REPORT

CONSULTATIVE MEETING
ON
HIV TESTING
AND COUNSELLING
IN THE
AFRICA REGION

15 - 17 November 2004
Johannesburg, South Africa
This meeting was co-sponsored and funded by UNAIDS, WHO and the United States Government

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<td>AIDS Information Centre</td>
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<td>AIDS</td>
<td>Acquired immunodeficiency syndrome</td>
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<td>Faith Based Organization</td>
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<td>HBVCT</td>
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<td>M &amp; E</td>
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<td>OI</td>
<td>Opportunistic Infection</td>
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<td>OPD</td>
<td>Out patient department</td>
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<td>PACP</td>
<td>Prison AIDS Control Programme</td>
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<td>PLHIV</td>
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<td>PMTCT</td>
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<td>ROT</td>
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<td>VCT</td>
<td>Voluntary Counselling &amp; Testing</td>
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Foreword

The impact of HIV and AIDS in the Africa region compels us to continually explore approaches to lessen the burden of the disease and work towards scaling up services, especially to those most in need.

The “3 by 5” Initiative to achieve targets towards universal access to treatment is a response to improve the quality of life of people living with HIV and lessen the impact of the pandemic. HIV testing and counselling is recognised as a key approach and a gateway to prevention, treatment, care and support. Promoting the development and operationalising of policies and guidelines that rapidly increase access to HIV testing and counselling must happen now.

This Consultative Meeting on HIV Testing and Counselling in the Africa region provided an opportunity to interrogate and clarify aspects of the UNAIDS/WHO Policy Statement on HIV Testing and Counselling and the WHO Regional Voluntary Counselling and Testing Guidelines. It was also a platform for countries to meet, compare and share experiences around HIV testing and counselling, and reach better understanding and consensus on the meaning and usage of terminology related to HIV/AIDS testing and counselling.

WHO and UNAIDS, in collaboration with the US Centres for Disease Control and Prevention (CDC), brought together government representatives, civil society and people living with HIV from 18 African countries to discuss HIV testing and counselling policies and approaches to improve service delivery. The meeting report highlights countries’ efforts to promote and increase access to HIV testing and counselling.

HIV testing is not only critical to treatment, it is an important prevention intervention and critical to realising the “3 by 5” targets for our region. It is our hope that the information from this meeting continues to build on the foundation to reach our targets for getting people to know their status, through HIV testing and counselling, and gain access to treatment.

Mark Stirling  
Director  
UNAIDS Regional Support Team  
For East and Southern Africa

Dr. Antoine B. Kaboré  
Director  
Division of Prevention and Control of Communicable Diseases, WHO/AFRO
The gap in access to HIV treatment services in the Africa region necessitates urgent and well-coordinated efforts to scale up these services in order to achieve the "3 by 5" treatment target by the end of 2005. The Consultative Meeting on HIV Testing and Counselling in the Africa Region, held in Johannesburg, South Africa in November 2004, and co-sponsored by UNAIDS, WHO and the U.S. Centres for Disease Control and Prevention, focused on what needs to be done, what has been learnt and, what changes need to be made to ensure that the necessary commodities for scaling up HIV testing and counselling services are in place.

The UNAIDS/WHO Policy Statement on HIV Testing and the WHO/AFRO Regional HIV/AIDS Voluntary Counselling and Testing Guidelines were key documents tabled and how these could be applied in countries. Country presentations highlighted ways to operationalize the policy and guidelines and evoked discussion. Participants sought UNAIDS and WHO’s clarification on the four types of HIV testing in the two categories.

From the discussions it became clear that while there is significant scaling up of HIV testing and counselling in a number of countries, service coverage is low. Countries face challenges to scaling up. These include providing treatment to all who have tested HIV positive and meet the criteria for ART; providing ART in limited treatment facilities; and limited implementation capacity to maintain scale up and create high demand for HIV testing. The need to strengthen infrastructure and build capacity for management information systems, logistics and supply chain management, and managing human resource development, particularly workforce shortages further compound these challenges. Participants proposed pragmatic innovative approaches such as task shifting, community education and involvement in T & C, and training, institutional support and partnerships to scale up testing and counselling services.

The Consultative Meeting on HIV Testing and Counselling provided a platform for countries to share experiences on HIV testing and counselling policies, guidelines and challenges to scaling up. Participants endorsed the 3 C's (confidentiality, counselling and informed consent) of HIV testing. A number of actions were suggested as ways in which countries and partners can work together to scale up testing and counselling services. Furthermore, they suggested, that a follow up regional consultation should be held in 2005, which could be linked with the ICASA in Abuja, Nigeria. This consultation should focus on results, challenges in implementation, solutions, and lessons learnt.

"Countries face challenges to scaling up which include providing treatment to all who have tested HIV positive and meet the criteria for ART yet providing ART is hampered by a lack of treatment facilities."
Introduction

Twenty-five million or more than 60% of people living with HIV reside in Sub-Sahara Africa and the majority of people (about 69%) that require antiretroviral therapy (ART) reside in Africa. Currently, 310,000 people are on ART, but this is only 8% of the estimated four million people in need of treatment in Sub-Saharan Africa. The "3 by 5" Initiative, a global effort aimed at treating three million people in developing and transitional countries with ART by the end of 2005 is a first step towards universal access to treatment. Two million of the three million people needing treatment are in Africa.

HIV testing and counselling (T&C) is the gateway to treatment, care and support. However, less than 10% of people in Africa have access to testing and counselling services, while twenty-four countries in sub-Saharan Africa have been designated high burden countries with HIV prevalence rates of up to 38%. Global concern with this state of affairs has led to urgent calls for increased access to testing and counselling services. In October 2003 and May 2004, Global Partnership Meetings were held in Geneva, Switzerland to review strategies for supporting country level efforts to expand access to HIV testing, counselling and treatment. In the East and Southern Africa region, Partners met in Harare, Zimbabwe, in May 2004 to develop a regional strategy for realising the "3 by 5" target. At this meeting, challenges to reaching the treatment targets in Africa were discussed and amongst these was the continuing low level of access to HIV testing and counselling.

The imperative to create a regional agenda for action gave rise to this Consultative Meeting on HIV Testing and Counselling in the Africa Region, which was held in Johannesburg, South Africa in November 2004. The meeting brought together representatives from 18 countries and aimed to develop a common approach to HIV testing and counselling in order to accelerate access to treatment. Meeting participants were stakeholders from government, non-governmental organisations, People Living with HIV (PLHIV), international development partners and the private sector. Country teams shared policy information, rich experience, research and innovative approaches and examples of integrating HIV testing and counselling.

The objectives of the meeting were to:

1. Review UNAIDS/WHO policy and guidelines on HIV testing and counselling
2. Share country experiences in 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. Explore advocacy and communications strategies for increasing uptake of HIV testing and counselling
5. Identify core competencies and innovative approaches for building capacity to scale-up HIV testing and counselling

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2. 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 and Zimbabwe
WELCOME & OPENING REMARKS

Dr Matshidiso Moeti, Regional Adviser for the Programme on AIDS, WHO Africa Regional Office (WHO/AFRO), Dr Okey Nwanyanwu, Country Director for the US Centers for Disease Control and Prevention (CDC), South Africa and Mr Mark Stirling, Director of UNAIDS Regional Support Team for East and Southern Africa made opening remarks.

Dr Moeti welcomed delegates and urged them to focus on the practical approaches needed to embrace both client-initiated Voluntary Counselling and Testing (VCT) and provider-initiated HIV testing. Dr Moeti highlighted the importance of partnerships, sharing and applying lessons learnt, and the need for policy change where necessary to ensure the provision of high quality services. She gave an overview of HIV Testing and Counselling in the Context of the "3 by 5" Initiative. Dr Moeti underscored the centrality of testing and counselling to ART scale up; limitations of the client-initiated HIV testing (VCT); the importance of provider-initiated HIV testing, considering patients’ human rights; and the simplification of testing and counselling approaches.

SUMMARY OF PRESENTATIONS

SUMMARY OF PRESENTATIONS

BY OBJECTIVES

1. Objective 1

UNAIDS/WHO POLICY AND GUIDELINES ON HIV TESTING AND COUNSELLING

Dr Catherine Hankins, UNAIDS Chief Scientific Advisor, gave an overview of the UNAIDS/WHO Policy Statement on HIV Testing. She outlined two approaches to testing — client initiated and provider initiated. Four types of testing were distinguished: Voluntary Counselling and Testing (VCT), Routine Offer of HIV Testing (ROT), diagnostic testing and mandatory testing. All testing is guided by principles of confidentiality, counselling and consent (which includes voluntarism), the 3 Cs.

