

# Evaluation of HIV voluntary counselling and testing services in Egypt. Part 2: service providers' satisfaction

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تقييم خدمات المشورة والاختبار الطوعيين لفيروس العوز المناعي البشري في مصر. القسم الثاني: رضا مقدمي الخدمة  
إبراهيم علي كباش، شاهيناز إبراهيم خيمر، نديرة منصور حسن، علي نعمان النواوي، أسماء عبد الرحيم عطالله

الخلاصة: تعد خدمات المشورة والاختبار الطوعيين لفيروس العوز المناعي البشري من المكونات الرئيسية للجهود الرامية لانتقاء ومعالجة العدوى به. وقد هدفت هذه الدراسة التي أجراها الباحثون في مصر إلى التعرف على رضا مقدمي خدمات المشورة والاختبار الطوعيين لفيروس العوز المناعي البشري، والتعرف على مواطن القوة ومكامن الضعف في تلك الخدمات. وقد أجرى الباحثون مقابلات مباشرة مع 50 عضواً من أعضاء تقديم خدمات المشورة والاختبار الطوعيين لفيروس العوز المناعي البشري، ومجموعات المناقشة، و16 مشاوراً، وأوضحت هذه المقابلات أن معظم هؤلاء يعتقدون أنهم قد تلقوا تدريباً كافياً (90%)، فيما طلب 66% منهم المزيد من التدريب، وأبلغ 50% منهم فقط عن حوافز كافية. أما المشكلات التي أسفرت عنها الدراسة فهي غياب توصيف ثابت للعمل، وفقدان الدعم الإداري، وعدم وضوح القواعد والتنظيمات العملية، وفقدان العمل على رفع مستوى الوعي في المجتمع. وأعرب المشاورون عن الحاجة إلى تحسين بيئة العمل لضمان الخصوصية والسرية.

ABSTRACT Voluntary counselling and testing (VCT) services are major components of HIV prevention and treatment efforts. A study in Egypt aimed to determine the satisfaction of service providers at VCTs to identify strengths and weaknesses in the service. Direct interviews with all 50 VCT team members and focus group discussions with 16 counsellors showed that the majority believed that they had received enough training (90%), but still 66% wanted further training. Only 50% reported receiving sufficient incentives. Problems that were highlighted included absence of a fixed job description, lack of administrative support, unclear working rules and regulations and lack of proper community awareness. Counsellors expressed the need for improving working environment to ensure privacy and confidentiality.

## Évaluation des services de conseil et de dépistage volontaires pour le VIH/sida en Égypte. Deuxième partie : satisfaction des prestataires de services

RÉSUMÉ Les services de conseil et de dépistage volontaires sont un élément essentiel de la prévention et du traitement du VIH/sida. Une étude a été réalisée en Égypte pour déterminer la satisfaction des prestataires de services vis-à-vis de ceux-ci afin d'identifier leurs points forts et leurs points faibles. Des entretiens directs avec les 50 membres des équipes des services de conseil et de dépistage volontaires, et des groupes de discussion réunissant 16 conseillers ont montré qu'une majorité des personnes interrogées (90 %) estimait être suffisamment formée, mais qu'ils étaient aussi 66 % à souhaiter une formation supplémentaire. Seuls 50 % d'entre eux considéraient que les mesures d'incitation étaient suffisantes. Les problèmes soulignés comprenaient notamment l'absence de description d'emploi fixe, le manque de soutien administratif, l'opacité des règles et réglementations relatives au travail, et une sensibilisation insuffisante du public. Les conseillers ont exprimé un besoin d'amélioration de leur environnement de travail afin de garantir le respect de la vie privée et la confidentialité.

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Received: 02/04/08; accepted: 18/06/08

## Introduction

Voluntary counselling and testing (VCT) is an important strategy for HIV prevention, care and support [1]. Identification of infected individuals is an essential step in control of HIV. Counselling aims to induce behaviour change among those who present for services. It was reported that individuals who take advantage of counselling show positive changes in behaviour and reduction in their risky activities, whether or not they actually test positive for HIV [2]. HIV counselling encompasses 2 components: provision of information and prevention counselling [3].

