training

Training curricula on core skills for administering rapid tests and managing data associated with testing and counseling are being developed in some guidelines.
Generally curricula must include:

- Basic principles of virology and immunology of HIV/AIDS.
- Bio-safety in testing and counseling settings.
- Principles of HIV testing with particular reference to rapid HIV testing, criteria for test kit selection, testing principles and procedures, the interpretation of test results, and problem-solving.
- Principles and concepts of quality control and quality assurance, particularly in testing and counseling settings.
- Practical sessions on specimen collection (e.g. finger-prick test, oral fluid test), HIV testing and bio-safety.
- How to read the test, provide clients with test results including an explanation of what preliminary reactive rapid tests, false positives and indeterminate results mean.
- Risk assessment/pre and post-test counseling.
- Client-referrals, linkage to care.
- Follow-up for results, treatment & further risk-reduction counseling.
- In outreach: how to recruit clients in challenging environments such as cruising areas, bathhouses and homeless shelters where staff could be required to interact with clients who may have been drinking or using recreational drugs or have mental issues.
- Continuous training should take into account new guidelines released on counseling and testing procedures, on general management of CBVCTs, and should also follow national guidelines and their updates where appropriate.

[21] Rapid HIV Tests: Guidelines for use in HIV Testing and counseling services in resource-constrained settings. WHO. 2004 Geneve

STAFF AND PEOPLE INVOLVED IN CBVCT
Whether health-care professionals or community members:

CBVCT needs community-friendly staff

- More culturally aware, empathetic, non-stigmatizing and non-judgmental.
- Better listeners = better counsellors.
- Trusting & respectful relationships > favorable climate.

CBVCT needs trained staff

- Initial training: core knowledge for performing rapid tests and reading the results, communication skills, counselling (non-judgmental), managing data associated with VCT.
- Continuous training: adapted to changing environment, improved and updated skills [linked to evaluation]; a global and interdisciplinary approach to sexual health.

CBVCT need well-cared for staff (preventing burn-out, over-exposure to information…)

- Debriefing
- Sharing knowledge of difficult cases
- Supervision

3.4 Tests Used

➲ ***Quality of tests used***

EU directives and regulations set down the specifications demanded for in-vitro diagnostic tests for the detection of HIV infection that can be sold and used for human diagnostics on the internal market. Using a combination of a screening test with a confirmatory test for verification of initial positive results is always required for diagnostic testing of HIV infection[22].

➲ ***Choice of tests: rapid tests and / or standard tests***

WHO European Region's Policy framework recommends that Rapid HIV tests should be used, where appropriate, to support efforts to increase access to and uptake of HTC (HIV testing & counseling) for most-at-risk and vulnerable populations.

Although rapid HIV tests with a CE validation are available in most UE countries, national legislations on their use vary a lot. In some countries, trained peer educators are allowed to perform rapid tests, whereas in other countries, the laws restrict their use to medical staff. Thus, due to their national regulations, all CBVCT centres do not have the same room for manoeuvre for their choice of test.

The introduction of sensitive, specific, simple-to-use, rapid HIV tests (also called point-of-care tests) that do not require sophisticated laboratory services is a considerable step forward. Such tests are increasingly used, including in outreach services. Their advantages – particularly for facilities where laboratory services are weak, community-based HTC settings or outreach – include visibility and quick turn-around. Testing can occur outside laboratory settings, in non-medical surroundings, does not require specialized equipment and can be carried out in clinical and non-clinical facilities by appropriately trained personnel, including counselors in some countries. However, trained laboratory supervisors are required for supervision, quality assurance, including quality control and bio-safety.

External quality assurance must be integrated for rapid and standard testing as recommended by the local legislation and by the manufacturer.

Staff of NGOs and community-based organizations should also be trained to perform rapid HIV tests. Tests should be high quality. Decisions on whether to use HIV rapid tests or traditional assays should take all the advantages and disadvantages into account, including cost and availability of the test kits, reagents and equipment, staff, resources, infrastructure, laboratory expertise and personnel, as well as considerations such as the number of samples to be

[22] HIV Testing: Increasing uptake and effectiveness in the European Union. Evidence synthesis for Guidance on HIV testing. European Centre for Disease Prevention and Control, 2010

tested, sample collection and transport methods, the testing setting, convenience and the tester's ability to return for results [23].