 Guidelines for client initiated testing include:

- expansion of entry points for VCT in a range of community settings
- simplification & standardisation of T&C
- expanded use of rapid tests
- training lay providers to play a more significant role in T&C
- adoption of new models of VCT focussing on couples, parents, men
- assisting HIV+ with disclosure

Dr Nwanyanwu, called attention to the need for increasing entry points and utilising existing T&C services. Nwanyanwu urged “respect for ethical principles” within the expanded HIV response. “Assurances of human rights and of access to integrated prevention, treatment and care...”

Mr Stirling concluded the opening session with a call to action saying: “We need to leave this meeting appropriating, understanding, and capable of taking forward the [UNAIDS/WHO] policy guidance.”
Guidelines for provider initiated routine testing in health facilities include:

- integration of T&C in TB, STI & antenatal care settings
- integration of T&C in all acute care settings
- integration of T&C in all health care facilities in communities where HIV prevalence is high & ART available
- pre-test counselling, tailored to clinical situation
- informed consent prerequisite for testing
- post test counselling for everyone who tests
- referral of HIV+ for medical & psychosocial supports

Guidelines for diagnostic testing include:

- signs & symptoms consistent with HIV infection
- when assistance with clinical diagnosis & management of patient is needed
- pre-test counselling with the right to decline testing
- referral for post test counselling & if positive, referral for medical & psychosocial supports

Dr. Hankins further clarified that routine testing may be interpreted in different ways by different people and stressed the use of a “routine offer to test”, which makes it clear that the 3Cs are followed. She also reiterated that UNAIDS/WHO do not support mandatory testing, (including testing for immigration or employment) on public health grounds. However, when testing is required for immigration or employment, counselling should be provided for both HIV-positive and HIV-negative individuals and for those who receive a positive test result. Referrals to medical and psychosocial services should also be made.

A routine offer of testing has been adopted in settings as diverse as health facilities in Malawi, and Botswana; tuberculosis clinics in Burkina Faso; and correctional facilities in Uganda and South Africa. ‘Routine Offer Testing’ does recognise the patients’ right to choose by either accepting (opt-in) or declining (opt-out) the offer to test. However it was pointed out that there are different understandings of the term ‘routine test’. Some related to the earlier practice of routinely testing a patient without her/his knowledge and withholding results, e.g. testing for medical reasons to assist in diagnosis. For this reason, the term ‘routine testing’ should be avoided in favour of terms that use the word ‘offer’ such as routine offer, universal offer or systematic offer of HIV testing. Therefore, training on HIV testing and counselling should stress the patient’s right to decide whether or not to be tested.

Many terminologies for describing nuances in testing and counselling have sprung up in the field. These have resulted in a great deal of confusion at the operational level. Terms in this category include:

- Voluntary Counselling and Testing (VCT)
- Routine Testing
- Routine Offer of Testing
- Diagnostic Testing
- Counselling and Testing (C and T)
- Testing and Counselling (T and C)
- Counselling, Testing and Referral (CTR)

Some participants suggested the use of one term, HIV testing, to describe the various categories and types of testing outlined in the UNAIDS/WHO Policy Statement on HIV Testing. All types of HIV testing should be accompanied by pre- and post-test counselling.

Dr Akiiki Bitalabeho, WHO Department of HIV/AIDS, Geneva, emphasised the right of individuals to refuse testing when there is a routine offer to test. She advocated for “normalisation of knowing your status” and use of the rapid test, endorsing the accuracy and simplicity of the test. Dr Bitalabeho said that comprehensive advocacy and communications strategies are essential to scaling up T&C and “substantial training for formal and non-formal health care workers” would be required to make the shift from VCT to health provider initiated T&C.

Focussing on the need to expand entry points for ART, Dr Buhle Ncube, Technical Officer with WHO/AFRO completed the session. Ncube showed how the prevalence of TB/HIV co-infections made TB clinics a natural entry point for HIV T&C and urged the mainstreaming of T&C in TB services. “There is need for urgent implementation of routine offer of T&C as standard of care” and for the “generation of demand for T&C through community education and social mobilisation, for example, through the Right To Know Campaigns.” Targeted outreach to vulnerable populations, she advised, should also complement provider initiated T&C.
DISCUSSION

The ensuing discussion uncovered new models. Each was considered in the light of the UNAIDS/WHO Policy Statement on HIV Testing (2004) to see if it raised concerns about human rights compliance. Examples of new models include:

- home based VCT offered for families of clients who test positive in VCT sites (Uganda, under consideration for Botswana)
- door to door testing offered by lay counsellors in community mobilising programmes (Uganda)
- mobile VCT vans (Uganda and Botswana)
- premarital, pre-cohabiting, married, co-habiting couple testing in which disclosure, communication and cooperation are key areas of focus

• testing of male and female parents in the context of pregnancy
• testing within youth friendly services (Zimbabwe, Malawi)
• routing offer testing at sites like TB clinics (Botswana, Burkina Faso)

It was suggested that the WHO/AFRO Regional HIV/AIDS Voluntary Counselling and Testing Guidelines (draft 2003) be updated and used to operationalise the Policy Statement, possibly with the aid of case studies. Furthermore, regional actions were outlined.

2. Objective 2

COUNTRY EXPERIENCES WITH HIV TESTING AND COUNSELLING

Country experiences focussed on the process of developing a national HIV testing and counselling policy and how these reflected the four types of testing. Malawi, Rwanda and Kenya made presentations on their policies, which were grounded in the 3Cs.

MALAWI

Dr Andrew Agabu, Head of Policy Development and Support, National AIDS Commission shared Malawi’s experience in developing its HIV testing and counselling policy. The policy’s development was characterised as intensely consultative, involving consensus building at the community level, reviews by parliamentary committees and international bodies prior to cabinet approval and adhering to the 3Cs. In addition, there was extensive media discussion and translation of the policy into local languages.

Individuals 13 years and older are allowed to test without the consent of a guardian and couples testing and counselling is promoted. Diagnostic testing is provided within clinical settings. Routine offer testing is practiced in antenatal care settings, including TB and STI settings. There is mandatory testing for blood donors and the uniformed services personnel.

HIV T&C has successfully increased in the public sector from 92,000 in 2002 to 155,000 in 2003; however only an estimated 7% of people living with HIV know their status. TB patients comprise the largest proportion of those who have tested (75%) and males are more likely to have tested than females (70:30) in urban stand-alone VCT sites.

Challenges

The shift from client initiated testing to routine offer T&C in health facilities has been met with resistance from implementing partners. Pregnant women’s right to “opt-out” of testing and the procedural shift to encourage disclosure have also created challenges for health care staff in terms of required skills. Full implementation of some of the new guidelines will require legislative changes.

Furthermore, acceleration of T&C is challenged by insufficient human resources, reallocation of existing health staff and resources to T&C activities, poor health system functioning and other institutional constraints such as:

- limited capacity to procure and distribute test kits
- inability of health system to accommodate increased demand for HIV testing
- uneven access to T&C due to concentration of VCT sites in urban areas

Strategies for Scaling Up

Agabu outlined a human resource development plan for creating full time, dedicated T&C counsellors trained in the use of rapid tests as a strategy for increasing T&C. Strengthening existing T&C sites, as well as creating more entry points through mainstreaming T&C within health services were other strategies presented for scale up.
**RWANDA**

Dr. Maurice Bucagu of the University of Rwanda, School of Public Health presented Rwanda’s experience. Development of the national HIV testing and counselling policy involved broad stakeholder participation (governmental bodies, civil society, private sector, PLHIV). Dissemination of the policy is so far limited to urban centres. Couples counselling is a priority strategy within the overall response. HIV testing has been a part of blood screening since 1985 however VCT was adopted in 1997. Rwanda now has 120 sites, which provided 380,000 tests in 2004. Test sites are integrated in health centres throughout the country and utilisation patterns reflect greater participation of females (78%) and young people 20-30 years old (57%). The National AIDS Commission projects an unmet need for T&C of 40%.

**Challenges** Weaknesses in the health system pose serious challenges to scale up HIV testing and counselling. Lack of resources at the district level, and the concentration of health facilities in urban areas are among these inadequacies.

Other challenges include:

- lack of knowledge on policy and protocols among providers
- weak systems for continuity of care across treatment, care & support
- low level of male involvement
- low level of community awareness
- absence of QA measures for testing functions
- health providers’ lack of skills in HIV counselling & testing
- poor logistics around maintaining supplies for testing & treatment
- stigma & discrimination
- fees for services

**Strategies for Scaling Up** Construction and rehabilitation of health facilities, training to improve performance and attitudes of health providers, outreach to underserved areas and community based T&C were key strategies highlighted for scaling up.

