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HIV/AIDS RESEARCH UNIT

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THE DEVELOPMENT OF HARMONIZED MINIMUM STANDARDS FOR GUIDANCE ON HIV TESTING AND COUNSELLING (HTC) IN THE SADC REGION

Assessment Report on HTC Policy Reviews



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Prepared by:
Directorate for Social and Human Development and Special Programs
SADC Secretariat
Private Bag 0095
Gaborone
Botswana

G. Sedawe
N. Mabin
J. Seeger
K. Pelber

TABLE OF CONTENTS

ABBREVIATIONS	2
EXECUTIVE SUMMARY	5
1. INTRODUCTION	7
1.1. Why the need for an assessment of HIV and AIDS in the SADC region.....	7
1.2. Rationale.....	8
1.3. Report structure	8
2. OVERVIEW OF HIV AND HTC IN THE SADC REGION.....	9
2.1. Overview of HIV and AIDS in SADC	9
2.2. Multiple epidemics	10
2.3. Key drivers of the HIV epidemic in SADC	12
2.4. Impact of the epidemic on SADC	13
2.5. Overview of HIV Testing and Counseling	14
2.5.1. Importance of HIV Testing and Counseling in HIV prevention and treatment.....	14
2.5.2. Impact of VCT on behaviour change.....	16
2.5.3. Reasons for the poor uptake of HTC	17
2.5.4. Policy, legal and social issues of HTC	17
3. METHODOLOGY	19
3.1. Process for reviewing HTC policies and programmes	19
3.2. Identifying HTC good and best practices in SADC	19
4. FINDINGS: ASSESSMENT OF HTC IN SADC	21
4.1. Approaches to HIV testing and counseling in SADC	21
4.1.1. Voluntary counseling and testing (VCT).....	21
4.1.2. Provider-initiated HIV testing and counseling (PITC).....	22
4.2. Availability of HTC policies, protocols and guidelines	23
4.3. Accessibility of HTC Services	24
4.4. Quality assurance issues	24
4.4.1. Accreditation of staff and facilities.....	25
4.4.2. Standard operating procedures.....	27
4.5. Monitoring and Evaluation (M&E)	28
5. DISCUSSION.....	29
5.1. Opportunities for HTC	29
5.2. Challenges in implementing HTC services	30
5.3. HTC policy issues in SADC Member States	31
REFERENCES	34
APPENDICES AND CASE STUDIES	
Appendix 1: HIV prevalence estimates in SADC	37
Appendix 2: Availability of HTC policies, protocols and guidelines in SADC Member States	37
Appendix 3: HTC implementation needs in SADC Member States.....	38
Appendix 4: HTC implementation challenges in SADC Member States	39
Case study 1: Botswana's Routine HIV Testing (RHT) programme as a best practice HTC intervention.....	41
Case study 2: Know Your Status Campaign in Lesotho as a best practice HTC intervention.....	43
Case study 3: UNAIDS good practice VCT projects in SADC.....	46

ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
AfDB	African Development Bank
BAIS	Botswana AIDS Impact Survey
BCC	Behaviour Change Communication
CBO	Community Based Organisation
DART	Demonstration of Antiretroviral Therapy
FBO	Faith Based Organisation
HTC	HIV Testing and Counselling
HIV	Human Immunodeficiency Virus
HSRC	Human Sciences Research Council
IDU	Injecting Drug User
IPT	Isoniazid Prophylaxis Therapy
KCTT	Kara Counselling and Training Trust
KYS	Know Your Status
MARP	Most-At-Risk Population
M&E	Monitoring and Evaluation
MS	Member State
MSM	Men who have Sex with Men
NAC	National AIDS Council
NDP	Ndola Demonstration Project
NGO	Non Governmental Organisation
OI	Opportunistic Infection
PC	Primary Counsellor
PFP	Project Focal Person
PITC	Provider Initiated Counselling and Testing
PLWHA	People Living with HIV and AIDS
PMTCT	Prevention of Mother to Child Transmission (of HIV)
QA	Quality Assurance
RHT	Routine HIV Testing
RISDP	Regional Indicative Strategic Development Plan
SADC	Southern African Development Community
SAHARA	Social Aspects of HIV/AIDS Research Alliance
STI	Sexually Transmitted Infections
TAC	Technical AIDS Committee
TB	Tuberculosis
UN	United Nations
UNAIDS	United Nations Joint Programme on AIDS
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation
ZAPSO	Zimbabwe AIDS Prevention and Support Organisation