Several studies[24] have shown that rapid tests are more suited to community testing sites for populations with restricted access to care and who have difficulty in returning to the facility to receive the results.

HIV testing can be performed using a serial or a parallel algorithm. In serial algorithm, the screening test (first test) is carried out and results are interpreted. Any subsequent test depends on the result of the screening test. In parallel testing, the screening and confirmatory tests are conducted at the same time[25].

Here is a helpful table of the comparative benefits of traditional tests *versus* rapid tests.

[23] Scaling up HIV testing and counseling in the WHO European Region as an essential component of efforts to achieve universal access to HIV prevention, treatment, care and support. Policy framework. 2010. Geneva, World Health Organization.
[24] HIV Testing: Increasing uptake and effectiveness in the European Union. Evidence synthesis for Guidance on HIV testing. European Centre for Disease Prevention and Control, 2010
[25] National Implementation guidelines on provider-initiated counseling and testing (PICT) Department Health. Republic of South Africa

Comparative benefits of "traditional" tests *versus* rapid tests

Items	Sub-items	Conventionnal Tests	Rapid Tests
Populations' needs	Invasive technique (e.g. DU)	+++	+
	Trust in reliability of the test	+++	+
	Receipt of results	++	+++
Accessibility	Affordability of testing process	+	++
	Time to obtain result	+	+++
	Anonymity	+	+
	Walk-in vs appointment	+	+++
Additional tests (same blood sample)	Confirmatory test	+++	
	Plus hepatitis tests	+++	
	Plus other STI tests	+++	
Efficiency	Early detection/ seroconversion period (6 weeks vs 3 months)	+++	+
	Sensitivity	++	++
	Specificity	++	++
	Ease of use	+	+
Location	Inside the center/ clinics	++	+
	Outreach settings/ Community venues	+	+++
	Mobile testing (vans & other facilities)	+	++
Staff	Medical staff	+++	+
	Community counsellors & testing staff/ volunteers		+++
	Peer educators trained to do test		++
Administrative and logistic organisation	Storage	+	+++
	Transportation	+	+++
	Reduced traceability steps	+	++
Post-test support	Immediate post-test Counseling *versus* counseling several days later	+	+++
	Positive prevention for P+	+	+++
	Quick linkage with formal health settings	++	++

3.5 The use of counseling in CBVCT

Counseling in CBVCT is one of many tools used in a global process. HIV counseling means that we receive information, support and referral through a dialogue with a trained counselor before and after the HIV test. In CBVCT we consider that the counselling, is a great opportunity for the clients to increase their health management skills.

We speak of pre-test and post-test counselling as two different opportunities to discuss multiple issues such as informed consent during the pre-test counseling and referral during the post-test. But in fact, it is important to look on these conversations as a whole and to consider the importance of providing these conversations by only one counselor. Thus, counseling can be adapted to each client, even giving him/her the choice to only talk about some issues or to skip others, in particular when it comes to those who get tested frequently.

Counseling during the HIV testing process can be conducted in different ways: directive or semi directive interviews, the Rodgers approach, motivational interviews, etc.

Numerous guidelines and check lists have already been produced on HIV counseling. These documents list important approaches and attitudes to be developed in order to conduct the counseling in the best possible way.

3.6 CBVCT practices.

The main principles for CBVCT's practices are not very different from those identified by most health policies in particular those drawn up by the World Health Organization.

According to what was said before, CBVCT should take some general factors into consideration before launching the service:

- As regards the environment (in public spaces or venues like bath houses, events, parties or the CBVCT office), it is very important to offer people a safe, quiet and warm place, which encourages confidentiality and fosters the expression of feelings (positive and/or negative). It is important to have enough time for the counseling, testing process and linkage to care (not being in a hurry).

  Finally, some basic conditions have to be met before performing a test: asepsis and hygiene, temperature, sufficient lighting to read the results, infectious waste management risk.
- CBVCT should clearly determine the referral process for those receiving a positive result (confirmatory test, linkage to health department HIV or STI specialist etc).
- To establish how those being tested will be supported while they are waiting for the result.