The first VCT centre in Egypt was launched in January 2005. If the VCT services are to be optimized counsellors need to be included in any evaluations of services, but they are rarely consulted about their professional opinion [4]. Especially in developing countries there have been few studies that describe counsellors' roles, barriers and experiences in providing HIV-related counselling [5]. Such information could be used for better supervision and support of counsellors, thereby improving the quality of VCT services in these countries and elsewhere.

The objectives of this study were: to determine the level of satisfaction of service providers with VCT services; to identify points of strength and weakness in the service; and to compare the services provided by fixed and mobile centres to help in the future planning of new centres.

## Methods

This was a cross-sectional study of service providers at VCT centres throughout Egypt utilizing quantitative and qualitative methods of data collection.

### Study setting

At the time of the study, VCT services were provided by 7 fixed and 9 mobile

centres distributed in 12 different governorates of Egypt. The study setting has been described in more detail in a previous paper [6].

### Quantitative data

For the quantitative part of the study data collection was performed through direct interviews with all the members of the VCT service team at each centre (physicians, laboratory technicians and counsellors/health educators) available at the time of the study. The total number interviewed was 50; 5 of the physicians were not available during the study period or refused to fill in the questionnaire, a default rate of 10%. These physicians are part-time workers and involved mainly in preventive services at the health directorate to which the centre is related and therefore had a limited role in counselling and testing services.

A checklist was used to evaluate the level of the service provider's satisfaction with the services offered at the VCTs. The questionnaire sheet included sociodemographic data (age, sex, marital status, job and educational level) and a set of 18 questions asking each respondent about: whether the training he/she had received was sufficient; satisfaction with different aspects related to the job environment and conditions; satisfaction with the VCT service provided; his/her opinion of its positive impact on the prevalence of HIV in Egypt; and how comfortable he/she felt dealing with the at-risk population visiting the VCTs.

### Qualitative data

For the qualitative part of the study 2 focus group discussions (FGD) were conducted with all the counsellors/health educators working at the VCT centres at the time of the study. FGDs were conducted by the same researcher who had training in qualitative research methods in health promotion. Informants in the first FGD were 6 counsellors at the fixed centres (2 females and 4

males) while those in the second FGD were 9 counsellors at the mobile centres (1 female and 8 males).

Discussions were conducted based on a previously prepared topic guide which included the following:

- Introduction: participants were told that the facilitators wanted to have their suggestions in order to increase the number of clients and to know about problems with the VCT service (their own problems and clients' problems) and their suggested solutions.
- Their job: description of a working day; perceptions of their job; objectives of their job [e.g. behaviour change, encouraging condom use, safe use of injections and fewer sexual partners, prevention of transmission of (STI) and HIV]; what objectives could be achieved and what could not; obstacles to achieving objectives; how they evaluated their work; how to improve the service; how to reach the objectives.
- Their own problems: problems with the centre, salary, working hours, time (their own and clients') and manpower; problems with clients; their needs as service providers.
- The clients' problems: clients' information and service needs; how to measure patient satisfaction and how to improve it.
- Training: type of training received; knowledge and skills acquired; opinions about training; their training needs.
- Type of VCT: difference between fixed and the mobile VCT in term of problems and client satisfaction.
- General problems.
- Solutions: suggestions about ways to improve the service to increase the number of clients and to increase patient satisfaction.

### Data analysis

The quantitative data collected were statistically analysed using SPSS statistical

software, version 12. The mean and standard deviation (SD) were used for quantitative variables and for categorical variables, the number and percentage distribution were calculated and Fisher exact test was used as a test of significance. The level of significance was  $P < 0.05$ .

For the qualitative data analysis transcripts of the audiotaped FGDs were analysed manually using the topic guide as a reference. Categories and subcategories were identified during the analysis and quotations were used when appropriate. The FGDs from the mobile and fixed VCTs were analysed separately to allow comparisons between staff working in the different services.

