

Egypt



**Service Provision Assessment
Survey 2002**

Egypt

Service Provision Assessment Survey

2002

Ministry of Health and Population
Cairo, Egypt

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Cairo, Egypt

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Additional information about the ESPA may be obtained from the Ministry of Health and Population, Family Planning Sector, Cairo, Egypt (telephone 20-2-794-4833; fax 20-2-7958097). Additional information about the MEASURE *DHS+* project may be obtained by contacting: MEASURE *DHS+*, ORC Macro, 11785 Beltsville Drive, Suite 300, Calverton, MD 20705, USA (telephone 301-572-0200; fax 301-572-0999; e-mail: reports@orcmacro.com; internet: www.measuredhs.com).

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Preface

The 2002 Egypt Service Provision Assessment Survey (ESPA) was designed to collect information on the provision of reproductive health and child health services in Egypt in order to complement the information obtained through the 2000 Egypt Demographic and Health Survey.

The ESPA collected information on the preparedness of health facilities in Egypt to provide high-quality care to clients seeking services for family planning, maternal health, child health, and sexually transmitted infections. A representative sample of 650 clinics of all types of facilities, in both government and non-governmental organization facilities, was assessed.

The survey included, in addition to the resources of the facilities, interviews with service providers, observations of consultations between the providers and clients, and interviews with clients after they were served.

The information included in the report is important to identify areas of intervention that will help improve the quality of family planning, maternal health, and child health services provided to clients.

The Ministry of Health and Population will ensure that implementation of activities in the proposed areas of intervention is followed through.

I am deeply indebted and grateful to all of the ESPA field and office staff members for their dedicated efforts to make these highly important data available in such a timely fashion.

Finally, I would like to take this opportunity to thank the U.S. Agency for International Development for its financial support for the 2002 ESPA.

Professor Dr. Awad Tag El-Din
Minister of Health and Population

Acknowledgments

There were a number of national demographic surveys conducted in Egypt in the 1980s. Information on the utilization of maternal and child health and family planning services data was desired in order to complement the household-based information. The Egypt Service Provision Assessment (ESPA) is a survey, conducted for the first time, that was designed to extract information about the general performance of outpatient facilities that provide health services related to pediatric, maternal, and reproductive health needs. In addition, information on health services for selected infectious diseases was sought. Drawing on a representative sample of public facilities and nongovernmental organization facilities, the survey gathered information that points out the strengths and weaknesses of the service delivery environment. The information that the ESPA elicited on health services at the level of the provider may help policy-makers and program administrators develop effective strategies to improve the utilization and coverage of services and prioritize resources in ways that will ensure better health outcomes.

The 2002 ESPA was accomplished through the collaborative efforts of many individuals and institutions. The Ministry of Health and Population (MOHP), under the leadership of Dr. Awad Tag El-Din, contributed to the success of the survey implementation. I would like to acknowledge the contributions of various technical committees at the MOHP, the staff of the Management Information System Unit of the MOHP/Family Planning sector, and of other professionals who individually and collectively gave comments and advice during the design and development of questionnaires as well as report writing.

Technical assistance was provided by ORC Macro through the worldwide MEASURE *DHS+* project. Its contribution throughout the design, implementation, and analysis stages of the ESPA is appreciated.

Furthermore, I would like to thank the staff of the Population and Health Office, U.S. Agency for International Development, for the financial and technical support they provided to the ESPA.

This survey could not have been conducted in such timely fashion without the combined efforts of the senior office staff of El-Zanaty Associates and the researchers who collected the data from clinics.

Finally, I would like to express my appreciation to all of the facilities, providers, and clients who responded in the survey; without their cooperation, this project would not have been possible.

Fatma El-Zanaty
Technical Director

Key Findings and Recommendations

The 2002 Egypt Service Provision Assessment (ESPA) was conducted in a representative sample of 650 health facilities throughout Egypt. The survey covered general, district, and integrated hospitals (referred to in the report as “general service hospitals”), fever hospitals, maternal and child health centers and urban health units (MCH/urban HUs), rural health units (rural HUs), mobile units, health offices, and nongovernmental organization (NGO) facilities. The ESPA used interviews with health service providers and clients, as well as observations of provider-client consultations, to obtain information on the capacity of facilities to provide quality services and the existence of functioning systems to support quality services. The areas addressed were the overall facility infrastructure and resources; specific child health, family planning, and maternal health services; and services for specific infectious illnesses—sexually transmitted infections (STIs) including HIV/AIDS, and tuberculosis. The objective was to assess the strengths and weaknesses of the infrastructure and systems supporting these services, as well as to assess the adherence to standards in the delivery of curative care for children, family planning, antenatal care (ANC), and consultations for STIs.

