SUMMARY
UNAIDS/WHO /United States Government
Consultative Meeting on HIV Testing and Counselling in the Africa Region
November 15-17, 2004
Johannesburg, South Africa

OVERVIEW

The gap in access to HIV treatment services in the Africa region necessitates urgent and well co-ordinated efforts to scale up these services in order to achieve the '3 by 5' treatment target. The WHO/UNAIDS launched the '3 by 5' Initiative in September 2003, declaring the lack of treatment in low and middle-income countries a global public health emergency. The aim is to have three million people living with HIV/AIDS and needing ARV to survive, accessing that treatment by the end of 2005; two million of these people live in the Africa region. HIV testing and counselling provides a gateway to care, treatment with antiretrovirals and support for those in need. However, the continuing low level of access to HIV testing and counselling is a constraint to achieving the '3 by 5' target as less than 10% of people in the Africa region have access to these essential services.

The Consultative Meeting on HIV Testing and Counselling in the Africa Region, which was held in Johannesburg, South Africa, focussed on what needs to be done; what has been learnt and; what changes need to be made in policies, guidelines, strategies, programs and systems to ensure that the necessary commodities for HIV testing and counselling and for scaling up services are in place.

The meeting's co-sponsors, UNAIDS and WHO, have issued a policy statement and regional guidance on HIV testing and counselling; and the U.S. Centres for Disease Control and Prevention have produced materials for training and promoting the shift in the approach to testing and counselling. The meeting brought together 18 countries[1] with a total of 101 participants, which included country teams and partners. It provided an opportunity to learn aspects of the UNAIDS/WHO Policy Statement on HIV Testing and the WHO/AFRO Regional HIV/AIDS Voluntary Counselling and Testing Guidelines; discuss how these could be applied in countries; and how countries and partners can work together to scale up testing and counselling services. Participants were stakeholders from government, non-governmental organisations, People Living With HIV/AIDS, international development partners and some representatives of the private sector.

Country teams shared policy information, rich experience, research and innovative approaches and examples of integrating HIV testing and counselling. While there is significant scaling up of HIV testing and counselling in a number of countries, services coverage is low and it is recognised that every opportunity to integrate these must be used. The challenges countries face include developing partnerships, human resources, capacity constraints, HIV test kits and HIV related stigma. The following key points for action were identified:

- WHO/AFRO Regional HIV/AIDS Voluntary Counselling and Testing [VCT] Guidelines (draft 2003) should guide HIV Testing and Counselling approaches
- WHO/AFRO Regional HIV/AIDS Voluntary Counselling and Testing [VCT] Guidelines (draft 2003) and the UNAIDS/WHO Policy Statement on HIV Testing (2004) should be consistent

[1] Angola, Botswana, Burkina Faso, Democratic Republic of Congo, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Swaziland, Uganda, United Republic of Tanzania, Zambia, Zimbabwe

- ❑ Access to HIV testing and counselling services should address coverage and equity in outreach to vulnerable groups
- ❑ HIV testing and counselling strategies need to be strengthened
- ❑ Monitoring and Evaluation for HIV Testing and Counselling needs clear guidance.

CONTEXT

The meeting's objectives were to:

1) brief participants on the UNAIDS/WHO policy and guidelines related to HIV Testing and Counselling
    - UNAIDS/WHO Policy Statement on HIV Testing (2004)
    - WHO/AFRO Regional HIV/AIDS Voluntary Counselling and Testing [VCT] Guidelines (draft 2003)

2) share countries' experiences in HIV testing and counselling
3) identify the challenges faced by national governments and civil society to provide an enabling environment to accelerate HIV Testing and Counselling
4) discuss advocacy and communication strategies to promote and to increase the uptake of HIV testing and counselling
5) identify core competencies and innovative approaches in building capacity to scale up HIV Testing and Counselling

SUMMARY OF PROCEEDINGS

- There is a plethora of terms— which aside from the term "mandatory testing" on which there seems to be agreement— that is leading to confusion:
    - o Voluntary Counselling and Testing (VCT)
    - o Routine Testing
    - o Routine offer of testing
    - o Diagnostic Testing
    - o Counselling and Testing (C and T)
    - o Testing and Counselling (T and C)
    - o Counselling, Testing and Referral (CRT) – CDC

Some participants suggested that the simplest solution would be to use one term, **HIV testing,** which is performed in different ways depending on the situation.

- The meeting endorsed the 3 Cs (confidentiality, counselling and informed consent) for all HIV testing.

- The framework contained in the UNAIDS/WHO Policy Statement on HIV Testing defines 4 types of testing in 2 categories: client-initiated testing (VCT) and provider initiated testing (diagnostic, routine offer, mandatory). It was perceived as needing urgent clarification, which the meeting provided.

- According to country representatives, scale up of HIV testing is underway in a number of countries including Rwanda (estimated 380,000 tests in 2004), Malawi (215, 269 on 2003), Uganda (estimated 130,000 in 2004, 980,963 from 1990 to Sept 2004 at the AIDS Information Centre).