## Results

### Quantitative study

The age of the 50 service providers ranged from 21 to 56 years with a mean of 36.7 (SD 10.2) years. Males represented 58.0% of all service providers interviewed: 61.3% in mobile centres and 52.6% in fixed centres. The majority of studied service providers were married

(72.0%). Differences in demographic characteristics were not statistically significant between service providers at fixed and mobile VCTs (Table 1).

The majority of the service providers said that they had received sufficient training (90.0%), but still 66.0% reported a need for further training. Nearly three-quarters reported having sufficient facilities for providing the service (78.0%) and sufficient counsellors (76.0%), and that the working hours were suitable (86.0%). Having long hours without work were reported by 47.4% of service providers in fixed centres compared with 35.5% of their peers in mobile ones. Only 50.0% of providers reported receiving the promised incentives (performance-related pay).

The majority of service providers believed that their clients were in need of the services provided and benefited from them and they believed that their work would help reduce HIV infection (98%, 100% and 100% respectively). Most of the service providers (80.0%) felt comfortable serving clients with socially unacceptable behaviours and 82.0% believed that clients accepted the concept of behaviour change. Only

44.0% of the service providers interviewed believed that most of the clients had risky behaviour for HIV infection. This percentage was higher among service providers in mobile centres (51.6%) compared with fixed ones (31.6%).

The majority of the service providers in mobile centres complained of an overload of clients (87.1%), while 68.4% of service providers in fixed centres complained about a low rate of attendance of clients. These difference were statistically significant ( $P = 0.001$ ) (Table 2).

### Qualitative study

#### General problems

In the FGDs, problems were identified among the 15 counsellors that led some to quit their job, made them feel reluctant to work and under a great deal of psychological pressure which affected the quality of their work.

For those working in the mobile units, they perceived the VCT vehicle as a major obstacle to work, while those working in the fixed units mentioned the unsuitable location of the VCT centre as lacking privacy and confidentiality.

**Table 1 Demographic characteristics of service providers at voluntary counselling and testing (VCT) services**

Demographic variable	Mobile VCT (n = 31)		Fixed VCT (n = 19)		Total (n = 50)		Test statistic	P-value
<b>Age (years)</b>								
Range	21-56		22-56		21-56			
Mean (SD)	36.5 (10.8)		37.0 (9.5)		36.7 (10.2)		$t = 0.182$	0.856
	No.	%	No.	%	No.	%		
<b>Sex</b>							$\chi^2 = 40.36$	0.547
Male	19	61.3	10	52.6	29	58.0		
Female	12	38.7	9	47.4	21	42.0		
<b>Occupation</b>							$\chi^2 = 0.34$	0.884
Physician	7	22.6	4	21.1	11	22.0		
Laboratory technician	9	29.0	7	36.8	16	32.0		
Counsellor/health educator	15	48.4	8	42.1	23	46.0		
<b>Marital status<sup>a</sup></b>							$\chi^2 = 2.27$	0.253
Married	20	64.5	16	84.2	36	72.0		
Single	10	32.3	3	15.8	13	26.0		
Divorced	1	3.2	0	0.0	1	2.0		

<sup>a</sup>For statistical analysis, single and divorced categories were grouped.  
SD = standard deviation.

**Administrative problems**

The administrative problems mentioned were: the poorly defined job description (all were asked to perform tasks which were not related to their job description); the delays in receiving their salaries and the incentive payments they had been promised; bad treatment from their supervisor; and feeling they were not esteemed and appreciated. Some counsellors complained about being bored with the small number of clients and with being linked to other health departments where the VCT was located, which sometimes led to the cancellation of the counselling service due to other assignments. The VCT

centre supplies, such as condoms and rapid test kits, were either in short supply or surplus to their needs.

Administrative problems faced by counsellors working in the mobile units were more severe. Apart from the above-mentioned problems, they complained about the following: unclear and contradictory working rules and regulations; lack of support from the authorities; lack of needed supplies; work overload; shortages in the number of counsellors; unsuitable working environment; problems with the mobile vehicle; having no fixed working hours; working during their day off with no compensation; working double shifts;

staying in a far away location for a week with no day allowance and with no insurance; staying inside the mobile unit for long hours; working with dangerous groups of the public; and inadequate numbers of female counsellors.