The ESPA was undertaken jointly by the Egyptian Ministry of Health and Population (MOHP) and El-Zanaty Associates, with technical assistance provided through ORC Macro under the MEASURE *DHS+* project. The U.S. Agency for International Development provided financial support for the survey.

Facility Infrastructure and Infection Control

Eighty-nine percent of facilities have regular electricity or a generator with fuel.

Year-round, onsite water was available at 86 percent of facilities, with almost all (96 percent) indicating that their water was normally supplied through a piped system. Large facilities have multiple locations for providing client consultations and examinations, and small facilities often have only one location. Items for infection control were assessed for each service delivery area included in the ESPA. Although water was present in each service area in most facilities (62 percent), soap for hand-washing was rarely present in each assessed service delivery area in a facility (15 percent).

When assessing procedures used in the principal location in a facility where equipment to be reused is sterilized or high-level disinfected for reuse, 78 percent of facilities (96 percent of general service hospitals, but only 33 percent of fever hospitals) had functioning equipment for either high-level disinfection (HLD) or sterilization of reusable equipment. Only 45 percent (75 percent of general service hospitals) had the equipment, staff present who knew the correct processing time and temperature (when relevant), and equipment with an automatic timing device. Equipment may be processed in different locations within the same facility, depending on the size and organization of a facility. The area where equipment for specific services is processed was assessed (whether it was the main facility processing area or another location) for family planning, delivery, and STI services. The equipment and knowledge for processing family planning and delivery equipment were somewhat better, with 78 percent of family planning equipment processed in an area with functioning equipment and staff who knew the correct processing time and temperature. This was true for 77 percent of delivery service equipment. Sixty percent of delivery equipment was processed in areas with sterilization equipment and staff with knowledge of the processing time and temperature for sterilization. An additional 17 percent used HLD procedures. HLD does not kill the tetanus spore.

Service Availability

The MOHP does not expect all facilities to offer all basic health services. For example, district and general hospitals do not routinely offer child immunization services, but integrated hospitals do; mobile units rarely offer immunization, but they offer family planning, ANC, and curative care; and health offices primarily offer child immunization and family planning. Health offices are often located adjacent to hospitals, so services may be conveniently accessed, even if they are not in the same building or under the same manager. In total, 35 percent of facilities offer some level of each of the assessed basic child, maternal, and reproductive health services. As expected, MCH/urban HUs and rural HUs are more likely to offer the package of assessed services (39 percent and 51 percent, respectively). NGO facilities rarely offer child immunization or growth-monitoring services.

Essentially all facilities had at least one physician assigned.

Sixty-three percent of general service hospitals (69 percent of fever hospitals) and few other facilities had all items available that were assessed for supporting high-quality, 24-hour emergency services (overnight or inpatient beds; at least two secondary-level qualified staff; 24-hour onsite or on-call staffing, with a duty schedule present; access to 24-hour emergency communication; a client latrine; and an onsite water source). All elements, plus a year-round onsite water supply and a 24-hour regular supply of electricity (or a generator), were available at 53 percent of general service hospitals (66 percent of fever hospitals).

Facility Management

Fifty-one percent of facilities reported that they had management meetings at least every six months, with half reporting monthly or more frequent meetings. Only 13 percent, however, had any documentation of the meetings. General service hospitals (34 percent), fever hospitals (31 percent), and MCH/urban HUs (22 percent) were more likely to have documentation (such as minutes from meetings) available.

Fifteen percent of all facilities (21 percent of general service hospitals and 18 percent of rural HUs) had documentation of functioning quality assurance activities for any service area.

Structured in-service training on topics related to the services provided had not been consistently experienced by interviewed providers. At least half of the interviewed health service providers from a facility had received in-service training related to their work during the past 12 months in 28 percent of facilities, with 30 percent of all providers having received in-service training. An additional 43 percent had received related in-service training within the past five years. Providers of family planning and antenatal services were more likely than others to have received related in-service training during the past five years.