**KENYA**

Dr. Isaiah Tanui, Deputy Director, National AIDS/STD Control Programme, presented Kenya’s experience in developing its HIV T&C policy. He highlighted a process informed by a broad-based multisectoral committee involving academics, PLHIV, laboratory technicians, government, NGOs, and scientists. Subcommittees focused on counselling, site operations, testing, monitoring and data management. The national guidelines for HIV testing considered thorny issues like minimum age for informed consent, partner notification, anonymous vs. confidential testing, who should be trained and whether VCT staff should be tested. However the major debates revolved around types of HIV tests to be used, protocols for confirming HIV status, quality assurance measures and the most contentious of all - whether lay counsellors could/should be trained to perform rapid tests. The HIV testing and counselling policy guidelines were subjected to five drafts before securing approval and ratification in December 2001.

Guidelines for HIV testing of pregnant women and clinical HIV testing in general followed in 2002 and 2004 respectively. Strong leadership and commitment from government contributed to the completion of all guidelines.

Kenya has seen uptake in T&C rise from zero in 2000 to 200,000 in 2003. Four hundred sites administering 350,000 tests were projected for 2004.
Challenges included the lack of dedicated staff, strong divergent viewpoints and the absence of international ‘templates’ for T&C. In fact, Tanui reported that some issues still lack resolution, such as:

- Should HIV testing be anonymous or confidential?
- Should HIV testing be parallel or serial?
- Should HIV test results be entered into patients’ medical records?
- Should the HIV testing be at “point of care” or in the laboratory?
- How to best insure uninterrupted supply and distribution of HIV test kits
- Current emphasis on “social” testing in VCT sites appears to discourage diagnostic testing
- How to link VCT sites to medical care for people who test positive.

Strategies for Scaling Up Uganda has expanded access to T&C through the introduction of routine offer testing and the establishment of test sites in each health district. These are complemented by proactive community-based outreach and most innovative of all, home-based T&C services provided by lay counsellors.

Dr Molotsi Monyamane of the NGO Lifeworks highlighted the process, which contributed to ‘normalising’ knowing your status and created demand that repeat testing occurred. The Prime Minister of Lesotho launched the campaign for universal offer testing. The country has shifted from VCT to T&C and mobilised communities to create new social norms around testing in preparation for the introduction of ART, and built local capacity for T&C. Popular education on testing is conducted by professional HIV counsellors. Individuals electing to test are then provided private, one on one counselling pre and post rapid tests. From March through October 2004, 10,000 tests had been conducted. Monyamane also referred to the ethical dilemma posed by minors requesting HIV tests and highlighted its implication for children's rights.

Dr Hitimana-Lukanika, Executive Director, AIDS Information Centre and Dr Akol Zainab, National Coordinator VCT, Ministry of Health shared Uganda's experience with T&C. VCT was initiated by the AIDS Information Centre (AIC) as a stand-alone service in 1990. Through the MoH and Partners Uganda now has over 370 test sites. Routine offer testing, diagnostic testing and home-based VCT (HB-VCT) provide a full compliment of testing options. AIC estimated 130,000 HIV tests were performed in 2004 and a total of 980,963 tests from 1990 to Sept 2004.

In Uganda, T&C practices preceded the formalisation of policy. Uganda’s policy, guided by the National HIV/AIDS Policy, Strategic Framework for HIV/AIDS and MOH policies, was approved in 2002. The policy is currently under review following developments such as ROT and HB-VCT. The need for management structures to coordinate a continuum of care for PLHIV also motivated policy review.

Challenges For Uganda, challenges to scale up include:

- aligning practice with policy
- coordinating multi-partner response
- establishing guidelines for minors
- expanding capacity to match high demand for T&C
- including private sector in HBVCT
- achieving & maintaining quality in T&C
- improving laboratory functions
- harmonising human rights, with field practices

LESOTHO

Dr Molotsi Monyamane described the Masa Programme, which provides free ART in 25 public health facilities for 28,000 Batswana (as at end of October 2004). Freers outlined the consultative process for mainstreaming testing as a standard of care. As of January 2004, patients attending public health facilities are routinely offered HIV testing and tested unless they “opt out.” Behaviour change communications promoting testing is implemented at the community level throughout the country so that “the offer of routine testing does not require standard pre-test counselling.” Qualified health workers do routine offer testing on site. Over 95% of patients accept routine offer testing. Botswana is now training lay counsellors to offer and perform rapid HIV tests as a part of the effort to scale up T&C in PMTCT programmes.

BOTSWANA

A comprehensive approach to T&C was presented by Ms Mary Grace Alwano, CDC, Professor Jeurgen Freers, a former WHO consultant involved in designing the rollout of routine offer testing, and Dr Ngcongco Ndiki, WHO Botswana. Alwano described the Masa Programme, which provides free ART in 25 public health facilities for 28,000 Batswana (as at end of October 2004). Freers outlined the consultative process for mainstreaming testing as a standard of care. As of January 2004, patients attending public health facilities are routinely offered HIV testing and tested unless they “opt out.” Behaviour change communications promoting testing is implemented at the community level throughout the country so that “the offer of routine testing does not require standard pre-test counselling.” Qualified health workers do routine offer testing on site. Over 95% of patients accept routine offer testing. Botswana is now training lay counsellors to offer and perform rapid HIV tests as a part of the effort to scale up T&C in PMTCT programmes.
Ndiki presented institutional and human resource challenges to routine offer testing and treatment. Some of these challenges, she said, were deliberated in a consultative process that led to the simplification of T&C and the consequent inclusion of a wider range of lay providers in the response.

**BURKINA FASO**

Care Unit Manager for the Ministry of Health, Dr Genevieve Onadja, gave Burkina Faso’s experience integrating routine offer testing in TB care services. Two pilot sites were initiated in 2003, after training 20 counsellors and 20 laboratory assistants for each site. Preparations also included provisions for laboratory supplies, supervision and implementation of quality assurance measures. From a population of 764 TB patients, 339 accepted to be tested and 23% of those tested were HIV positive.

**SWAZILAND**

Ms Beauty Mnisi, VCT Monitoring and Evaluation Adviser, Ministry of Health, described another model for scaling up integrated VCT and care services by providing these services ‘under one roof.’ This model was shown to facilitate the necessary linkages to care services from VCT centres. Before establishment of the VCT and Care centers, people were reluctant to take an HIV test even when referred, Mnisi reported. However, the number of people taking the test has increased. This model, she said, has contributed significantly to reducing stigma of ART and living with HIV. Swaziland, with an estimated 26,000 in need of treatment, aims to have 13,000 on ART by 2005.

**DISCUSSION**

Discussion highlighted:

- The confusion of terms regarding routine testing and routine offer of testing was clarified.
- There were concerns about the need to emphasise child counselling when dealing with children.
- There should be mechanisms to ensure that blood donors know their HIV status and have access to ART if eligible.
- Issues of burn-out among counsellors should be addressed.
- There are advantages of having free ARVs for those who cannot afford to pay.
- The term lay counsellors must be clearly defined. Permitting the use of lay counsellors to carry out rapid HIV tests may require legislation to protect them and:
- encouraging all counsellors and other health personnel to go for VCT is important as this will improve the quality of service they deliver to patients and give them a deeper understanding of the process.
- Routine offer of HIV testing to all patients seen in clinical and community home based care settings where HIV is apparent is needed.
- If clinicians are not offering HIV tests, they are not doing their jobs and are therefore violating the human rights of their patients— who have a right to be provided with appropriate services.
- Youth friendly services are important.

The Marketplace provided further opportunities for countries to present rich experiences with HIV testing and counselling. Additionally, rich feedback was garnered from country participants responses to questions raised by the Mozambique country team (see Appendix 2). Uganda (Dr. Eric Lugada, CDC), Ethiopia (Sara Emru, National HIV/AIDS Prevention & Control Office; Dr. Tekeste Kebede, Executive Director, Family Guidance Association; and Dr. Ermias Mulugeta, General Manager Bethzatha Health Services), Zimbabwe (Ms. Gertrude Ncube, VCT Coordinator, AIDS and TB Programme, MOH), Tanzania (Ms. Zebina Msumi, Focal Person for Home Care/VCT, National AIDS Control Programme) and Burkina Faso (Dr. Jean Francois Some, VCT Manager) made presentations. These presentations (See Appendix 2) showed that policies and guidelines for HIV testing and counselling generally involved broad based consultative development processes, however dissemination of and adherence to guidelines were not always complete. Most countries cited the number of VCT sites in operations; however, coverage, utilisation patterns and calculations of unmet needs for testing were not uniformly provided.