- To establish algorithms of actuation for every situation (window periods, negative results, candidates for pre and post-exposure prophylaxis
- Consider the legal aspects in every country for carrying out the test (for example what kind of tests are possible to use, which personnel are authorized to perform the test, etc..), for offering other health services (medication, vaccines,...) and for facilitating access to health services (free or not free access, social security coverage, ...)
- To stimulate the work between peers and among communities
- Initial and continuous training on issues like HIV, sexual health, harm reduction and counseling for staff.
- Identification of the users in the centers where anonymity is guaranteed and how data collection is organized.

Information on those factors (and others that may be relevant for CBVCT) should be collected in a quality assurance program (see following chapter).

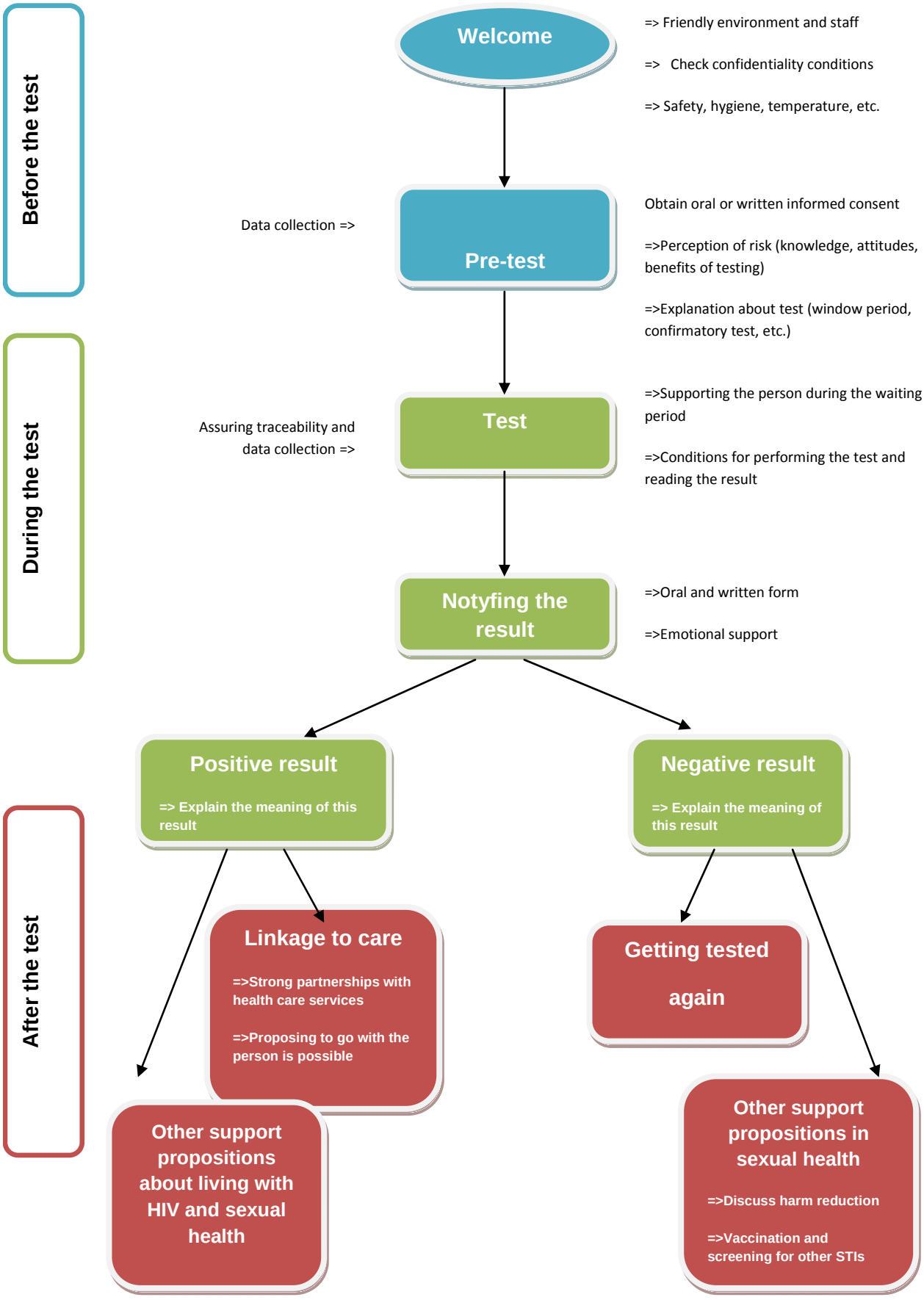
Attending a CBVCT centre is a voluntary act. Those attending should get adequate information and specific support appropriate to each one's choices (sexual practices, their willingness or otherwise to adhere to harm reduction programmes, life and health priorities).