GLOSSARY OF TERMS

Confidentiality	Right of every person to have their medical information, including HIV status, kept private
Counselling	A confidential dialogue between a client and a trained counsellor aimed at enabling the client to cope with stress and take personal decisions related to HIV/AIDS. Counselling may be provided by a professional or a lay counselor.
ELISA test	Enzyme Linked Immuno-Sorbent Assay is the test used to identify the presence or absence of HIV antibodies
Epidemic	A sudden unusual increase in cases that exceeds the number expected on the basis of experience.
Endemic	Usually prevalent; persistent at relatively constant levels
Concentrated epidemic	An HIV epidemic in a Member State in which 5% or more of individuals in groups with high-risk behavior, but less than 5% of women attending urban antenatal clinics, are infected.
Generalized epidemic	An HIV epidemic in a Member State in which 5% or more of women attending urban antenatal clinics are infected; infection rates among individuals in groups with high-risk behavior are also likely to exceed 5% in Member States with a generalized HIV epidemic.
High risk behaviour	Unprotected sexual intercourse (i.e., without a condom) with many partners, or sharing of unsterilized injecting equipment.
Hyper-endemic	A situation where 15% or more adults aged 15 years and older are living with HIV.
Incidence of HIV	The number of new cases of HIV in a given time period, often expressed as a percentage for a given number of the susceptible population
Pretest counseling	Counselling given to an individual before an HIV test, to make sure that the individual has sufficient information to make an informed decision about having an HIV test.
Post-test counseling	The counselling provided when an individual receives his or her HIV test result. Post-test counselling involves one or more sessions
Policy	Written document that aims at setting out a Member State's position and practices on HIV/AIDS
HIV Testing	The obtaining of a bodily sample for the specific purpose of performing a medical test or a number of medical tests to determine the HIV status of a person.
Trained HIV counsellor	A person trained in HIV counselling skills, preferably on a course which meets accepted standards.
Window period	The incubation period between infection and detection of HIV

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- WHO, UNFPA, UNICEF, UNAIDS and other HTC experts who shared their expertise at the inception and consultative meetings in Gaborone and Victoria Falls and for reviewing the draft standards.

We wish to express our gratitude to representatives of Member States and related stakeholders who contributed immensely to the development and refinement of this report during the inception meeting in Gaborone in December 2008 and the consultative workshop held in Victoria Falls in May 2009.

EXECUTIVE SUMMARY

Introduction: Southern Africa is the epicentre of the HIV and AIDS epidemic and has accounted for almost one-third (32%) of all new HIV infections and AIDS deaths globally in 2007, with national adult HIV prevalence exceeding 15% in seven Member States in 2007. Among the interventions which play a pivotal role both in treatment and prevention, HIV testing and counseling (HTC) stands out as paramount, and has become increasingly important in national and regional prevention and care efforts.

Purpose: An assessment of HIV and AIDS in the SADC region was necessary to develop an understanding of the situation in the region and to inform the development and implementation of harmonized minimum standards for HTC. This assessment report reviewed approaches to HTC used by SADC Member States. It also reviewed the availability of HTC policies, protocols and guidelines; accessibility of HTC services; and quality assurance issues related to the provision of HIV testing and counseling services.