- A routine offer of testing has been adopted in settings as diverse as Malawi, Botswana and Burkina Faso tuberculosis clinics and Uganda and South African

prisons and military recruits. The term 'routine testing' was used interchangeably by the Botswana delegation and their members clarified that in clinical settings, HIV testing may be part of the diagnostic package and that patients have the right to refuse to be tested (opt-out). In other settings, routine offer of testing with the possibility to opt-in is undertaken.

- Several participants recalled that 'routine testing' referred to the practice established in 1985 when the HIV test became available. At that stage, the HIV test was often routinely performed without the knowledge of the person and without revealing the results, e.g. testing patients for medical reasons to assist in diagnosis. (Some countries adopted the practice to test all pregnant women, IDUs or anyone who came for minor or major surgery).

- Various challenges were raised:

    - High demand for testing leading to inability to provide treatment to those eligible for treatment.

    - Lack of antiretroviral treatment facilities to refer patients when HIV infection detected – countered by view that availability of treatment should not slow down HIV testing scale up since individuals can benefit from assistance with positive living practices (prevention and treatment of HIV-related illnesses, nutritional counselling and support, psychosocial support, etc).

    - Need for capacity building: management information systems, logistics and supply chain management and infrastructure.

    - Human resource issues: capacity building, training, idea of task shifting. Different models in the following countries allow different cadres to perform HIV tests: South Africa requires a registered health care provider; Malawi uses lay counsellors trained to counsel and perform rapid tests; Lesotho uses lay counsellors who are school leavers trained by Ministry of Health, backed up by trainers and medical and nursing professionals.

    - Interesting models are being rolled out (however, need to look at human rights implications):
        - home based VCT offered for families of clients who test positive in VCT sites (underway in Uganda, being considered in Botswana) and offered in community mobilising/leadership programmes with door to door testing (Uganda)
        - mobile VCT vans (Uganda and Botswana)
        - couple testing (premarital, pre-cohabiting, married, co-habiting): addresses disclosure, facilitates communication and cooperation required for risk reduction, opportunity to reduce tension and avoid blaming each other
        - parental testing in the context of pregnancy – good response from men in Zimbabwe but no tests available; Rwanda only 10 to 15% of men agreed
        - Youth friendly services –Zimbabwe; Malawi (strategy in development)
        - Utilisation of different entry points, to start with TB clinics e.g. Botswana and Burkina Faso.

These models were in some instances challenging the UNAIDS/WHO Policy Statement on HIV Testing (2004) because of confusion around the plethora of terms used for HIV testing.

A decision must be made on whether case studies will be attached to the WHO/AFRO Regional HIV/AIDS Voluntary Counselling and Testing (VCT) Guidelines (draft 2003) as a way to operationalise the policy

- Areas identified as in need of additional consideration include:
    - adolescent testing – concerns raised in the context of consent laws of 18 years and issues of incest and rape. Malawi's age of consent is 16 years but VCT consent is agreed to be 13 years and above (in part because adolescents can get married at 13)
    - reaching disabled people, particularly hearing impaired (Uganda)
    - need for programmes for visually impaired people
    - promotion of self-disclosure: what are the legal & social supports to minimise risk of violence and family break-up.

- Variable fees being charged but generally considered a deterrent: Rwanda 300 francs (government moving to free testing); Burkina Faso (500 francs), Uganda (free).

- UNAIDS presented the United Nations Department of Peace Keeping Operations (UNDPKO) testing policy, which indicates that mandatory testing of peacekeepers is not justified. Outreach approaches to families, military orphans, and host communities were described. South Africa presented its policy, which does not call for HIV testing of military recruits as an entry requirement but a routine offer of HIV testing for armed services.

- The many questions which followed the presentations on prisons (Uganda and South Africa) suggest that a regional consultation on the issue of HIV and Prisons (testing policies for prisoners and guards, access to ART, confidentiality provisions, seamless referrals to and from prison settings for people on ART, consensual and non-consensual sexual activity in prison, PEP for prison guards) will be highly useful.

- Outstanding issues:

    - There is an urgent need for a regional consultation on **HIV and prison** settings

    - Several countries raised the issue of Adolescent Testing. It was suggested that further discussion is needed.

    - Development of adequate **monitoring, evaluation and operational research tools** is critical in this era of natural experiments occurring in so many countries with high prevalence. This should include more than process indicators and should include documentation of:

        - nature of enabling legal frameworks in place
        - countries with HIV testing policies
        - informed consent practices
        - community involvement in design/implementation and evaluation
        - strategies for treatment and testing literacy
        - opting out uptake rate
        - referral practices
        - age and gender disaggregated data on numbers tested and numbers receiving HIV test results
        - site specific practices and outcomes
        - couple testing outcomes

- o service models and quality
- o involvement of people living with HIV in programming
- o impact on stigma
- o methods for documenting discrimination
- o client satisfaction.