Creating a supportive environment (confidential and safe) between clients and providers is necessary. With this aim, the WHO policy framework "Scaling up HIV testing and counseling in the WHO European Region" highlights five principles of HIV testing (the "five Cs")[26]:

- Counseling and information about HIV/AIDS before and after the test
- Consent to be tested given in an informed, specific and voluntary way by the person being tested
- Confidentiality regarding test results and the fact of seeking a test
- Correct test results. Testing must be performed and quality assurance measures followed according to internationally-recognized testing strategies, norms, and standards based on the type of epidemic. Results must be communicated to the person tested unless that person refuses the results.
- Connection/linkage to prevention, care, and treatment

These five principles are present throughout the process: before, during and after the test as in the next figure.

[26] World AIDS Day 2012: Statement on HIV testing and counselling. http://www.who.int/hiv/events/2012/world_aids_day/hiv_testing_counselling/en/index.html


Before the test
During the test
After the test
Welcome
=> Friendly environment and staff
=> Check confidentiality conditions
=> Safety, hygiene, temperature, etc.
Data collection =>
Pre-test
Obtain oral or written informed consent
=>Perception of risk (knowledge, attitudes, benefits of testing)
=>Explanation about test (window period, confirmatory test, etc.)
Assuring traceability and data collection =>
Test
=>Supporting the person during the waiting period
=>Conditions for performing the test and reading the result
Notyfing the result
=>Oral and written form
=>Emotional support
Positive result
=> Explain the meaning of this result
Negative result
=> Explain the meaning of this result
Linkage to care
=>Strong partnerships with health care services
=>Proposing to go with the person is possible
Getting tested again
Other support propositions about living with HIV and sexual health
Other support propositions in sexual health
=>Discuss harm reduction
=>Vaccination and screening for other STIs

a) Before the test

Pre-test information or counseling in order to obtain informed consent

Before performing the test, it is important to offer the client space and time for discussion where they can receive and ask for information.

This discussion must be oriented to allow clients to make an informed choice and to give their consent. Some issues must be discussed:

- Possible exposure to HIV (which and when) and verify knowledge about HIV transmission (risk perception, real life-experiences, etc.)
- Information about the HIV test, especially when a rapid test is used
- Anticipate results, how a positive or negative result will be managed and how the result could have an impact on the client's quality of life (clinical benefits and risk).

This issue is one of the key principles for the WHO European Region policy framework on scaling up HIV testing and counseling when HIV testing is offered. It is a legal requirement in most EU countries.

Two aspects must be kept in mind in the pre-test phase to obtain informed consent when CBVCT centres use rapid tests:

- Consent should include additional information about the HIV test: clients must understand the meaning, including the fact that no tests are 100% accurate and understand the purposes of the procedure. Clients must understand that results will be available during the session. Also, they have to be told that positive rapid test results require confirmatory testing which can be carried out at the same time and in the same place depending on the possibilities available in a particular CBVCT centre.
- Anticipating results. A commonly cited barrier to community-based HIV testing was not being prepared for testing or receiving a test result the same day. It is particularly true for people who are getting a rapid test for the first time in their lives and in communities where CBVCT facilities providing rapid tests is a new service. Identify with the client the social and emotional support they have available to them in particular if the result is positive. Also, it is important to communicate on the support possibilities provided by the CBVCT staff.

An analysis[27] of several studies suggests that verbal consent is adequate and that a separate consent form is not mandatory.

b) During the test

The waiting period for getting the result can be stressful in some cases. Actually, people coming to the CBVCT centre declare that waiting for the HIV results is very difficult and distressing. Therefore the rapid tests used in many CBVCT centres means that this waiting time has been shortened and so the whole testing process is made easier[28].
Whether the test used is rapid or traditional, it is important to anticipate how the waiting period will be organized within the CBVCT centre and how the person should be accompanied so as to alleviate anxiety.