Supervision was particularly strong across all government facilities and services, but less so for NGO facilities. Ninety-six percent of facilities had experienced a supervisory visit from officials external to the facility (70 percent of NGO facilities) during the past six months.

At least half of the interviewed health service providers within a facility had been individually supervised during the past six months at 94 percent of the facilities. These were 90 percent of all interviewed health service providers. Supervision patterns were similar for providers of the various services assessed, with most reporting being personally supervised at least once per month.

Management of Vaccines, Contraceptives, and Medicine Supplies

Seventy-six percent of facilities that stored vaccines had all of the components for maintaining and monitoring the cold chain. The temperature was not within the accepted range (0° to 8°C) for 17 percent

of facilities. Health offices had the strongest systems (94 percent) and integrated hospitals the weakest (71 percent) for monitoring and maintaining the cold chain. NGO facilities had no systematic means for monitoring the cold chain.

Storage conditions for contraceptives were adequate at 86 percent of facilities, but storage conditions for medicines were adequate for only 68 percent of facilities. Medicine storage areas for 22 percent of facilities had evidence of rodents or pests, and 21 percent did not have the medicines off the ground and protected from water.

Among the selected medicines or contraceptives checked, expired items were rarely found (4 percent of facilities).

Up-to-date inventories (or daily registers that easily reconciled the stock with the inventory) were present in 69 percent of the facilities storing vaccines, 79 percent of facilities with contraceptive methods, and 72 percent of facilities with medicines.

Service-Specific Findings

Use of individual client cards, important for providing a record of findings and treatments and for continuity of care, varies by service and type of facility. An individual card or other means for supporting continuity of care for sick children was available in 40 percent of facilities offering sick child services. Individual records for family planning clients were more widely available (87 percent), with NGO facilities the least likely to have them (63 percent), although use during consultation (the provider referred to information on the card or wrote on the card) was observed for less than half of the clients. Individual records for ANC were widely available in MCH/urban HUs and rural HUs (83 percent and 81 percent, respectively) but were available in less than half of the general service hospitals and in less than one in four NGO facilities. Use of ANC client cards during observations was similar to the findings for availability of the cards. Client cards were used for only one in three observations for clients assessed for STIs.

Most services are provided under conditions where the clients have visual and auditory privacy. This was available in 78 percent of the STI client counseling areas (and 82 percent of the client examination areas) and 76 percent of family planning client counseling areas (and 81 percent of the client examination areas). These are two services where privacy is critical to ensure client confidentiality and to encourage sharing of necessary information.

Any guidelines or protocols that can be used as references by providers for the delivery of specific services—and/or management of health issues related to that service—are not available in the service delivery area for most facilities and for most services assessed. Family planning services were the most likely to have service guidelines or protocols (46 percent), followed by sick child services (24 percent). Only 12 percent of facilities had protocols or guidelines for ANC in the service area, 9 percent had protocols for delivery, and 19 percent had guidelines or protocols for STI diagnosis and treatment in the service area.

Visual aids for client education were available in most family planning service areas (93 percent) and in many STI service areas (41 percent), but they were available in only one of four sick child or ANC service areas. Overall, visual aids were rarely used (3 percent of observed sick child consultations, 9 percent of observed family planning consultations, 2 percent of ANC clients, and less than 1 percent of STI clients).

Neither basic oral medicines nor prereferral medicines or medicines to manage common complications for clients receiving the services assessed are widely available in the facilities.

Essential advice related to prevention of complications and early identification and help-seeking for problems was rarely provided during the observed sick child or ANC consultations. Side effects of family planning methods are also not consistently explained.

Child Health Services

All basic child health services (curative care, growth monitoring, and immunization) are available at 81 percent of rural HUs and 65 percent of MCH/urban HUs. Although 88 percent of facilities provide consultation services for sick children, fewer provide preventive services such as growth monitoring (60 percent) and immunization (71 percent). Immunization and growth monitoring are most often offered one or two days per week, whereas sick child services are offered at least five days per week in 92 percent of facilities offering any child health services.