Methods: The process of reviewing HTC policies and programmes was coordinated by the SADC Secretariat in collaboration with SADC Member States and international cooperating partners, and involved:

- a review of regional, continental, and global literature on HTC practices and emerging issues;
- a review and analysis of HTC policies, protocols and guidelines of the SADC Member States;
- development of an inception report outlining the major issues from the literature and the initial assessment of documents from Member States;
- field assessments and policy discussions with major stakeholders in the Member States to identify major achievements, challenges and best practices that would inform the development of the regional minimum standards on HTC and PMTCT;
- a consensus-building workshop where all stakeholders reviewed the proposed regional minimum standards, endorsed and adopted them.

Findings: All but one SADC Member State said they have approved national HTC policies and guidelines. The policies were approved between 2001 and 2009. Reports from SADC Member States show that HTC programmes are expanding in the region. Most Member States are offering HTC services at all public health facilities, and multiple approaches to HTC are being used in the region. These include provider-initiated testing and counselling (PITC) or routine HIV testing (RHT); voluntary counselling and testing (VCT); and, in selected cases, mandatory testing (e.g. for the armed forces).

Generally, the common features of HTC service delivery in the SADC Member States include: pre- and post-test counselling; voluntary nature of services; confidentiality is recognized as essential, although disclosure of HIV status to partners and family is promoted; services are anonymous; counselling sessions are tailored to the individual or couple attending; and continuity of counselling is emphasized.

Most Member States do not have functional and effective monitoring and evaluation (M&E) systems specifically for HTC services. However, most Member States have adapted M&E frameworks developed for other HIV and AIDS services to monitor and evaluate HTC services.

Recommendations for best and good practices: Using the SADC framework for developing and sharing best practices on HIV/AIDS (2006), two best practices have been identified. These are Botswana's policy of routine HIV testing (RHT) and Lesotho's "Know Your Status" (KYS) campaign. The same framework was used to identify five good practice HTC interventions. These projects include the Demonstration of Antiretroviral Therapy (DART) project in Soweto, South Africa; the Ndola Demonstration Project in Zambia; the TB/HIV Pilot Project in the Western Cape, South Africa; the Kara Counseling and Training Trust (KCTT) in Lusaka and Choma, Zambia; and the Zimbabwe AIDS Prevention and Support Organisation (ZAPSO) in Harare and Chitungwiza.

1. INTRODUCTION

1.1. Why the need for an assessment of HIV and AIDS in the SADC region

The Southern Africa Development Community (SADC) is home to about 199 million people and comprises 15 Member States: Angola, Botswana, Democratic Republic of Congo, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland, Tanzania, Zambia and Zimbabwe.

SADC has the ultimate aim of regional integration, with a high degree of harmonization and coordination and free movement of goods and people across the region. SADC also aims to pool resources to achieve self-reliance amongst the Member States, and it seeks to improve the living standards of people. However, HIV and AIDS is one of the obstacles to the achievement of this objective, and it continues to threaten all aspects of health and development.

One of the main milestones of regional integration was achieved with the signing of the SADC Free Trade Agreement (FTA). The FTA will create a larger market and release the potential for trade, economic growth and employment creation. On the other hand, the FTA may result in increased movement of people, which has implications for the spread of communicable diseases, including HIV. It is thus necessary to put in place mechanisms to counter the potential negative impacts of increased movements of people across the region.

SADC Heads of State or Governments and Ministers of Health have made commitments to fight HIV and AIDS through a number of regional, continental and global declarations, including:

The *Maseru Declaration* (2003) on HIV that prioritized prevention and social mobilization among other regional priorities for the SADC region.

The *Maputo Declaration* (2005) by African Ministers of Health that proposes that efforts should be made to strengthen the national responses to accelerate HIV prevention.

Brazzaville Commitment (2006) called on countries to scale up efforts towards universal access to HIV prevention, treatment, care and support by 2010.

Abuja Declaration (2001 and 2006) resolved to consolidate the foundations for HIV prevention and control.

The Political Declaration of the United Nations General Assembly High Level Meeting on HIV/AIDS (2001 and 2006), which specifies targets for prevention.