Countries reported a mix of approaches to testing. Health facilities were becoming increasingly involved in initiating testing although routine offer testing was not yet mainstreamed as a standard of care. The presentations suggest that HIV testing remains a stand-alone activity with limited access through antenatal care (PMTCT programmes), or increasingly, through TB care points. New HIV testing technologies like rapid tests and expanded entry points to include work places, traditional healers, schools and other community settings remain peripheral in national responses. Likewise, the use of lay personnel to augment professional health workers in scaling up T&C remains experimental.
In summary, countries developing HIV policies are urged to:

- reflect on consistency between existing policies and WHO/UNAIDS guidance
- identify the gaps in policy framework and/or areas which need to be improved
- harmonise with human rights
- examine policy provisions for maximising entry points for T&C and enable access for vulnerable groups
- consider expansion of T&C services and integration of treatment, care and support services
- integrate provisions for M&E

Policy development should be accompanied by skills development. Participants advocated for specialised training and technical support at country level in the areas of:

1. monitoring and evaluation
2. management and roll out of T&C services
3. strategic planning

2.1 Human Rights & Public Health Considerations

South Africa and Zambia led the review of human rights and public health consideration related to HIV testing and counselling. Mr Mark Heywood, Head of the AIDS Law Project, University of Witwatersrand, described the transition from ‘testing as risk’ to ‘testing as gateway to benefits.’ Heywood urged reliance on evidence-based analysis for avoiding mistakes in the shift and cautioned against “artificial juxtapositions” like human rights vs. public health. He asserted human rights as integral to public health. The discrepancy between HIV testing and access to treatment as well as the potential for slippage from “routine offer” to “routine testing” pose real risks to human rights. Heywood concluded with a plea for “scale up not [to be] about technology [only] but about government obligation to create a human resource base to support the technology.” Failure to do this will lead to serial human rights violations” he said.

Ms Johanna Ngcala of the Treatment Action Campaign (TAC) provided an inside view on the issue. Ngcala identified poor counselling, lack of leadership and poor commitment as factors contributing to the low uptake of VCT. Drawing on her own experience as a PLHIV, she illustrated serious gaps and inconsistencies in the counselling and referrals offered to PLHIV. Ngcala asked for greater attention to standards and for the inclusion of “treatment literacy so that people can have a better understanding of how the virus works and how [they] can manage HIV.” TAC endorses routine offer of testing in both public and private sector institutions as well as efforts to increase entry points for testing beyond VCT sites.

They also advocated the use of WHO/AFRO as a clearing house and technical services support hub for:

- ensuring access to experts and advisors
- updating the field on the latest guidance, experience and information
- costing, budgeting and resource management
- unifying monitoring and evaluation standards
- developing community mobilisation strategies
- sharing regional experience and innovations in the field

Mr Kaumbu Mwondela, chairperson for Zambia AIDS Law Research and Advocacy Network (ZARAN) focused on advocacy efforts in southern Africa to increase access to treatment. He cited lack of confidentiality, insensitivity of health care providers, expensive ART and Zambia’s lack of an HIV policy as factors militating against treatment. Mwondela recommended:

- seminars with parliamentarians
- community training in advocacy
- strengthening structures e.g. Office of the Ombudsman, Human Rights Commission and other professional bodies
- training for judges and police
- Legal Aid Clinic
DISCUSSION

- Discussion focused on reaching illiterate women - who do not present for medical attention until they are very ill - with information and services
- The importance of bringing the media on board was highlighted so that they report accurately and present a balanced view of HIV/AIDS issues
- Participants recognised “not knowing one’s HIV status is no longer an option”
- The importance of fighting stigma and discrimination through community mobilisation activities
- Ensuring that the human right of both HIV negative and HIV positive people are addressed
- The important role of treatment literacy for PLHIV since this has a positive impact on treatment adherence
- The urgent need to educate health workers on AIDS and prioritise them for access to ART

3. Objective 3

CHALLENGES TO PROVIDING AN ENABLING ENVIRONMENT TO ACCELERATE HIV TESTING AND COUNSELLING

Challenges to accelerated HIV testing and counselling are summarised around two core areas for harmonisation and sustainability:

1. strategic principles that form guiding approaches for scale up effort - the “three ones” concept for country-level responses -
   - one HIV/AIDS action framework
   - one national HIV/AIDS coordinating authority
   - one monitoring and evaluation system

2. technical competence and systems capabilities that allow countries to stage efficient scale up efforts

<table>
<thead>
<tr>
<th>CHALLENGES RELATED TO STRATEGIC PRINCIPLES</th>
<th>CHALLENGES RELATED TO TECHNICAL COMPETENCIES AND SYSTEMS CAPABILITIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>differing levels of commitment to scale up</td>
<td>weak &amp; overburdened infrastructure in health sector</td>
</tr>
<tr>
<td>commitment to test not supported by responsibility to treat</td>
<td>poor quality of VCT services</td>
</tr>
<tr>
<td>VCT and ART perceived as vertical programs</td>
<td>inadequate systems for coordinating continuum of care at all levels</td>
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<tr>
<td>concentration of VCT services in urban areas</td>
<td>inadequate resources to expand T&amp;C services</td>
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<tr>
<td>stigma &amp; discrimination prevalent</td>
<td>lack of skills and resources to manage integration of T&amp;C into routine health care</td>
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<tr>
<td>response limited by age restrictions</td>
<td>poor logistics management</td>
</tr>
<tr>
<td>perceived conflict between human rights &amp; public health</td>
<td>insufficient staffing and other resource constraints</td>
</tr>
<tr>
<td>lack of research to inform effective programme designs</td>
<td>insufficient resources to train auxiliary health personnel</td>
</tr>
<tr>
<td></td>
<td>high turnover of trained health workers</td>
</tr>
<tr>
<td></td>
<td>lack of specialised counseling skills for groups like children, elderly family members, people with disabilities, etc.</td>
</tr>
</tbody>
</table>
3.1 Actions to Promote an Enabling Environment

Panelists from the private sector, a traditional healers association, a regional PMTCT programme and government highlighted a range of Actions Countries with Partners Can Undertake to Promote an Enabling Environment for accelerated testing.

Ms Carol O’Brien, Director of Global Business Coalition - Africa Office and Ms Sharon White, of Re-Action! described what the private sector could do to support expanded T&C. Community mobilisation and awareness to ensure uptake through employment based networks, assistance with marketing and distribution, involvement of opinion leaders and capacity building were among the actions outlined. Directing workplace activities towards “readiness for action” in the communities to which workers belong was emphasised, as well as integrating HIV testing and counselling into health services and community networks. Branding and social marketing of health “trends” were other actions the private sector could support to “get people talking and doing things differently”.

Dr James Hartzell, Nelson Mandela School of Medicine and Makhosi Queen Ntuli of the KwaZulu-Natal Traditional Healers Council focussed on the Role of Traditional Healers in Scaling Up Testing and Counselling Services. Traditional Healers (TH) serve large segments of the population and are very skilled at counselling. Healers have strong cultural influence in their communities, are widely respected and listened to by their patients. Anecdotal evidence indicates that many TH have effective treatments for opportunistic infections (OI) and many have been trained to support TB management and control. Research findings of the Medical Research Council indicated that TB patients with TH providing DOT supervision “had far greater compliance than the average population.” “Healers can play a powerful role in prevention counseling [and] it would make sense to combine this role with the ability to test.”

Dr Maurice Adams, Senior Regional Programme Adviser, Elizabeth Glaser Pediatric AIDS Foundation focused on actions for Scaling-Up Testing and Counselling Services in PMTCT. These include:

- routine counseling in a wider number of settings
- broad pre-test education with emphasis on longer-term post-test counseling
- encouraging disclosure & greater male involvement
- integrating T&C services within MOH structures with links to care and treatment
- providing community and peer support for people (and their families) who test HIV+ and HIV

Adams pointed out that there were some good examples of such practice. However, apart from some notable exceptions, even with many dedicated individuals, serious challenges to sustainable scaling up such as fledgling commitment, inadequate capacity and scarce resources within ministries of health remain. Patients’ reluctance to test and/or disclose and well as integrating HIV testing and counselling into health services and community networks. Branding and social marketing of health “trends” were other actions the private sector could support to “get people talking and doing things differently”.

Dr. Velepi Catherine Mtonga, Director, Clinical Care and Diagnostic Services, Zambia Central Board of Health highlighted actions to promote an enabling environment. Zambia has created an enabling environment through:

- clear articulation of policies and guidelines in the national HIV/AIDS strategic framework and intervention plan, with the participation of a rich cross section of partners
- the involvement of the entire health sector and other sectors
- clearly articulated roles for stakeholders with mechanisms for their involvement in development planning as well as implementation

These actions have resulted in:

- HIV/VCT strategies with M&E components generated at district level
- decentralised management of finances
- 261 sites offering VCT with at least 1 site in each district
- Close to 400,000 people tested
However, the coordination of such a broad based partnership and the standardisation of prevention and care messages in training and meaningful integration of traditional healers in the national response remains a challenge.