Other major problems perceived by providers at mobile VCTs were: the cancelling of the awareness sessions which were supposed to be conducted in the community prior to the arrival of the VCT unit; and the poor quality health education materials available for clients before the counselling, which they described as unprofessional and unscientific. Counsellors also criticized the way that the community mobilization

**Table 2 Service providers' opinions about voluntary counselling and testing (VCT) services by type of centre**

Variable	Mobile VCT (n = 31)		Fixed VCT (n = 19)		Total (n = 50)		P-value
	No.	%	No.	%	No.	%	
Received enough training before service	28	90.3	17	89.5	45	90.0	1.000
In need of further training	21	67.7	12	63.2	33	66.0	0.767
Have enough facilities to provide service	26	83.9	13	68.4	39	78.0	0.293
Service environment is suitable	31	100.0	17	89.5	48	96.0	0.140
Have sufficient counsellors	24	77.4	14	73.7	38	76.0	1.000
Working hours are suitable	26	83.9	17	89.5	43	86.0	0.695
Sometimes have long hours without work	11	35.5	9	47.4	20	40.0	0.553
Receive enough incentives	16	51.6	9	47.4	25	50.0	1.000
Clients are in need of services provided	30	96.8	19	100.0	49	98.0	1.000
Clients get benefit from services provided	31	100.0	19	100.0	50	100.0	1.000
Feel that my work will help reduce HIV infection	31	100.0	19	100.0	50	100.0	1.000
Counselling time is sufficient to give information to clients	28	90.3	19	100.0	47	94.0	0.279
Counselling time is sufficient for questions and answers	26	83.9	18	84.7	44	88.0	0.387
Clients accept the concept of changing behaviour	27	87.1	14	73.7	41	82.0	0.273
Sometimes suffer from overload of clients	27	87.1	3	15.8	30	60.0	0.001
Feel comfortable serving clients with socially unacceptable behaviours	26	83.9	17	73.7	40	80.0	0.474
Most clients have risky behaviours for HIV infection	16	51.6	6	31.6	22	44.0	0.242
Rate of attendance is less than expected	6	19.4	13	68.4	19	38.0	0.001
Rate of attendance is gradually increasing	24	77.4	11	57.9	35	70.0	0.205

was conducted using the microphone to announce the arrival of free blood testing services, so that huge numbers of people sometimes gathered and fought to have the hepatitis tests, and not the HIV test or the VCT services.

### **Training problems**

Counsellors identified the following training problems: there was a very long time lapse between training and the start of their actual work; training was short and covered multiple subjects; training rarely touched on the area of skills development; and counselling skills were taught as steps which should be followed. Training was criticized for being far from the real-life working situation. Another problem noted was the lack of regular counsellors' meetings, with each other or with their superiors, to exchange ideas, needs, concerns and difficulties encountered and to counsel each other.

### **Clients' problems with the service**

When asked about problems faced by clients, counsellors noted that clients were reluctant to use the VCT centre due to the perceived stigma of HIV, feeling insecure about using the service, being afraid about the consequences of a positive test, e.g. the misconception that they might be imprisoned, or not trusting the test results. Clients were unaware of the existence of the service and were often unable to find the location of the mobile unit as the destinations changed. Counsellors working in fixed units highlighted the fact that clients suffered a lack of privacy and confidentiality due to the unsuitable locations of the VCT centre. The delay in knowing the test results, which could be up to 15 days, created considerable anxiety for clients.

### **Counsellors' problems with clients**

Asked about their own problems with clients, counsellors reported that clients lacked information or had misconceptions about HIV, e.g. some clients believed that they were not at risk of HIV

or that infection was only transmitted by contact with foreigners. Counsellors felt that it was difficult to change client's behaviour, e.g. convincing clients to use condoms, to limit their partners or to persuade their partners to use the VCT services. Some clients were not willing to receive the pre-test counselling or to do the HIV test as they were only interested in hepatitis testing.