The regional health agenda is articulated by the Protocol on Health. Implementation of HIV- and AIDS- related activities are led by the Maseru Declaration and are operationalised through the SADC Protocol on Health, HIV and AIDS Strategic Framework and Business Plan (2005-2009). The Business Plan identifies key intervention and priority areas, activities and performance indicators. Among the priorities of the Business Plan is policy development and harmonisation.

Spurred by the above commitments, SADC Member States have developed policies, guidelines and protocols to address different aspects of the HIV and AIDS epidemic. Harmonization of the

regional policies and strategies is, therefore, among the major priorities of the SADC region. The SADC Protocol on Health is legally binding and has placed the response to communicable diseases, including HIV and AIDS, among its priorities.

Article 10 of the Protocol calls for the harmonization of policies for prevention and control of HIV infection. The article further calls for the implementation of approaches to HIV and AIDS in a coherent, comparable, harmonized and standardized manner. A policy agenda to develop regional minimum standards as a framework for harmonisation of approaches to HTC, therefore, goes a long way towards operationalising the Maseru Declaration, and responding to the Protocol.

An assessment of HIV and AIDS in the SADC region was necessary to develop an understanding of the situation in the region and to inform the development and implementation of harmonized minimum standards for HIV testing and counseling (HTC).

1.2. Rationale

The aim of this project was to develop regional harmonized minimum standards for policies, protocols and guidelines for HTC in the SADC region as a framework for the harmonisation of regional approaches. This was in keeping with the spirit of the SADC protocol.

The interconnectedness of the people of the region and the commonality of the challenges necessitates a common regional approach, notwithstanding the major variations in the nature of the epidemic in different member states. An important area of focus, therefore, is the creation of unified policy and standards for HTC. Specifically, this assessment report seeks to identify the situation of HIV counseling and testing in the SADC Member States in order to delineate similarities and differences, challenges, achievements and good practices that will inform the harmonization of policies and guidelines.

1.3. Report structure

Section 1: Introduction and description of the need for an assessment of HIV and AIDS in SADC.

Section 2: Broad overview of HIV in the SADC region, key drivers of the epidemic, its impacts and national responses. This section also focuses on the importance of HTC in HIV prevention and treatment.

Section 3: Methodologies used for conducting the assessments in Member States, and criteria for identifying good or best practice HTC interventions.

Section 4: Results of the assessments and policy discussions conducted in Member States. These focus on: approaches to HTC; availability of HTC policies, protocols and guidelines in Member States; accessibility of HTC services; quality assurance issues; and issues related to monitoring and evaluation.

Section 5: Discussion of strengths, weaknesses, opportunities and threats to viable HTC in SADC.

2. OVERVIEW OF HIV AND HTC IN THE SADC REGION

2.1. Overview of HIV and AIDS in SADC

There were an estimated 33.2 million people living with HIV in 2007 globally¹. SADC is the region most affected with HIV and AIDS in the world. The combined population of the SADC Member States is about 4% of the world population, yet the region accounted for more than 37% of all people living with HIV and AIDS (PLWHA). It is estimated that between 11.7 and 18.8 million people in the region are currently living with HIV².

According to the SADC AIDS epidemic update (2007), the scale and trends of the epidemics in the SADC region vary considerably, with Member States in southern Africa forming the epicentre of the global pandemic. This sub-region accounted for almost one-third (32%) of all new HIV infections and AIDS deaths globally in 2007, with national adult HIV prevalence exceeding 15% in seven Member States in 2007. About three Member States have HIV prevalence rates for adults aged 15-49 exceeding 30%, while other three have prevalence rates below 6%.