**DISCUSSION**

- Psychosocial support and male involvement in PMTCT settings are important
- Ways to ensure that men are tested outside the PMTCT setting should be explored
- The role of the private sector should be defined in attending to employees and their families
- Human resource challenges
- Lack of clarity on the age of consent for HIV testing
- Challenges faced in ensuring that girls access VCT services were stressed

### 3.2 Striking A Balance

Presentations on HIV testing in the military, prison and peacekeeping operations explored ways in which T&C can be expanded. 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 includes a routine offer of HIV testing for armed services. The many questions that followed the presentations on prisons suggest that a regional consultation on HIV and Prisons’ will be highly useful.

**Ms Sinead Ryan**, Regional Adviser on AIDS, Security and Humanitarian Response, UNAIDS presented the United Nations Department of Peace Keeping Operations (UNDPKO) testing policy, and emphasized that mandatory testing of peacekeepers is not required by UNDPKO. ‘Fitness to perform duties’ remains the governing criterion for service. VCT is however, strongly encouraged.

**Dr Dhesi Achary**, Military Health Services of South Africa, described Masibambisane, the Department of Defence’s (SADOD) response. Recognising the cost and increased risk of HIV infection within the uniformed forces, SADOD has implemented a comprehensive strategy for prevention and care. The strategy employs:

- behaviour change communications aimed at decreasing risk behaviour and motivating testing
- routine offer HIV testing and
- multidisciplinary approach to management of people living with HIV

Masibambisane has thus succeeded in increasing levels of awareness and knowledge among uniformed personnel, reduced risk behaviours and reduced stigma.

Senior Assistant Commissioner of **Prisons in Uganda, Mary Kaddu** and **Gustav Wilson**, HIV/AIDS Director, **Correctional Services, South Africa** shared experiences around HIV testing in prisons, clarifying their multi-disciplinary approach.

Uganda maintains an inmate population of about 20,000. Staff and their families make up another 15,000. Uganda’s Prison System (UPS) recognised the debilitating impact of AIDS in the early 1990s and established the Prison AIDS Control Programme (PACP) in 1994. PACP aimed to curb the spread of HIV, mitigate the effects and build institutional capacity to respond. Committees of staff and inmates in each of the country’s prisons plan and implement AIDS control activities in their respective units. Education, VCT services and ART are included in the effort. Counsellors are recruited and trained from both staff and the inmate population with over 2,000 inmates trained in the care and management of PLHIV and 20 certified as counsellors. The surrounding communities access educational and VCT services and some have been assisted through programmes formed by ex-prisoners.

Acceptance of VCT services among inmates has exceeded UPS capacity to respond. Forty-eight percent of female inmates and 52.8% of male inmates have been tested. However, uptake among UPS staff, their families and the surrounding communities has been low. Kaddu attributes the high demand for VCT among inmates to:

- more time for structured education, & reflection
- free HIV tests
- access to treatment for OI, nutritional support
- eligibility for antiretroviral therapy if HIV+
- eligibility for early release
- work load reduction if HIV+

Low uptake among prison personnel is attributed to fear of stigma, greater opportunity to access VCT sites outside the workplace and limited access to treatment.

South Africa’s Department of Corrections (DOC) adopted its policy on management of HIV/AIDS in 2002. The DOC
Ms Katie Schwarm and Ms Miriam Mhazo described social marketing as a successful approach for creating demand for VCT. Through branding, PSI not only increased recognition of VCT but also increased understanding about the quality of services. PSI communications strategy aims at changing perceived benefits and barriers to T&C. It thereby responds to prevailing concerns about T&C and challenges the notion that knowledge of status leads to loss of hope.

PSI programmes in Zimbabwe, Zambia, Botswana and other countries have demonstrated that:

- social marketing of T&C can be used successfully to reduce stigma
- social marketing (and mass media) can be used to increase demand for VCT services by focusing on the positive benefits of VCT

Ms Thebisa Chaava, HIV/AIDS Community Capacity Enhancement Specialist, UNDP presented on community conversations on HIV/AIDS, which requires both personal and collective engagement. The main objective of community conversations is to speak in the nuance of the target audience. Some tools include story telling, mapping and analysis of issues and resources, strategic questioning and generative listening and participatory reflection and reviews. Chaava said that most people in communities are not necessarily health professionals, so it is important that community conversations clarify the complex issues and concepts around prevention, care and treatment, such as the difference between cure and treatment. In most local languages these words are more or less the same. Another objective of conversations is to highlight and address the social and cultural factors limiting acceptability,
affordability and accessibility of services; generating and nurturing community preparedness for the uptake and utilisation of VCT, PMTCT and ART services.

DISCUSSION

• There are some difficulties with measuring the impact of communications, in particular when programs don’t have clear communications objectives and defined targets, and there is a need to measure context. Having very clear objectives, conducting national surveys and associating an intervention with measurable change don’t necessarily demonstrate that the intervention caused the impact. A thorough problem analysis, analysis of the recipients and the context would help to confirm measuring of impact.

• In developing universal, core messages for VCT or T&C promotion certain medical principles that are utilised. However, communication is to and with people who are essentially in very different situations and countries, therefore messages should be tailored to the context.

• Promoting testing and counselling in an era of treatment: testing and counselling should be part of the campaign for treatment and treatment literacy.

• Examples were given in Uganda where communities are involved to identify and own their communications programs (CHAI- Community HIV/AIDS Initiatives).

• Most social marketing messages target the general population and communities but targeting health workers should also be considered.

5. Objective 5

CORE COMPETENCIES & INNOVATIVE APPROACHES TO BUILDING CAPACITY FOR EXPANDING HIV TESTING AND COUNSELLING

Theo Mahlangu, Project Manager, Abbott Access Initiatives, outlined Abbott Laboratories commitment to scaling up testing and treatment efforts in Africa. He identified the following areas for consideration in plans for scaling up:

• drug import regulations
• distribution networks
• cold chain
• logistics for managing inventories
• absorptive capacity of ART programmes
• lead times from order to delivery

He stressed that these areas also call attention to the competencies required for expanding T&C.

Dr Ernest Darkor, Operations Manager of Botswana’s National ARV Project Team described the process of integrating T&C into clinical settings. After the roll out of ARVs in public health facilities, the demand for testing escalated beyond the capacity of the health system. Health facilities provided routine T&C using rapid tests or Elisa assays. Referrals to off site T&C centres were used only when there were no test kits available. If an individual tested HIV positive, CD4 count was established and referrals made for treatment.

Core Competencies for integrating T&C in public health services include:

• HIV detection using various assays
• managing logistics for reagents and rapid tests
• pre and post test counselling
• coordinating across prevention, diagnosis, treatment & care services
• developing appropriate & effective IEC

The Approach outlined called for dedicated implementation teams and effective supporting structures. Large scale capacity building across all functional areas management, drugs, laboratory & testing logistics, training, IEC development, community mobilisation, monitoring, evaluation and operational research was also included. This was complemented by intensive IEC and community mobilization campaigns, “splitting the queue for appropriate triage”, i.e. shared management of PLHIV needing treatment between hospitals and community health centres to facilitate continued enrollment of people eligible for treatment. Finally, the approach also included efforts to strengthen and scale up primary and secondary prevention efforts.

Professor Juergen Freers of Mulago Hospital, Uganda outlined Practical Approaches for Integrating T&C into Existing Health Services. Using the service delivery in Mulago Hospital as a case study, he showed that the VCT model with counselling protocols
guided by CDC GAP, UNAIDS and MOH is inappropriate for routine clinical work. A pilot study with 395 medical inpatients revealed that 67% of them did not know their serostatus and only 64% indicated willingness to participate in VCT. In April 2004, provider initiated T&C was piloted in all medical and one obstetric ward as operational research. Outpatients, spouses of patients, staff and students were offered counselling and testing with VCT counselling protocols.