Sixty-five percent of facilities that stored child vaccines had all basic vaccines (BCG, polio, DPT, and measles) and 61 percent had all basic vaccines as well as hepatitis and measles, mumps, and rubella (MMR) vaccines. All types of vaccines were missing in equal proportion, with each type of vaccine missing in at least 10 percent of facilities.

Disposable syringes are universally used for immunization.

Although immunization services are not integrated to allow sick children who are not fully immunized to be immunized at the time they are seeking curative care, it is important to note that the national immunization coverage is very high (92 percent), so this may not be a program priority.

Seventy-two percent of facilities offering immunization had records showing they monitor community coverage levels. This was true for 91 percent of health offices and 37 percent of MCH/urban HUs.

The MOHP standards specify that most seriously ill children (specifically including those requiring intravenous rehydration) be referred to hospitals. This necessitates that seriously ill children be referred (and the caretaker follow up on the referral) for quality care. Only slightly more than half of general service hospitals and fever hospitals had medicines for all prereferral treatments in accordance with guidelines recommended by the Integrated Management of Childhood Illness (IMCI) programs.

Assessments of sick children rarely adhere to IMCI guidelines, with a notable lack of a thorough history and physical examination. In spite of this, the assessment, reported diagnosis, and prescribed treatments for observed sick children indicated that providers reasonably fit their evaluations to the illness and their perception of its severity.

Provision of essential information to the caretaker about continuing to provide (or providing more) food and fluid to sick children was noted during fewer than one in five observed consultations. Information on symptoms for which the child should immediately be brought to a facility was provided during 10 percent of observed consultations for sick children.

While 42 percent of the observed ill children were weighed, only 20 percent were weighed and the weight plotted against a standard. Assessment of immunization status was not a common component of the evaluation.

Forty-nine percent of children diagnosed with a nonsevere respiratory illness (primarily cough or cold) received or were prescribed antibiotics, and 58 percent of all observed children received an antibiotic. The appropriateness of current use of antibiotics should be assessed and standards for use developed. The proportion of injectable antibiotics compared with oral antibiotics did not appear excessively high (11 percent of injectables).

Family Planning Services

The intrauterine device (IUD), injectable progesterone, combined oral pill, and male condoms are the four most commonly offered contraceptive methods (all four offered at 84 percent of facilities that offer modern temporary methods of family planning). Almost all (90 percent) of the facilities offering these methods had all four methods available on the day of the survey.

Among the visual aids available, 87 percent of facilities had trays with samples of methods, 79 percent had teaching aids about specific types of family planning, and 84 percent had information pamphlets for clients to take home. Visual aids related to STIs were available in the family planning service area in 17 percent of the facilities, and information pamphlets on STIs that clients can take home were available in 32 percent of facilities.

All items for infection control were available in the client examination area in 20 percent of facilities. All items were most commonly found in MCH/urban HUs (31 percent) and least commonly found in mobile units (9 percent). Latex examination gloves and hand-washing soap are the items most commonly lacking (in half of all family planning service areas).

Diagnosis of and treatment for sexually transmitted infections are provided by family planning service providers in 82 percent of facilities offering family planning. All infrastructure and equipment assessed for conducting a pelvic examination under quality conditions were available in 71 percent of facilities, with an examination light being the item most often lacking.

Among facilities offering a method with estrogen, 11 percent (primarily rural HUs) had no blood pressure apparatus.

Although 87 percent of facilities had individual client cards available for family planning clients, cards were reviewed by the provider either prior to or during the family planning consultation for only 46 percent of observed family planning clients. Providers wrote information on the cards either during or after the consultations for 65 percent of observed family planning clients.

A followup visit was mentioned for 74 percent of observed family planning consultations.

Thirty-seven percent of first-visit consultation clients were assessed for symptoms of STIs, and 40 percent were asked about chronic illness.

Among all first-visit clients, 66 percent had their blood pressure measured. Among clients receiving a method including estrogen, 71 percent had their blood pressure measured.

Breast examinations were conducted on 4 percent of the observed family planning clients, although 13 percent indicated that they had been taught self breast examination either during this visit or a previous visit.

Fourteen percent of women who received either contraceptive pills or injections were observed being given information on how to use the method, side effects, and what to do for problems, as well as information on a followup visit. Among these same women, the proportion was higher when they were asked if they had received these four items of information (43 percent). The women may have been reporting on knowledge or information received previously, rather than information from this specific visit.