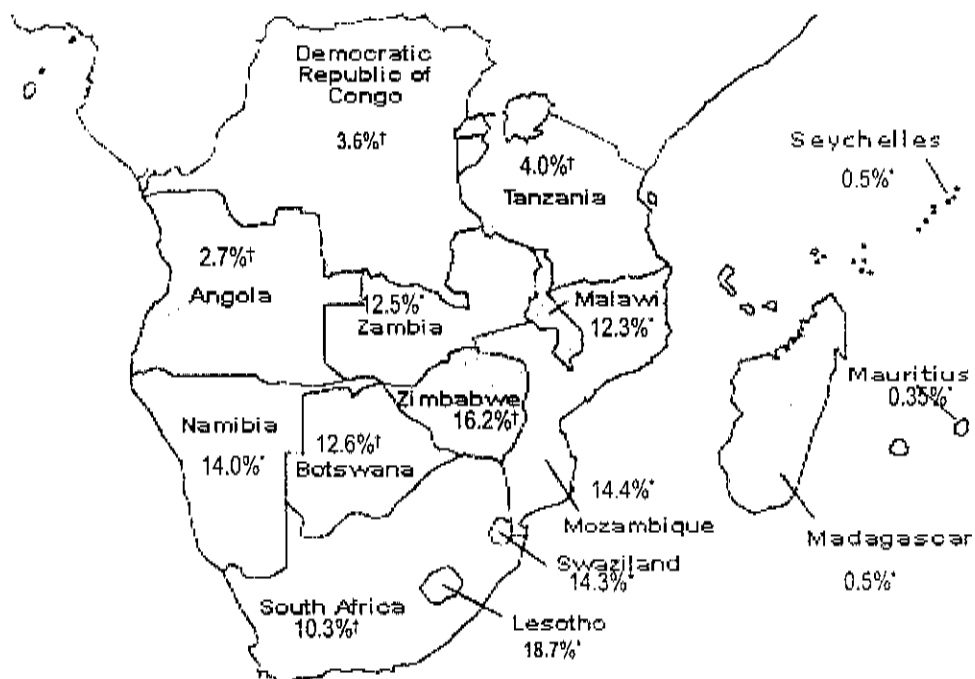
Based on sentinel surveillance data and national population-based survey data in the SADC region, the HIV prevalence rates among young adults aged 15-24 years in 2007 ranged from 0.35% to 18.7% (see Figure 1 below). This shows that SADC Member States are at very different levels in terms of the burden of the disease on this population sub-group. Figure 1 also shows some parts of the region where more than 1 in every 10 persons aged 15-24 years are living with HIV and AIDS. Most of those infected will naturally progress to AIDS, and will require treatment for the rest of their lives, thereby contributing to a heavy burden on the Member States and the region as a whole. Island states such as Mauritius, Madagascar and Seychelles have low-level epidemics with HIV prevalence rates of less than 1%, while Member States such as Angola, DRC and Tanzania have generalized epidemics with moderate HIV prevalence rates (2.7% and 4%). Most of the Member States in southern Africa such as Swaziland, Botswana, Lesotho, Zimbabwe, Namibia, Mozambique, Malawi, Zambia and South Africa have hyper-endemic HIV situations with national prevalence rates of 10% or more³.

¹ UNAIDS. Global AIDS epidemic 2008

² UNAIDS. Global AIDS epidemic 2008

³ SADC AIDS Epidemic Update, 2007

Figure 1: HIV prevalence among 15-24 year-olds in the SADC region as at December 2007



Source: SADC Epidemic Update. HIV and AIDS reports from Member States, 2007

*Estimates based on sentinel surveillance data. † Estimates based on population based survey data

Significant proportions of young women and men in the SADC region continue to engage in risky sexual behaviours. For example, in 10 out of the 11 Member States that provided data on risky behaviours, at least 10% of the men reported having had sex with more than one sexual partner in the last 12 months. However, the distribution of responses on this variable among women is different from that of men. Only one Member State had more than 10% of women who reported that they had had sex with more than one partner in the past 12 months.

Knowledge levels of modes of HIV transmission are still relatively low. For example, only 3 out of 11 Member States had more than 50% of females aged 15-24 years who both correctly identified ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission. The same three Member States had more than 50% of males who both correctly identified ways of preventing the sexual transmission of HIV and rejected major misconceptions about HIV transmission⁴.