- There was little discussion of cost of testing and of overall programme cost including community mobilisation. Some NGOs are receiving over a million dollars for VCT programmes. Methods should be developed to determine **cost efficiencies.**

WAY FORWARD

It would be useful to hold a follow up regional consultation next year, which should focus less on how policies were developed (which was useful at this meeting) or emerging experience, and more on **results, challenges in implementation and solutions and lessons learnt.** This meeting could also be linked with ICASA in Abuja next year.

A. <u>Country Actions Needed</u>

1. Immediate actions
   - ❑ Challenged to develop a 100 day plan of action as a follow up to this meeting
   - ❑ Urged to arrange a debriefing with partners to reflect and inform on the meeting's proceedings
   - ❑ Suggested that 10 steps are identified to scale up testing and counselling
   - ❑ Urged to develop an initial 30-day implementation plan

2. In developing HIV policies, urged to
   - ❑ reflect on existing policies and if they are consistent with WHO/UNAIDS guidance
   - ❑ identify the gaps
   - ❑ identify areas which need to be improved

3. Examine HIV policy regarding integration and the multiple entry points

   - ❑ are HIV Testing and Counselling strategies addressing particular vulnerable groups? Reflect further on vulnerable groups viz their integration and the extent to which programs focussed on multiple entry points.
   - ❑ consider the expansion of testing and counselling services and integration with treatment, care and support services
   - ❑ reflect upon the human rights dimensions of public health
   - ❑ reflect on the need for opportunities for innovation
   - ❑ relect on M&E strategies to ensure that experience is noted and considered in future plans
   - ❑ use every opportunity to extend the right to testing and counselling

4. Strike a balance between policy and partnerships

B <u>Regional Actions Needed (WHO, UNAIDS, CDC)</u>

1. Policy dissemination- UNAIDS/WHO Policy Statement on HIV Testing (2004)
   - ❑ decide whether to review the Policy Statement vis a vis the apparent confusion regarding the plethora of terms. In this regard, the WHO/AFRO Regional HIV/AIDS Voluntary Counselling and Testing [VCT] Guidelines should be

updated and finalised to be used to operationalise the Policy Statement, including clarifying the plethora of terms.

- scale up the dissemination of the Policy Statement
- translate the Policy Statement into French, Portuguese, and local languages.
- link the Policy Statement with case studies related to specific topics

2. Programme guidance
    - WHO/AFRO Regional HIV/AIDS Voluntary Counselling and Testing [VCT] Guidelines (draft 2003) incongruent with UNAIDS/WHO Policy on HIV Testing and Counselling (2004) because it is out of date. The Guidelines need to be updated urgently

    - update the WHO AFRO Regional HIV/AIDS Voluntary Counselling and Testing [VCT] Guidelines (draft 2003) to include how should the Policy should be implemented. Include the experiences of countries, such as Botswana, Burkina Faso, Malawi, Lesotho and Rwanda, which have gone through a process of introducing policy changes- what worked and what didn't work. - share experience of policy development

    - integration and ART entry points: human resources issues etc., needs to be reflected in stronger guidance (WHO AFRO 2003 draft) should include:
      vulnerable groups
      human rights
      PMTCT
      children and youth
      HIV in the prison population
      Tuberculosis
      Sexually Transmitted Infections (STIs)

    - strengthen costing and budgeting estimation of resource requirements and how to better engage service providers. WHO and CDC may collaborate to conclude this task

3. Training
    Effective training needs to take place in countries. Suggestions were:
    - specialised training for: policy makers, testing and counselling programme managers or health service managers responsible for the roll out and strengthening of HIV Testing and Counselling programmes

4. Strengthen technical support services for countries developing policies
    Use WHO/AFRO as a clearing house and technical services support hub to/for:
    - ensure that there are accessible databases of experts and advisors; and they have the latest guidance, experience and information
    - costing and budgeting- resource management
    - uniform monitoring and evaluation standards
    - strengthen technical support services for countries that are developing strategies
    - develop strategies on how to mobilise communities

5. Better draw on evolving regional experience, e.g. innovative approaches

6. Explore supplies planning and management

7. Documentation and exchange
    - write and disseminate case studies and innovative experiences

8. Follow up meeting
   - move discussion from plans to actions
   - propose a satellite meeting at the next ICASA in Abuja, or a separate meeting at the end of 2005.

9. Political commitment and leadership
   - use Botswana, Lesotho, Malawi as examples
   - Direct specific agenda on political engagement on testing and counselling

10. Ensure that the available financial resources are channelled towards HIV Testing and Counselling programmes
    - GFATM, PEPFAR, World Bank

11. Meeting Deliverables

Report	December 2004
CD-Rom	December 2004
Websites postings- UNAIDS, WHO, CDC	December 2004
Feedback meeting	End 2005