Maternal Health Services

ANC is offered by 88 percent of eligible facilities, with about half (57 percent) offering the service five days per week.

Tetanus toxoid (TT) immunization services are not always available at the same time as ANC. Although 56 percent of facilities indicated they offer TT immunization whenever ANC is offered, on the day of the survey, 71 percent of facilities were offering ANC, but only 33 percent were offering both ANC and TT immunization.

All equipment and medicines for basic ANC assessment (blood pressure apparatus, fetoscope, iron tablets, folic acid tablets, and TT vaccine) were all available at only 22 percent of facilities. Folic acid, TT vaccine, and a fetoscope were each missing from about half of the facilities.

Medicines for management of common complications of ANC or for postpartum infections were not routinely available. Methyldopa (for hypertension) was available in only 10 percent of general service hospitals.

Diagnosis of and treatment for sexually transmitted infections are provided by ANC service providers in 87 percent of facilities offering ANC. Testing for syphilis or for HIV/AIDS is not a routine component of ANC in Egypt. Population rates for these illnesses are low.

Twenty-five percent of facilities had a functioning ultrasound machine with a trained health service provider to use it. Blood typing and testing for Rh factor capacity were described as routine components of ANC in 44 percent of facilities, and 25 percent had the capacity to provide these services; however, only 22 percent had the capacity on the day of the survey and said that testing the blood was a routine component for ANC. Testing urine for glucose and testing urine for protein were described as routine components of ANC in 83 percent and 82 percent of facilities, respectively, with the capacity to conduct the tests available in 45 percent and 69 percent of facilities, respectively, on the day of the survey. Glucose testing and protein testing were both routine for ANC and available in 41 percent and 64 percent of facilities, respectively.

Among first-visit ANC clients whose consultation was observed, only 29 percent were asked about any medicines they were taking. Forty-two percent were given or prescribed TT immunization, 60 percent had their urine tested (or a test was prescribed), and 47 percent were given (or prescribed) iron tablets.

Among all observed clients, the assessment of current health status was not routinely complete. Seven percent were asked about vaginal bleeding, and 3 percent were counseled on vaginal bleeding being a risk sign: Forty-six percent of women at least five months pregnant were asked about fetal movement, and 75 percent of women at least eight months pregnant had the fetal position assessed (either through palpation or ultrasound); 92 percent had their blood pressure measured.

About one in four first-visit and followup-visit ANC clients received education about nutritional needs during pregnancy. Less than 10 percent of observed first-visit or followup-visit clients were advised on specific risk symptoms for which they should seek help. During the exit interview, one in five of the interviewed clients reported that they had been told about risk factors either during this or a prior visit. Advise on exclusive breastfeeding is not commonly provided. It was observed being provided during 1 percent of ANC consultations and reported by 10 percent of interviewed clients to have been discussed during this or a prior visit.

Partographs are not commonly used (available in 6 percent of facilities offering delivery services). All assessed basic supplies (a cord-cutting item, cord clamp, any suction apparatus, antibiotic eye ointment

for newborn, and skin disinfectant for perineum) were all only available in 21 percent of facilities (44 percent of MCH/urban HUs and 31 percent of general service hospitals).

Although, in Egypt, management of complications during pregnancy or labor and delivery is not routinely expected to be provided below the hospital level, facility-supported emergency transportation for referrals is available at only 13 percent of facilities, and caesarean sections are offered at only about half of the general service hospitals.

Emergency medicines for severe preeclampsia or eclampsia, as well as injectable antibiotics for sepsis, were available in only half of the general service hospitals providing delivery services, with four in ten having both. Equipment to support insufficient labor (forceps or vacuum extractor) is available in only half of the general service hospitals, and blood transfusion services are available in 60 percent.

Sexually Transmitted Infections and HIV/AIDS

STI services are offered at 62 percent of facilities; however, services are available through family planning and ANC services even when facilities do not offer STI services as a walk-in service. STI services are provided by ANC and family planning providers in about two of three facilities that reported they provide no routine services for STIs.