The study showed that provider initiated ROT was acceptable to patients and that T&C in the hospital care was more efficient in identifying & referring undiagnosed individuals than VCT. The study also showed that recording HIV results in patients' files was acceptable to patients and that the involvement of family was possible in health care settings. 903 inpatients were offered ROT and 95% accepted. Of the 862 inpatients tested, (778 medical, 84 obstetric) 56% on the medical side and 31% on the obstetric side tested positive. Ninety-nine percent allowed disclosure of their status to other health care workers and all but one agreed to have this information recorded in their medical file. Only 268 outpatients tested and 51% of these were HIV positive. It was however recognised that confidentiality was compromised by the operating conditions which included an open ward with attendants, patient names on results & referral forms, and medical files accessible to many. The study concluded that:

- existing counseling protocols were inappropriate for a hospital setting with very ill patients
- procedures are too lengthy for the busy hospital environment filled with competing priorities

The study recommended the following approaches for integrating T&C in clinical health care settings:

- instead of pre-test counseling rely on IEC efforts and focus energies on thorough post-test counseling
- ELISA tests should be part of routine laboratory procedures
- rapid tests should be reserved only for OPD and special occasions
- verbal consent should be obtained; however when patient is unable to give consent physician can request test (diagnostic testing)
- HIV test results should be kept confidential as is the case with other medical tests
- HMIS should contain only the most essential information
- all patients requiring further action (particularly ART) should be informed (e.g.- price, adherence) and referred according to patients' preferences or whatever it is best for the condition

Dr Francesca Celleti introduced WHO's simplified guidelines and training focus for Integrated Management of Adolescent and Adult Illness (IMAI). The simplified guidelines set new standards for response within first-level health care facilities. They also describe core competencies for certification of response staff. IMAI includes, training packages for country use in efforts to achieve the "3 by 5" targets. The training modules are written for lay and professional health workers at first-level health facilities. The management of patients near their homes is important for achieving equity in access to care and high levels of ARV adherence. This shift in approach empowers and enhances community response. The training modules cover general principles of good chronic care, acute care and palliative care. Key features of IMAI include:

- facilitation of universal access to T&C
- decentralisation of HIV services, strengthening role of communities in the response
- contribution to addressing the human resources crisis by including PLHIV and lay providers in HIV T&C
- integration of HIV case detection, testing and prevention into clinical care
- expansion and strengthening of routine health services thereby contributing more broadly to disease control
- harmonisation, simplification and standardization of HIV care and treatment response

Beth Dillon of the US CDC outlined several areas for monitoring and evaluation including the status of national policy on testing and counselling, the reach of HIV T&C services, capacity available and the functioning of systems. Monitoring should focus on the match between patterns of infection and patterns of T&C utilisation. WHO/UNAIDS with the US Government are working on a set of draft indicators for Monitoring and Evaluation, which are directed at the national programme level, e.g. Ministry of Health, National AIDS Control Programme. The framework has four indicator domains:

- policy and guidelines
- referral
- coverage & demand
- capacity building

Dillon encouraged the establishment of management information systems for routine data collection on core indicators as well as special studies. There should be sufficient high quality data to support management decisions about service delivery (progress and quality), effectiveness and overall impact. Programmes need to define what information is
needed and how it will be used; negotiating trade offs between quality, quantity and costs of data collection. Guidelines for selection of indicators were offered including the selection of indicators for multiple levels of programming. Monitoring and evaluation of quality was also emphasized and quality assurance markers at each level of oversight encouraged.

DISCUSSION

VCT Referral systems
- Practical experiences to motivate service providers were offered. Motivation in the public health sector is a challenge, which oftentimes would benefit from improved remuneration. Feeding back data to providers so they see the progress of their work- patients getting better-generates a sense of pride and real motivation to do better.
- The demand for rapid tests has increased substantially over the past few years and the demand in Africa is being met.

Some key questions for HIV testing and counselling monitoring and evaluation:
- What is the match between who is being reached and who needs to be reached?
- Who has been left out? the uniformed personnel? couples?
- How to obtain essential information from M&E?
- Establish a management information system
- Conduct routine data collection; core variables- age, sex, urban/rural
- Undertake special studies

WORKING GROUPS

Delegates shared ideas around scaling up new approaches to testing and counseling within four working groups. Each group tackled a specific area of challenge and offered recommendations for progress in scaling up T&C.

Summary of the Working Group Outcomes

WG 1: Practical Approaches for Integrating T&C into Existing Health Services
1. Policymaking should be approached with caution and informed by evidence and allow flexibility to adapt to contextual reality and available options.
2. Stakeholders should continue this dialogue especially with service delivery networks across all disciplines in different countries.
3. Countries should convene national stakeholder forums to thrash through the issues and present evidence [from] this meeting.
4. WHO & UNAIDS should initiate research on what is available and where, and facilitate more exchange or study visits between countries.
5. Build community capacity [to respond effectively and scale up T&C].

WG 2: Ensuring Access to Testing and Counseling for the Most Vulnerable
1. Open dialogue at country & community levels.
2. Address needs of vulnerable groups in guidelines.
3. Ensure strong coordination bodies and systems in countries.
4. Document best practices and conduct operational research into the new approaches.
5. WHO to help countries to implement the new guidelines.

WG 3: Identifying Capacity Building Needs and Appropriate Training Approaches
1. Discuss the implications of task shifting and the quality assurance and control needs of this approach
2. Train nurses to conduct HIV tests.
3. Build competence of all existing staff in T&C.
4. Train youth club members, women associations, teachers, PLHIV, traditional leaders, community leaders, church members and social workers [to provide counselling and testing services].

WG 4: Monitoring and Evaluation
1. Develop practical M&E strategies that can actually be operationalised and achieved in realistic time frames.
2. Develop uniform and standard evaluation and monitoring systems based on workable models that actually exist.
3. Develop national expertise in monitoring and evaluation.
4. Develop both physical and information infrastructures to make these M&E strategies possible.
5. Conduct the necessary surveys and site visits required to systematize and streamline data systems and data structures.
A snapshot of scale up

<table>
<thead>
<tr>
<th>Country</th>
<th>Policy for HIV T&amp;C in place</th>
<th>Number of VCT sites in operation</th>
<th>Diagnostic testing in health facilities</th>
<th>Routine offer of Testing and Counselling integrated in health services (TB, ANC, STI)</th>
<th>ROT as standard of care</th>
<th>Community-based T&amp;C involving 'lay personnel'</th>
<th>Estimated unmet need for VCT</th>
<th>Numbers of people tested in 2003</th>
<th>Numbers of people tested in 2004</th>
<th>Treatment target for 3 X 5 initiative</th>
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<td>Angola</td>
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Y = yes  N = no  P = partial  NA = information not available

* Tebelopele VCT centres only

The table with information provided by participants shows the range of scale up and approaches.
Recommendations

Scaling up HIV Testing and Counselling in the Africa Region

1. Continuing the dialogue on HIV T&C and expanding participation to service delivery networks across all disciplines in different countries.
2. Stakeholder forums to resolve differences between policy, guidelines and practice.
3. WHO & UNAIDS should initiate research on best practices
4. More technical and financial resources should be allotted to building local human and institutional capacity.
5. WHO should continue to clarify communication on WHO guidelines for T&C and IMAI. Support to countries for implementation of new guidelines should also be provided.
6. More support is needed to enhance local understanding of human rights issues and translate these into programme design and implementation practices.
7. Operational research into the new approaches needed to inform strategies for scale up and uncover implications of task shifting on health services.
8. Develop a uniform evaluation and monitoring systems based on actual models that actually function effectively within the contexts of HIV/AIDS responses in the region.
9. Develop skills for effective M&E at national level, including data storage and management capabilities within institutions at each level of response.
10. Involve SADC Health Secretariat in more substantive ways.

Regional Actions Needed

Countries
1. Explore supplies planning and management
2. Prepare and disseminate country case studies and innovative experiences on HIV T&C
3. Use the examples of Botswana, Lesotho and Malawi, which have demonstrated political commitment and leadership on HIV T&C, in lobbying for a stronger agenda on testing and counselling
4. Advocate for the channelling of available financial resources (GFATM, PEPFAR, World Bank) towards HIV testing and counselling programmes

Partners
2. Link policy statement to guidelines with case studies to illustrate specific areas of application
3. Update and finalise the WHO AFRO Regional HIV/AIDS Voluntary Counselling and Testing Guidelines (draft 2003) and use to operationalise the UNAIDS/WHO Policy statement on HIV Testing. Updated guidelines should include guidance on integrating HIV testing and counselling, e.g:
   - ART entry points
   - human resources issues
   - PMTCT
   - prison population
   - sexually transmitted infections
   - Clarification of HIV testing terminology
   - vulnerable groups
   - human rights
   - children and youth
   - tuberculosis

4. Strengthen capacity to budget accurately for implementing/scaling up HIV T&C according to established policy and guidelines.