The interpretation of the result by the person who performs the test is another important moment and it is their responsibility. As it is a stressful time, it is advisable to give the test provider the optimal conditions for reading and getting ready to announce a result:

- Do not read the test result in front of the person. It is difficult to concentrate on it and, at the same time be attentive to the feelings of the person. If the location allows it, get the client to wait outside the room/van
- Have sufficient lighting.
- Assure the traceability of the tests used and the data collection of the results.
- Keep in mind what the client said during the pre-test counseling that could help in delivering the result.

C) After the test

➲ *Notifying the test result*

In order to respect confidentiality, policies and regulatory frameworks emphasize that *the result of HIV testing should always be given to the person being tested. It is the person's decision to share this result with others*[29]. In some countries, the law states that the result of the test must be notified only through an individual interview even if the client asks to be accompanied by another person. In the same way, the document giving evidence of the result must be delivered personally to the client.
After announcing the result, it is important that the speaker creates a space for the client to express his/her feelings regarding the result (negative or positive).

[27] HIV Testing: Increasing uptake and effectiveness in the European Union. Evidence synthesis for Guidance on HIV testing. European Centre for Disease Prevention and Control, 2010
[28] Implementation of Community-Based Voluntary Counseling and Testing (CBVCT) Programs and Services. COBATEST- Quality report
[29] Rapid HIV Tests: Guidelines for use in HIV Testing and counseling services in resource-constrained settings. WHO. 2004 Genève.

Whether oral and / or written, the test result must be accompanied by some information. This information will vary depending on the positive or negative outcome. In CBVCT centres, special attention should be given to the comprehension of the result and should, if possible, be expressed in the language and culture of the client.

When CBVCT staff consider that conditions for confidentiality and quality of referral to care are not met in some venues (like bath houses, squats, public spaces, etc.), they can choose not to deliver the results in those spaces and ask the clients to come and get them at their main office.

Whether the result is negative or positive (but especially if it is positive), the post-test counseling should be used as an opportunity to encourage the client to invite partners to access HIV counseling and testing also.

Negative result

- Emphasize the importance of doing the test again, when necessary or on a regular basis like once a year.
- If the test was done during the window period, remind the person of the importance of doing the test again at the end of this period. Arrange an appointment if possible.

Positive result

- Emphasize the advantages of knowing one's positive status as soon as possible and the fact that treatment is now available which decreases the amount of virus in the body and rebuilds the immune system (treatment that can prevent further development of the infection).
- Discuss with the person the question of telling other people about the result. Who can they say it to? It is important to remind them that they are under no obligation to do so.
- Offer to go with the person to get the test confirmed in a specialized HIV medical service.
- Discuss the use of condoms to prevent transmission to others and to protect oneself, even if the sexual/s partner/s is/are positive.
- Discuss the possibility of inviting the client's sexual partner to do the test.
- Reassure the person and reduce the sense of guilt they could be feeling. Inform them about the fact that when treatment is initiated and when the viral load is undetectable, the risk of the virus being transmitted is significantly reduced.

➲ *Support after positive result*

According to the COBATEST Qualitative study report, it is particularly important that CBVCT staff offer emotional and personalized support at the same time as they help clients regarding linkage to hospital and treatment follow-up.

- ⇨ CBVCT staff have to offer the possibility of organizing an appointment for the confirmation of a positive result and for at least the first medical consultation. Proposing to go with the person is recommended. Give precise information such as the day, time and name of the doctor they are going to see, give a map showing how to get there.
- ⇨ Propose an appointment at the CBVCT service when the client will have received the first results from the hospital, to answer their questions and help in this first phase of diagnosis, in the decision to begin treatment, etc.

Some CBVCT centers include HIV positive people among their staff and these people can choose to talk about their experiences of living with HIV. In other cases, specific self-help groups are available, focused on announcing HIV positive status.

➲ *Linkage and referral to care*

It seems extremely important to ensure this linkage with high-quality post-test counseling, in order to support those clients who have to wait for a confirmatory result in a different setting to the CBVCT and who face the possibility of living with HIV.

Because many outreach, community-based services and CBVCT centres only provide the screening test and the health system provides the confirmatory test, care and treatment for referred HIV positive people, it is very important to develop prompt and durable linkages to ongoing medical care.

Some experiences, like those in Denmark, Spain and Germany, where confirmatory results are performed in their own centers, show that they do have very good linkage to medical centers because they do not depend on an institutional setting.