Medicines for treating gonorrhea are available at less than one in five facilities offering STI services. Medicines to treat other STIs were more widely available, with 63 percent having metronidazole for trichomoniasis and about half having a medicine for chlamydia and for syphilis. Almost all facilities (87 percent) had condoms available, with 58 percent having condoms in the STI service delivery area.

All assessed infrastructure for high-quality pelvic examinations was available in 74 percent of the service areas where STI clients are normally examined. All items for infection control were available in only 23 percent of these areas, with hand-washing soap the item most often missing (about half of the examination areas). Capacity to provide laboratory confirmation of specific STIs is lacking, with 16 percent of general service hospitals having testing capacity for syphilis and 9 percent (29 percent of fever hospitals) having testing capacity for gonorrhea. Microscopic examination using wet-mount testing was available in 30 percent of general service hospitals and 35 percent of fever hospitals.

HIV/AIDS diagnostic and care and support services are newly developed. Voluntary counseling and testing (VCT) and anti-retroviral treatment (ART) services are not yet available. HIV-testing capacity exists in 23 percent of general service hospitals and fever hospitals that offer STI services.

Abbreviations

AFB	Acid-fast bacillus
AIDS	Acquired immunodeficiency syndrome
AIDSCAP	AIDS Control and Prevention
ANC	Antenatal care
ARI	Acute respiratory infection
ART	Anti-retroviral treatment
BEOC	Basic essential obstetric care
BCG	Bacille de Calmette et Guérin
CDC	Centers for Disease Control and Prevention
CEOC	Comprehensive essential obstetric care
CAOA	Central Agency for Organization and Administration
CCO	Curative Care Organization
CDD	Control of Diarrheal Diseases
CSI	Clinical Service Improvement
D&C	Dilatation and curettage
DHS	Demographic and Health Survey
DOTS	Directly Observed Treatment Short-course
DPT	Diphtheria, pertussis, and tetanus
DR	Delivery room
EDHS	Egypt Demographic Health Survey
EFPA	Egyptian Family Planning Association
EmOC	Emergency obstetric care
EPI	Expanded Program on Immunization
ESPA	Egypt Service Provision Assessment
FHT	Fetal heart tone
FP	Family planning
GM	Growth monitoring
GS	General service
HIO	Health Insurance Organization
HIV	Human immunodeficiency virus
HLD	High-level disinfection
HM/HC	Healthy Mother/Healthy Child
HSRP	Health Sector Reform Project
HU	Health unit
IEC	Information, Education, Communication
INH	Isonicotinic acid hydrazide (isoniazid)
IMCI	Integrated Management of Childhood Illness
IUD	Intrauterine device
KOH	Potassium hydroxide
MCH	Maternal and child health
MMWR	Morbidity and Mortality Weekly Report
MNH	Maternal and Neonatal Health Project
MOF	Ministry of Finance
MOHP	Ministry of Health and Population
MOSA	Ministry of Social Affairs
NACP	National AIDS Control Program
NAMRU	Naval Medical Research Unit

NEDSS	National Electronic Diseases Surveillance System (NEDSS)
NGO	Nongovernmental organization
NMMS	National Maternal Mortality Study
NPC	National Population Council
OPD	Outpatient department
OPV	Oral polio vaccine
ORC	Opinion Research Corporation
ORS	Oral rehydration salts
ORT	Oral rehydration therapy
OVC	Orphans and vulnerable children
PHIF	Public and Health Insurance Fund
PIO	Pensioners Insurance Organization
PLHA	People living with HIV/AIDS
PMTCT	Prevention of mother-to-child transmission
PNC	Postnatal care
PVO	Private voluntary organization
QA	Quality assurance
QIP	Quality Improvement Program
RPR	Reactive protein reagent test
RTI	Reproductive tract infection
SC	Curative care for sick children
SHIP	Student Health Insurance Plan
SIO	Social Insurance Organization
STI	Sexually transmitted infection
TB	Tuberculosis
TBA	Traditional birth attendant
THO	Teaching Hospital and Institutes Organization
TPHA	Treponema pallidum hemagglutination assay
TST	Time-steam-temperature-sensitive (tape)
TT	Tetanus toxoid
UNAIDS	Joint United Nations Program on HIV/AIDS
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VCT	Voluntary counseling and testing
VDRL	Venereal disease research laboratory
WHO	World Health Organization