Some counsellors mentioned the difficulty of convincing sex workers to persuade clients to use condoms because sex workers reported that if they insisted on using a condom, the client would think that they were diseased. Also, counsellors found it difficult to change the behaviour of men who have sex with men (MSM), who received money in exchange for sex and believed that anal sex was more pleasurable. Condom use in general was perceived as the behaviour most often rejected by clients. Some clients perceived condom use as a way of propagating bad behaviour.

Counsellors also mentioned that some target groups at risk were difficult to deal with, such as street children, those aged under 16 years (as the father's consent was needed), prisoners and military personnel.

Some counsellors mentioned that in some of the areas visited they had to face dangerous and threatening target groups, such as drug dealers and illegal weapons merchants. One said "They were over 60 clients and all wanted to do the test, they broke the car windows and threatened us with weapons"

One group identified as a particular problem was the security forces, for whom counselling was difficult to perform as they visited in large numbers (40 clients to be counselled/day) and as the soldiers rejected any counselling because they had been ordered by their superiors only to give a blood sample. Similar problems were identified when counselling prisoners as there was no time for voluntary counselling in prison

and no opportunities for counselling prisoners in confidence.

Failure to conduct counselling was perceived as a major problem. Many clients had the fixed idea that the service was only for hepatitis testing. Some counsellors explained that an Egyptian cultural belief is that becoming infected with a disease is one's destiny and "God's will", which in turns adversely affected people's health-seeking behaviour. AIDS patients and their care-givers, who are in a state of psychological stress, often resented any counselling efforts and did not have any infection control information.

### **Personal problems**

Counsellors were asked about personal problems encountered due to working in the field of HIV counselling and testing. Some counsellors mentioned that they were stigmatized by people in the areas they visited, who called them the "AIDS people". HIV was stigmatized as it was perceived by the community to be related to bad sexual behaviour, hence the community sometimes rejected the mobile services and even refused the vehicle entrance to an area.

### **Enabling factors**

Enabling factors identified by counsellors were related to personal support from some of the programme managers and to the link they had with the central laboratory team. Referral of clients from nongovernmental organizations working on drug use and from STI clinics, renal dialysis units and blood banks was another perceived enabling factor. Having posters and health education materials, and raising doctors' and health care workers' awareness about HIV and how to deal properly with positive cases, were among other enabling factors mentioned.

### **Work evaluation**

Counsellors had no defined way to evaluate their work. The only positive indicators available were data about the number of clients visiting the centre or

their personal impressions about the success of their work, e.g. when clients brought their friends or their partners to the VCT centre, when clients asked questions, when clients shared the given information with other family members and when clients agreed to have fewer sexual partners. Some mentioned that they believed they had been successful in changing clients' injection practices, e.g. not reusing or sharing needles, and in helping clients to quit drug use.

Some evaluated their work negatively and said that the VCT services were moving backwards as, due to budget shortages, the Ministry of Health and Population had cancelled the awareness-raising sessions that should have preceded the arrival of the VCT units and as counsellors had not received the incentive pay they had been promised for 6 months work. Some of the negative indicators were personal impressions that clients were only interested in hepatitis not HIV testing and their frustration with the difficulty of changing clients' behaviour, e.g. persuading them to use condoms, change their sexual or risky behaviours or limit the number of sexual partners.

Counsellors were asked to try and identify what clients liked and disliked about the VCT service. Some counsellors mentioned that clients liked confidentiality, good treatment and the fact that the service was free of charge. Clients disliked the delay in knowing the test results, as when rapid test kits were unavailable or when the confirmatory test results had to be sent to the central laboratory.

## Discussion

In the present study counsellors highlighted some of the factors that hindered and facilitated the quality of VCT services and hence the objectives of the service. Hindering factors were mainly related to the working rules and regulations and managerial problems,

together with the problems related to working in the field of HIV.