Thus, CBVCT becomes a bridge between the community and formal health settings.

To optimize staff skills, and also reduce the extent of referral, some services have expanded their clinical services to include culturally sensitive programs to address substance use, parenting issues, and domestic and homophobic violence as well as specialized medical care programs for lesbians, bisexuals, and transgendered individuals[30].

[30] Pedrana,A.,Guy,R.,Bowring,A.,Hellard,M.&Stoove,M.(2011) Community models of HIV testing for men who have sex with men(MSM): Systematic Review 2011. Report commissioned by ACON

➲ *Confidentiality, anonymity, privacy*

Confidentiality, both as an ethical principle and a legal right, is fundamental for health care. Indeed one of the main worries expressed by people is the lack of confidentiality or name reporting when getting tested.

Privacy has to be ensured, ranging from informed consent (sought and given in a private setting) until post-test counseling for HIV-positive clients and other communications relating to HIV status, that must take place away from other clients or staff not involved in the case at hand.

There should be nationally approved privacy, confidentiality and security definitions, guiding principles and recommendations for HIV-related data, with relevant capacities for their maintenance.

Anonymity, i.e. not requiring names or any other personal identifier is one step beyond confidentiality. Anonymous testing (that is also usually free of charge in UE countries –except for Germany) enhances the protection of people's privacy for communities or settings where there is fear of discrimination and stigma but also when some legal or financial barriers exist, for instance for uninsured undocumented migrants.

The criticism that is often raised by institutions about anonymous testing is the difficulty of ensuring linkage to care for those diagnosed with HIV. The quality of pre- and post-test counseling is crucial if we want to avoid some people slipping off the radar. At that moment, it is very important that the person receiving a positive test understands his/her individual benefits, e.g. early diagnosis enables ART (antiretroviral therapy)to be initiated at the most appropriate time, facilitating better health outcomes and therefore longevity. Knowing the efficiency of ART in preventing sexual transmission to one's partners can also facilitate the acceptance of a positive result and disclosure to one's partner.

When CBVCT centres have developed prompt and durable linkages to ongoing medical care, referring individuals who tested positive to hospital centers is made easier. An anonymous referential can even be given to the person so that he/she will be identified and quickly taken care of at the hospital.

Still, CBVCT coordinators report some difficulties in developing and ensuring strong collaborations/partnerships with referral agencies and medical settings. Even if the feasibility and quality of community based testing have been proved, some physicians or other medical actors remain suspicious as if community-based services were "less professional"

3.7 Monitoring and evaluation of CBVCT

CBVCT activities must be carefully monitored and evaluated[31].

WHO programmes (32) have recognized the need to develop and offer a variety of service delivery models for HIV testing and Counseling (HTC) to more effectively meet the needs in different epidemic contexts, while maintaining the core values of informed consent, confidentiality and counseling, and ensuring accurate HIV test results.

Monitoring and evaluation (M&E) plays an important role in the effective and efficient management of health programmes by ensuring that:

- Resources devoted to a program are used appropriately;
- Services provided are accessed by the target population;
- Program activities happen in a timely manner;
- The services provided have improved quality ;

  Expected results are achieved.

The establishment of collaborative partnerships with public health and epidemiologic professionals is helpful to improve the quality of monitoring and evaluation programmes.

Data collection and monitoring

The COBATEST project includes a document entitled "Core indicators to monitor Community Based Voluntary Counselling and Testing (CBVCT) for HIV [33]"

The purpose of this document is to provide guidance on human immunodeficiency virus (HIV) community-based voluntary counselling and testing (CBVCT) services on the use of indicators to monitor and evaluate their activities.

These indicators are designed to help CBVCT services to assess the current state of CBVCT activities in achieving their objectives and/or targets with respect to the increasing proportion of people infected with HIV by early HIV diagnosis among key populations at higher risk of HIV exposure, such as men who have sex with men (MSM), sex workers (SW), injecting drug users (IDU), and migrants from countries with generalised epidemics. The guidelines are designed to improve the quality and consistency of the data collected at CBVCT services level for M&E

[31] World Health Organization. Scaling up HIV testing and counseling in the WHO European Region as an essential component of efforts to achieve universal access to HIV prevention, treatment, care and support. Policy framework. 2010. Geneva, World Health Organization.