Areas in Need of Additional Consideration

- Minimum age for informed consent to test and conditions under which minors can consent to test
- Reaching people who are hearing impaired, visually impaired and physically challenged in other ways
- Ways to encourage disclosure while safeguarding HIV+ people who disclose their status from violence and family break-up
# Appendix 1

## Meeting Agenda

### Objectives

**Objective 1**

**To Brief Participants on the UNAIDS/WHO Policies and Guidelines Related to HIV Testing and Counselling**

**Chair**

Dr. Okey Nwanyanwu, Country Director, U.S. Centers for Disease Control and Prevention - South Africa

**Presenters**

- Country Experiences in the Development of HIV Testing and Counselling Policies
  - **Malawi**: Dr. Andrew Agabu, Head of Policy Development and Support, National AIDS Council, Malawi
  - **Rwanda**: Dr. Maurice Bucagu, Academic Registrar/National University of Rwanda, School of Public Health (Member of The CCM/GFATM)

### Programme of Work

<table>
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<tr>
<th>Day</th>
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<td>Dr. Matshidiso Moeti, Regional Adviser, World Health Organisation Africa Regional Office (AFRO)</td>
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<td><strong>Welcome</strong></td>
<td>Objectives and Expected Outcomes by Mr. Mark Stirling, Director, Regional Support Team for Eastern and Southern Africa</td>
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<td><strong>Joint United Nations Programme on HIV/AIDS (UNAIDS) RSTESA</strong></td>
<td>HIV Testing and Counselling in the Context of the 3 by 5 Initiative by Dr. Matshidiso Moeti, Regional Adviser, Programme on AIDS WHO/AFRO</td>
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<td><strong>OBJECTIVE 1</strong></td>
<td>To Brief Participants on the UNAIDS/WHO Policies and Guidelines Related to HIV Testing and Counselling</td>
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<td>Mr. Mark Stirling, Director, UNAIDS RSTESA</td>
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<td><strong>Presenters</strong></td>
<td>UNAIDS/WHO Policies and Guidelines on HIV Testing and Counselling by Dr. Catherine Hankins, Chief Scientific Adviser and Associate Director, Strategic Information, Department of Social Mobilisation and Information, UNAIDS</td>
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<td>Dr. F. Akiki Bitalabeho, Scientist, Treatment Care and Prevention Team, WHO</td>
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<td><strong>Overview of Entry Points to Antiretroviral Therapy</strong> by Dr. Buhle Ncube, VCT Technical Officer, WHO/AFRO, Regional Programme on HIV/AIDS</td>
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<td><strong>Discussion and Break</strong></td>
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<td><strong>OBJECTIVE 2</strong></td>
<td>To Share Countries’ Experience in HIV Testing and Counselling</td>
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<td><strong>Chair</strong></td>
<td>Dr. Karen Heckert, Senior Adviser, USAID</td>
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<td><strong>Panel Discussion</strong></td>
<td>Human Rights and Public Health Considerations in HIV Testing and Counselling</td>
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<td><strong>Facilitator</strong></td>
<td>“The Marketplace of Experience” Country Presentations by Kai Crooks-Chissano, Programme Adviser, UNAIDS Regional Support Team for East and Southern Africa</td>
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<td><strong>Panelists</strong></td>
<td>Increasing Access to Treatment, Influencing Policy and Legal Frameworks: Advocacy efforts in Southern Africa by Mr. Kaumbu Mwondela, Chairperson, Zambia AIDS Law Research and Advocacy Network (ZARAN)</td>
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<td>Human Rights and Legal Considerations of HIV Testing and Counselling by Mr. Mark Heywood, Head, AIDS Law Project, University of the Witwatersrand</td>
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<td>“An Inside View” on the current approach to HIV Testing and Counselling by Ms. Johanna Ngcala, Gauteng Treatment Literacy Coordinator, Treatment Action Campaign</td>
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<td><strong>Discussion and Wrap Up</strong></td>
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OBJECTIVE 3 TO IDENTIFY THE CHALLENGES FACED BY NATIONAL GOVERNMENTS AND CIVIL SOCIETY TO PROVIDE AN ENABLING ENVIRONMENT TO ACCELERATE HIV TESTING AND COUNSELLING

CHAIR
Professor Nkandu Luo, CEO, Luo & Associates (Zambia)

PANEL DISCUSSION: Actions Countries with Partners Can Undertake to Promote an Enabling Environment
Mobilising the Private Sector to Scale-Up Testing and Counselling Services in the Workplace and Community

PANELISTS
Ms Carol O’Brien, Director Global Business Coalition- Africa Office
Ms Sharon White, Director, Re-Action! Consulting

The Role of Traditional Healers in Scaling Up Testing and Counselling Services
Dr James Hartzell, Honorary Lecturer and Coordinator Traditional, Complementary and Alternative Medicine
School of Family and Public Health
Nelson R. Mandela School of Medicine
University of KwaZulu-Natal
Makhosi Queen Ntuli, General Secretary
KwaZulu-Natal Traditional Healers Council

Scaling Up Testing and Counselling Services in PMTCT
Mr Maurice Adams, Senior Regional Program Advisor
Elizabeth Glaser Pediatric AIDS Foundation

Comment
Dr Velepi Catherine Mtonga, Director
Clinical Care and Diagnostic Services, Central Board of Health, Zambia

Discussion
“The Marketplace of Experience” Country Presentations

PRESENTER
Country Experiences in the Development of HIV Testing and Counselling Policies
Kenya Dr Isaiah Tanui, Deputy Director
National AIDS and STD Control Programme (NASCOP)
Ministry of Health

TEA BREAK
PANEL DISCUSSION: “Striking A Balance”

PANELISTS
HIV Testing on the “Front Line”
Ms Sinead Ryan, Regional Advisor

OBJECTIVE 4 TO DISCUSS ADVOCACY AND COMMUNICATION STRATEGIES TO PROMOTE AND INCREASE THE UPTAKE OF HIV TESTING AND COUNSELLING

CHAIR
Dr Jantine Jacobi, Senior Adviser
Country Support for Care and Treatment, UNAIDS

PANELISTS: PANEL DISCUSSION: Using Advocacy and Communications Strategies to Scale Up HIV Testing and Counselling
Designing Effective Communication Strategies to Increase Uptake of Testing and Counselling
Dr Sue Goldstein, Senior Manager
Researchers and Special Projects
Soul City: Institute for Health and Development Communication

Community Capacity Enhancement through Community Conversations
Ms Thebisa H. Chaava
HIV/AIDS Community Capacity Enhancement Specialist, UNDP - RSA - SEA

VCT Social Marketing and Communications
Ms Katie Schwarm, Director
Population Services International

VCT Social Marketing Service Delivery Models
Ms Miriam Nhazo, Program Manager, PSI

Discussion

TEA BREAK
“The Marketplace of Experience” Country Presentations
DAY 3  17 November 2004

OBJECTIVE 5  TO IDENTIFY THE CHALLENGES FACED BY NATIONAL GOVERNMENTS AND CIVIL SOCIETY TO PROVIDE AN ENABLING ENVIRONMENT TO ACCELERATE HIV TESTING AND COUNSELLING

CHAIR  Dr George Ki-Zerbo, WHO AFRO

PRESENTERS

Ensuring a Sustainable Supply of Products and Distribution Networks
Mr Theo Mahlangu, Project Manager
Access Programme, Abbot Laboratories

Integrating Testing and Counselling into Clinical Settings- Routine Offer and Diagnostic Testing
Dr Ernest Darkor, Director, National ART Program Botswana

Provider-Initiated HIV Counselling and Testing within Tuberculosis Clinics
Ms. Beth Dillon, US CDC, Global AIDS Program

Practical Approaches for Integrating HIV Testing & Counselling into Existing Health Services
Professor Juergen Freers
Makerere University- Kampala, Uganda

Identification of Capacity Building Needs and Appropriate Training Approaches
Dr Francesca Celletti
Treatment, Prevention & Scale-up Team, WHO

Discussion

TEA BREAK

PRESENTER

Monitoring and Evaluation of Testing and Counselling
Ms Beth Dillon
U.S. Centers for Disease Control and Prevention

LUNCH

Introduction to Group Work:
Scaling-Up New Approaches to Testing and Counselling

Dr Melanie Duckworth
Public Health Advisor, GAP- CDC South Africa

Group 1  Practical Approaches for Integrating HIV T & C into Existing Health Services
Professor Juergen Freers, Facilitator

Group 2  Ensuring Access to Testing and Counselling for the Most Vulnerable
Ms Jackie Sallett, Facilitator

Group 3  Identifying Capacity Building Needs and

Appropriate Training Approaches
Dr Francesca Celletti, Facilitator

Monitoring and Evaluation for Counselling and Testing
Professor Nkandu Luo, Facilitator

Plenary
Presentations of group work and Discussion

Summary of Proceedings and Way Forward
WHO, UNAIDS
## List of Participants

<table>
<thead>
<tr>
<th>COUNTRY</th>
<th>PARTICIPANT</th>
<th>POSITION</th>
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<tr>
<td>Angola</td>
<td>Ms Sonia Furtado</td>
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<td>Tel: +24492426642</td>
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<tr>
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<td>Ms Mary Grace Alwano</td>
<td>VCT Technical Advisor-CDC</td>
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<td>Burkina Faso</td>
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<td>Care Unit Manager - Ministry of Health</td>
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<tr>
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<td>Mobile:(243) 81 700 6686 (e):<a href="mailto:motingia@ecdc.org">motingia@ecdc.org</a></td>
</tr>
<tr>
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<td>Head-Care and Support Unit-National AIDS Programme</td>
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<tr>
<td>Ethiopia</td>
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<td>Executive Director-Family Guidance Association of Ethiopia</td>
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<td>National HIV/AIDS Prevention &amp; Control Office</td>
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<tr>
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<td>Dr Isaiah Tanui</td>
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<th>TITLE</th>
<th>CONTACT DETAILS</th>
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</table>
Appendix 3

Presentations (on CD-Rom)