Another study showed that HIV counsellors considered their job to be stressful [5]. In our study, it was found that there has been a relative lack of attention to the organizational and systemic issues faced by counsellors. They are involved in a dynamic inter-relationship not only with their clients but also with the organization in which they work. Counsellors were concerned about the impact that their unclear role had on their work. Moreover, there may be a clash between the holistic counselling approach used in the VCTs and the task-oriented health system of Egypt [7].

In Kenya and Tanzania, in focus groups and individual interviews with counsellors providing HIV counselling services, counsellors said that their jobs were both rewarding and stressful. In addition to their obligations to counsel clients, there was stress related to external economic and political conditions [5]. In Zambia, a qualitative study was complemented by a survey to explore the impact of HIV/AIDS on health care providers. The respondents expressed their fear of becoming infected. Despite the fact that health workers were relatively motivated, emotional stress was suffered by 62% of respondents. Organizational support for health workers to deal with HIV was either haphazard or not in place at all [8].

As in other studies [9–11], the service providers said that the major barriers to HIV counselling and testing for clients were the fear of stigma, fear of positive results and lack of privacy and confidentiality in the fixed VCT locations. It has been observed that AIDS stigma affects patients as well as health care providers [12].

VCT services provide an opportunity for intensive education about HIV/AIDS prevention on a one-to-one basis [13]. Therefore counsellors need continuous training with great stress on practical skills. It has been observed

that nurse counsellors who received in-service rather than formal training for HIV counselling demonstrated better interpersonal skills [10]. It has been recommended that all counsellors in the field should have formal counselling training and receive regular supervision as a part of adherence to good standards of clinical practice [14].

Our study revealed that the fixed VCT centres had many enabling factors for providing a good service, but that clients could not benefit from them because they did not know where VCT services could be obtained and what VCT entailed. The same problem was described by undergraduates in a Nigerian tertiary institution [15]. According to the experiences of our studied counsellors, strategies for improving utilization of VCT services should include proper community awareness. Also, strategies for improving acceptance of HIV counselling and testing need to include information about access to anonymous testing and early treatment [16].

In the present study service providers concluded that community-based health education programmes are an effective method for improving and promoting acceptance of VCT, which has also been documented by other studies [13,17]. A significant increase was noted in participation of VCT services immediately after implementation of a brief STI/HIV education programme [18]. Our study highlighted concerns among counsellors about the lack of such a programme, which had been cancelled by the Ministry of Health and Population, despite its perceived importance.

As NGOs were mentioned as one of the enabling factors for VCT services in our study, they could be encouraged to share in prevention services, especially for females where there was a shortage of female counsellors. In China, a study demonstrated the feasibility of Chinese NGOs providing VCT for intravenous drug users, documenting the processes and outcome of the programme, and

concluded that NGOs have the potential to deal with other high-risk populations [19].

Our study revealed that there is an urgent need to improve the working conditions of service providers at VCT centres, taking in consideration all the problems mentioned by counsellors. Convenience and accessibility for clients appear to have a critical role in community-based VCT [20]. It was suggested that counsellors' stress might be reduced, with a consequent improvement in the effectiveness and retention of staff, through allowing greater work flexibility, providing supportive, non-evaluative supervision (i.e. not conducted on-the-job during sessions with clients), acknowledging the "emotional

labour" of counselling and providing skills for dealing with it, and providing frequent information updates and more intensive training [5].

## Conclusions

A number of working problems and enabling factors in VCT services were identified by counsellors. Interventions that are needed to improve the quality of VCT services include: fixed job descriptions for VCT staff; settled working rules and regulations for VCTs; better administrative support and attention to administrative problems; conducting proper community awareness and health education sessions to support

the VCT service; more training for VCT staff; solving vehicle problems in mobile VCTs; improving the working environment; and ensuring privacy and confidentiality for clients.

## Acknowledgements

This investigation received technical and financial support from the joint WHO Eastern Mediterranean Region (EMRO), Division of Communicable Diseases (DCD) and the WHO Special Programme for Research and Training in Tropical Diseases (TDR): the EMRO/DCD/TDR Small Grants Scheme for Operational Research in Tropical and Communicable Diseases.

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