[32] Guide for monitoring and evaluating national HIV testing and counseling (HTC) programmes: field-test version. World Health Organization 2011

[33]http://www.cobatest.org/mant/php/generic-download-md5-public.php?f=5382ac764c27f8c2a25036b3908a4d2a.pdf@@@CBVCT_core_indicators_field_test_version_FINAL_Corrected.pdf

purposes and thus also to enhance the accuracy of conclusions drawn from it, if collected at national and European level. The standardised M&E will allow for comparability of data within the European HIV-COBATEST network of CBVCT services, and between CBVCT services in member states.

M&E of CBVCT at individual services level requires the allocation of needed resources such as personnel time and logistic support which should be planned for and ensured. For participating individual CBVCT services such M&E results will provide information for improving their services and enable them to compare their performance to other similar services. M&E results may also be useful for advocacy for CBVCT services to be provided in addition to health care based HIV testing and counselling (HTC) services and providing evidence of their activities and impact when seeking funding.

System for conducting assessments of service quality at CBVCT centres

Structured and standardized data collection tools for assessment of service quality at CBVCT sites should be developed as part of a protocol of good practices. Quality assurance (QA) refers to planned, step-by-step activities that let one know that testing is being carried out correctly, results are accurate, and mistakes are found and corrected to avoid adverse outcomes. Quality assurance is an ongoing set of activities that help to ensure that the test results provided are as accurate and reliable as possible for all persons being tested. Quality assurance activities should be in place during the entire testing process; this means from the time a client asks to be tested using the rapid HIV test to providing the test result.
For improving the quality of CBVCT, a quality improvement framework and tools are available[34]. These could include surveys of clients at facilities that provide testing. This can monitor the quality and acceptability of services and identify problems. It can also be done in the context of operational research or program evaluation.

The protocol for collecting and analyzing the information that each country develops may or may not be extensive, depending on who is responsible for conducting the assessment, the number of sites to be covered, the diversity of CBVCT service delivery models in the program, and the resources allocated for assessing service quality.

[34] WHO (2010) Handbook for improving HIV testing and counselling services http://whqlibdoc.who.int/publications/2010/9789241500463_eng.pdf

Resources are needed to establish and maintain a QA program, no matter how simple the test is. Someone designated by the management of the CBVCT centre should oversee the programme and ensure the necessary staff and supplies are available. Knowledge about national/regional regulations is needed.

The quality process is intended to combine the myriad of guidelines and requirements normally found in many different locations. Every new CBVCT's staff member should be able to read this plan and understand the ins and outs of HIV testing there. However, it is also intended to function as a reference tool for more experienced testers and counselors, when special circumstances or questions arise.

What is the value of feedback for quality assurance?

Site-level CBVCT data are generally forwarded to a more central site such as a district, province or state office where they may be further aggregated and then forwarded to the national level. M&E data have a use at every managerial level and should be actively reviewed. Information collected for the national HTC program should be made available at all levels (i.e. national, sub national, and CBVCT site) through strategically designed feedback mechanisms. Communication between management levels should flow in two directions; just as systems for reporting data to higher levels of management are established, so should feedback and data analysis flow regularly back down.

The dissemination of program results from data analysis and use of findings for program improvement and policy development is a key step in the M&E process. This includes allowing sites to understand their performance in the context of how other sites are performing and can encourage sharing of best practices and joint problem-solving among sites.

Broader sharing and discussion of CBVCT programmatic data at all levels is intended:

- to lead to improved service provision and delivery;
- to identify target populations in need of strengthened CBVCT efforts;
- to motivate programme staff and stimulate programme performance;
- to address issues in data quality;
- to ensure that CBVCT sites, as well as district and national offices, realize the benefits of dedicating resources to the M&E process.

Proposal for developing quality processes in CBVCT programmes

To implement a good quality process in CBVCT programs, most international guidelines state that the following steps have to be respected[35]:

- To write an explanation of the fundamentals of the HIV testing program at your CBVCT. Thus to describe types of HIV testing currently available and the intended clinic flow of your site – how clients should experience the services once they arrive.
- To add the description of CBVCT procedures (one for rapid testing and one, if necessary for conventional testing).
- To add laboratory requirements and services as they apply to HIV testing at CBVCT, and some information about laboratory safety.
- To describe the link with others services i.e. linkage to care for those with a reactive result, offer a global service in sexual health (STI diagnosis, psycho-social support, linkage to care, etc.)
- To write the monitoring process of the whole programme: what is the community participation and what is the place of the programme in the field.
- To describe the Quality Assurance process. This QA document should specify at length who at CBVCT is responsible for each element of the HIV testing program, and provide a series of corrective actions that may be taken if necessary at any given time.