2.2. Multiple epidemics

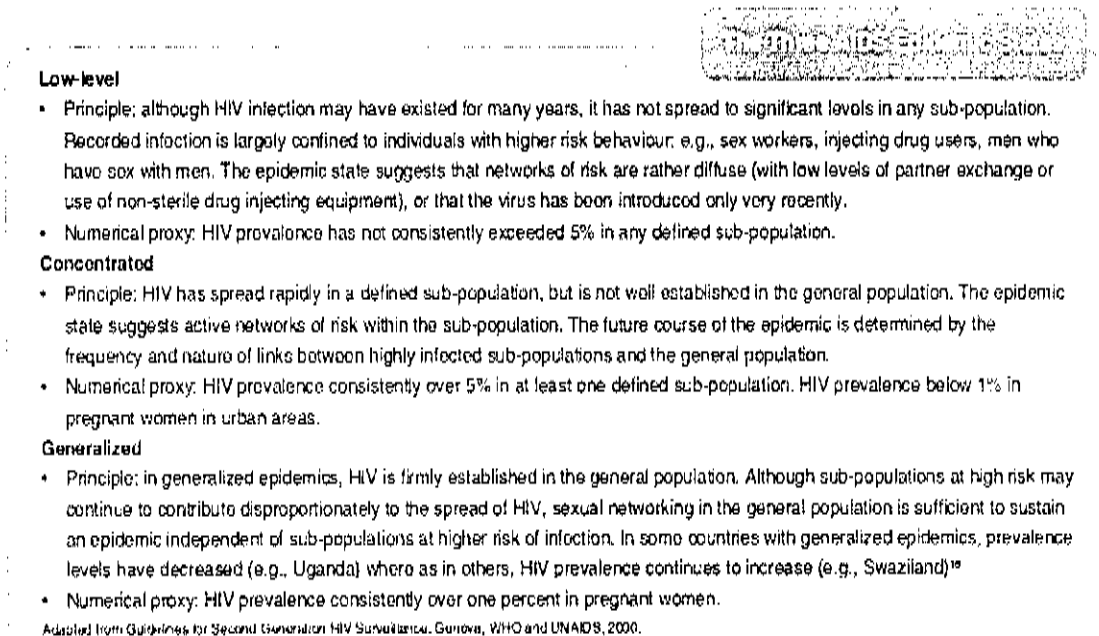
The epidemic in the region is diverse, with varying levels of adult HIV prevalence driven by a diverse range of behavioural, social, cultural and economic factors.

UNAIDS, in describing multiple AIDS epidemic states, characterises these states under three categories - low-level, concentrated and generalised, with each of the categories calling attention

⁴ SADC AIDS Epidemic Update, 2007

to the nature (populations most affected), dynamics (patterns of change over time) and characteristics (severity of impact) of local epidemics. In so doing, the typology facilitates a more strategic response to planning, to better fit local conditions. (See Figure 2)

Figure 2: The three AIDS epidemic states



Source: UNAIDS, 2007

In addition, the concept of *hyperendemic* has been added to the above epidemics for the purpose of programme planning. This describes a situation in which HIV is established in the general population and exceeds 15% among adults. Botswana, Lesotho, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe are countries with hyperendemic scenarios.

Madagascar and Mauritius provide a sharp contrast with adult prevalence of less than 1%, exhibiting a low and concentrated scenario. Even though the sexual transmission of HIV is low in the general population of these countries, it is concentrated in certain population groups. In Mauritius, for example, adult prevalence is estimated at 0.6% but amongst prison inmates, commercial sex workers and injecting drug users (IDUs) it is between 15–25%. Mauritius estimates that 93% of all new HIV infections occur amongst IDUs and their sexual partners. This is mainly through the sharing of infected needles and inconsistent condom use.