DAY 1

• HIV Testing and Counselling in the Context of the "3 by 5" Initiative
  Dr Matshidiso Moeti, Regional Adviser, WHO/AFRO

• UNAIDS/WHO Policies and Guidelines on HIV Testing and Counselling
  Dr Catherine Hankins, Chief Scientific Adviser, UNAIDS

• UNAIDS/WHO Policies and Guidelines on HIV Testing and Counselling
  Dr Akiki Bitalabeho, Treatment, Care & Prevention Team, WHO

• Entry Points to Antiretroviral Therapy (ART)
  Dr Buhle Ncube, VCT Technical Officer, WHO/AFRO

• Malawi’s Experience with HIV Testing and Counselling
  Dr Andrew Agabu, National AIDS Council, Malawi

• Rwanda’s Experience in Developing Testing and Counselling Policy
  Dr Maurice Bucagu, University of Rwanda, School of Public Health, Rwanda

• Uganda’s Experience in HIV Testing and Counselling
  Dr. Hitimana Lukanka, AIDS Information Centre, Uganda

• Lesotho Universal Testing
  Dr Motosi Monyamane, Lifeworks Lesotho

• Human Rights and Legal Considerations for HIV Testing & Counselling
  Mark Heywood, AIDS Law Project, South Africa

• VCT Linkages to Care and Treatment: Kingdom of Swaziland Experience
  Beauty Mnisi, Ministry of Health, Swaziland

• Mobilising the Private Sector to Scale-Up Testing and Counselling Services in the Workplace and Community
  Ms Carol O’Brien, Global Business Coalition- Africa Office and Ms Sharon White, Re-Action! Consulting South Africa*

• Role of Traditional Healers in Scaling Up Testing and Counselling
  Makhosi Queen Ntuli and Dr James Hartzell, South Africa

• Scaling Up Testing & Counselling Services in PMTCT
  Dr Maurice Adams, Elizabeth Glaser Pediatric AIDS Foundation

• Striking a Balance: HIV Testing on the Front Line
  Ms Sinead Ryan, UNAIDS

• HIV Testing in the South African Department of Defence
  Dr Dhesi Achary, Military Health Services, South Africa

• Issues and Experience Around HIV Counselling and Testing in Uganda Prison System
  Ms Mary Kaddu, Sr. Assistant Commissioner of Prisons, Uganda

• Experiences Around HIV Testing in Correctional Centres in South Africa
  Mr Gustav Wilson, Correctional Services, South Africa

• Developing a Communications Strategy for VCT
  Dr Susan Goldstein, Soul City, South Africa

• Community Capacity Enhancement through Community Conversations
  Ms Thebisa H Chaava, HIV/AIDS Community Capacity Enhancement Specialist

• UNAIDS/WHO Policies and Guidelines on HIV Testing and Counselling
  Ms Remark Mhazo, PSI Zimbabwe

DAY 3

• Ensuring Sustained Supply of Products and Networks
  Mr Theo Mahlangu, Abbott Access Initiatives

• Integrating Testing and Counselling into Clinical Settings: Routine Offer and Diagnostic Testing
  Dr. Ernest Darkoh, Ministry of Health, Botswana

• Provider Initiated HIV Counselling and Testing Services within Tuberculosis Clinics
  Ms Beth Dillon, CDC-GAP

• Practical Approaches for Integrating HIV Testing & Counselling into Existing Health Care Service
  Professor Juergen Freers, Mulago Hospital, Uganda

• Identification of Capacity Building Needs and Appropriate Training Approaches
  Dr Francesca Celletti, WHO

• Monitoring HIV Counselling & Testing
  Ms Beth Dillon, CDC-GAP

MARKET PLACE PRESENTATIONS

• HIV and Rapid Testing in Nyanza Province
  Dr Josiah Akoth, Kenya

• Development of National Policies and Guidelines for HIV Testing and Counselling in Kenya
  Dr Isaiah Tanui, Ministry of Health, Kenya

• HIV Counselling and Testing in Tanzania
  Ms Zebina Msumi, Ministry of Health, Tanzania

• The Next Frontier on HIV Testing & Counselling
  Dr Eric Lugada, CDC Uganda

• Zimbabwe’s Experience in Counselling and Testing
  Ms Gertrude Ncube, MOHCD, Zimbabwe

• Questions for Participants
  Responses compiled by Dr Irene Benech, CDC Mozambique
# Evaluation of Meeting

<table>
<thead>
<tr>
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<td>Opening Session</td>
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<td>UNAIDS/WHO Policies and Guidelines on HIV Testing and Counselling</td>
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<td>Entry Points to Antiretroviral Therapy (ART)</td>
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<td>Country Experiences in the Development of Testing and Counselling Policies</td>
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<td>Key Components of the UNAIDS/WHO Policy Statement on HIV Testing</td>
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<td>PANEL: Human Rights and Public Health Considerations in HIV Testing &amp; Counselling</td>
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<td>PANEL: Mobilising Partners to Support Rapid Scaling-up of Treatment &amp; Prevention</td>
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<td>PANEL: Striking a Balance</td>
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<td>Integrating Testing and Counselling into Clinical Settings</td>
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<td>Integrating Testing and Counselling into TB Settings</td>
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<td>Practical Approaches for Integrating T &amp; C into Existing Health Services</td>
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<td>Identification of Capacity Building Needs and Appropriate Training Approaches</td>
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<td>Monitoring and Evaluation of Testing and Counselling</td>
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**EVALUATION OF FACILITIES, ORGANISATION & ADMINISTRATIVE SUPPORTS**

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<td>Marketplace</td>
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<td>Methodology</td>
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<td>UNAIDS Secretariat Support</td>
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<tr>
<td>Overall Administrative Support</td>
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N = 55
Respondents felt that time allocated to the overall meeting, its opening activities, meals and breaks were adequate; however 69% respondents felt that there was insufficient time allotted for plenary sessions and 53% felt the market place activity needed more time assigned.

Positive Aspects of the Meeting
All respondents found at least one aspect of the meeting positively noteworthy. This list is topped by the sharing of country experiences, the “excellent quality of expert presentations” and the “richness of the panel discussions.” The meeting was felt to have created a “great environment for the debate and cross fertilisation of ideas” that moved participants to think beyond the “orthodoxy” or “dogma” of HIV testing and inspired urgent action. Other positive aspects of the meeting mentioned included:

- leadership & management
- group work
- consultative approach to testing guidelines
- details on types of testing
- supportive materials
- focus on uniformed services
- identification of new entry points for T&C
- clarification of new terms
- diverse mix of attendees

Sixty-eight percent of respondents felt that the meeting “met their objective” however 32% felt that there were important issues ‘left hanging,’ like monitoring and evaluation, or that the way forward was not clear. These respondents expressed dissatisfaction with the ‘lack of interaction’ and insufficient time to ‘discuss and share.’ The programme was “too packed” for many who reported “feeling like we were run through the mill.”

Areas for Improvement
The allocation and management of time headed the list of areas respondents felt could be improved. Many felt that there was insufficient time for presentations, group work and interactions. Other areas included:

- provision of more examples & practical advice
- more defined scope on market place presentations
- panel discussions

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<th>Technical Issues</th>
<th>Structural &amp; Systems Issues</th>
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<td>orientation for staff &amp; policy makers on new trends</td>
<td>review, update and expansion of existing policies</td>
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<td>human rights</td>
<td>curriculum to guide training of T&amp;C providers at various levels</td>
<td>guidelines &amp; protocols for various types of testing</td>
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<td>rights of PLHIV</td>
<td>innovative approaches to expanding T&amp;C services</td>
<td>upgrading of facilities</td>
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<tr>
<td>guiding approaches to T&amp;C</td>
<td>practical steps towards making the shift a reality modalities for multisectoral integration of T&amp;C</td>
<td>support from MOH</td>
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Participants offered many suggestions for future meetings. These included:

- practical advice on how to operationalise routine T&C
- community aspects of T&C
- counselling the elderly as primary care providers and children
- monitoring & evaluation
- guidelines and protocols for T&C
- integration of VCT in labour unions, private sector
- involvement of PLWHA in T&C
- preventive aspects of T&C
- mandatory testing
- sustainability of ART
- quality assurance mechanisms for T&C
- human rights
- transitioning health workers from VCT to ART
- implementation issues within overstretched health systems
- counselling strategies in the absence of ART
- impact of T&C on health service provision
- couples T&C
- training different categories of T&C providers
- progress & impact assessments
- development of referral systems
- integration of VCT in secondary schools & universities
- issues in disclosure & confidentiality
- integration of T&C into SRH services
- management of VCT sites
- supplies/logistics management
- strategies for scaling-up among youth & at community level
- rights of PLWHA, especially children
- how to move forward full scale with national screening
- scaling-up T&C among health workers themselves
- cost effectiveness of various types of testing