This document should be reviewed periodically to ensure that it is kept up to date and that the program is continuing to align with the plan, which has been carefully thought out and should be followed closely.
To conduct CQI, each CBVCT site must create mechanisms for communication so that those who need to know are informed about QA issues, as well as all staff, when appropriate[36].

In practice we can suggest building a framework to check quality criteria and to observe the possibilities of improving CBVCT projects. This framework can be inspired by the European Quality Instrument for Health Promotion (EQUIHP)[37]:

Consistency with health promotion principles

CBVCT embraces the principles of health promotion (sexual health), including a positive and comprehensive approach to health (and sexuality), attention to the broad determinants of health, participation, empowerment, equity and equality.

[35] According to the proposition of San Francisco Department of Public Health
[36] id
[37] *European Quality Instrument for Health Promotion (EQUIHP), User manual*. Project: Getting evidence into practice. September 2005

Developing and implementing CBVCT

The CBVCT project is based on a systematic analysis of the context, health problems, and needs of the targeted population. Stakeholders are associated in this analysis[38].

The aims and objectives of CBVCT are clearly defined.

The groups and communities that CBVCT intends to mobilize and reach are clearly outlined.

The strategies and methods for an effective intervention are clearly outlined.

There is a clear description of the way the CBVCT interventions will be carried out.

The effects (effect evaluation) and quality (process evaluation) of the CBVCT interventions will be assessed.

Project management

Leadership: A person has been designated who is ultimately responsible for and capable of managing the CVBCT.

Planning and documentation: The working plan and organization of the CBVCT are firmly established.

Capacity and resources: The expertise (skills of staff) and resources (funds, means, etc.) necessary to implement CBVCT successfully are available.

Participation & commitment: The ways in which various parties will be involved and committed to the project is clearly outlined.

Communication: The way in which all participants (target group and stakeholders) will be informed about CBVCT projects is clearly established.

Sustainability

The involvement of intermediaries, the use of resources, direction of investments, orientation of technological and institutional development in ways that ensure the continuation of the CBVCT projects are required

[38] Collaboration with organizations (academic or governmental) working on the field of HIV epidemiology will help update this analysis by taking into account the latest local or national HIV trends.

Appendix

WHO EUROPE, *Scaling up HIV testing and counselling in the WHO European Region as an essential component of efforts to achieve universal access to HIV prevention, treatment, care and support,* 2010.

This policy framework contains **ten main principles** and provides detailed recommendations to guide member states as they endeavor **to scale up HIV testing and counselling.**

- Scaling up HIV testing and counselling is both a public health and human rights imperative and must be linked to broader efforts to achieve universal access to comprehensive, evidence-based HIV prevention, treatment, care and support (page4).
- Expanded HIV testing and counselling must be tailored to different settings, populations and client needs (page 5).
- Efforts to increase access to and uptake of HIV testing and counselling should include implementation of provider-initiated testing and counselling in health facilities when appropriate (page 6).
- Efforts to increase access to and uptake of HIV testing and counselling must meet the needs of most-at-risk and vulnerable populations and expand beyond clinical settings and involve civil society and community-based organizations in providing HIV testing and counselling services (page 8).
- Rapid HIV tests should be used where appropriate (page 9).
- Regardless of where and how HIV testing is done, it must always be voluntary and with the informed consent of the person being tested, adequate pre-test information or counselling, post-test counselling, protection of confidentiality and referral to services (page 10).
- HIV testing policies and practices should be reviewed to eliminate any non-voluntary forms of testing (page 12).
- Efforts to increase access to and uptake of HIV testing and counselling must be accompanied by equal efforts to ensure supportive social, policy and legal environments (page 12).
- In each country, consultations should be undertaken to formulate plans for expanded HIV testing and counselling based on this framework (page 13).
- Efforts to expand access to HIV testing and counselling must be carefully monitored and evaluated (page 14).