The other Member States have a generalized epidemic. This includes Angola, the Democratic Republic of Congo, Malawi and Tanzania.

The presence of multiple epidemics requires the appropriate alignment of responses. Where HIV prevalence is low and/or concentrated, sub-populations at highest risk (IDUs, inmates and sex workers) should be targeted for focused prevention activities. In generalised epidemics, where a large proportion of the population is affected, a combination of prevention services aimed at higher-

risk sub-groups (e.g. people with multiple sexual partners), as well as general prevention campaigns for the population as a whole, are recommended.⁵

Sound epidemiological and behavioural information is needed to describe the dynamics of each epidemic and design appropriate responses. Knowing the characteristics of the epidemics within the area of focus is key to designing effective prevention programmes.

Most at Risk Populations (MARPs)

Commitments by Member States to MARPs

Put people at the centre of the HIV and AIDS response, especially vulnerable people (e.g. men who have sex with men; migrants; prisoners; sex workers; the disabled, people affected by conflicts; injection drug users (Abuja 2006)).

The MARPs are critical in concentrated epidemics. For instance, IDUs play a critical role in the spread of HIV in Mauritius. Similarly commercial sex work is instrumental in the spread of HIV in Madagascar.

There is however limited documented information of this particular group. There is need to prioritize the collection of information for MARPs.

2.3. Key drivers of the HIV epidemic in SADC

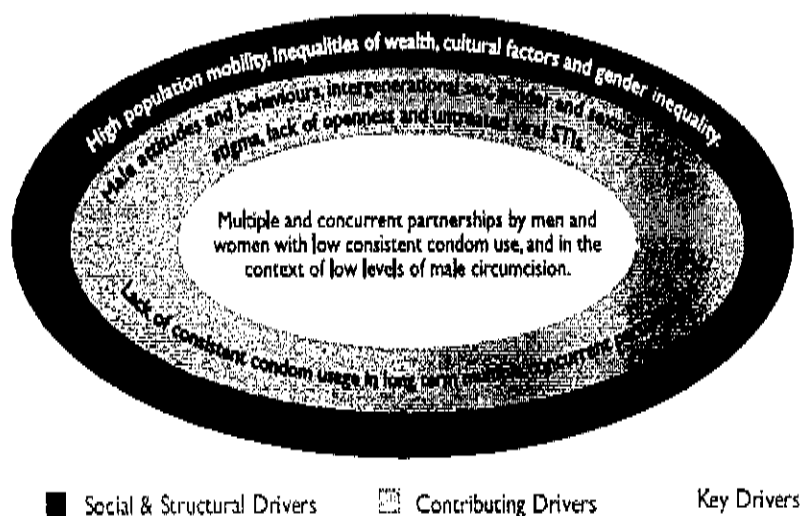
The SADC expert think tank meeting on HIV prevention in high-prevalence countries in Southern Africa concluded that multiple concurrent partnerships, low and inconsistent condom usage, and low levels of male circumcision are the key drivers of the epidemic in these countries.

Other key factors contributing to HIV and AIDS in SADC include: high levels of untreated viral sexually transmitted infections (STI); cross-generational sexual partnerships; stigma and discrimination associated with HIV and sex; sexual violence; cultural practices and social norms regarding multiple concurrent sexual partnerships; and cultural practices that negatively impact on vulnerability and sexual health.

⁵ UNAIDS. Intensifying HIV Prevention, op. cit.

Figure 3: Drivers of the epidemic in high-prevalence countries in SADC

Figure 1: Drivers of the HIV Epidemic in SADC



2.4. Impact of the epidemic on SADC

Limited implementation of effective prevention strategies has had a devastating impact, and has resulted in decreased life expectancy, a marked decline the Human Development Index (HDI)⁶, and increasing poverty for most Member States. For some, the HDI has fallen to pre-independence levels. Nine Member States experienced slow to no growth (4% or less) in gross domestic product between 1996 and 2005.⁷

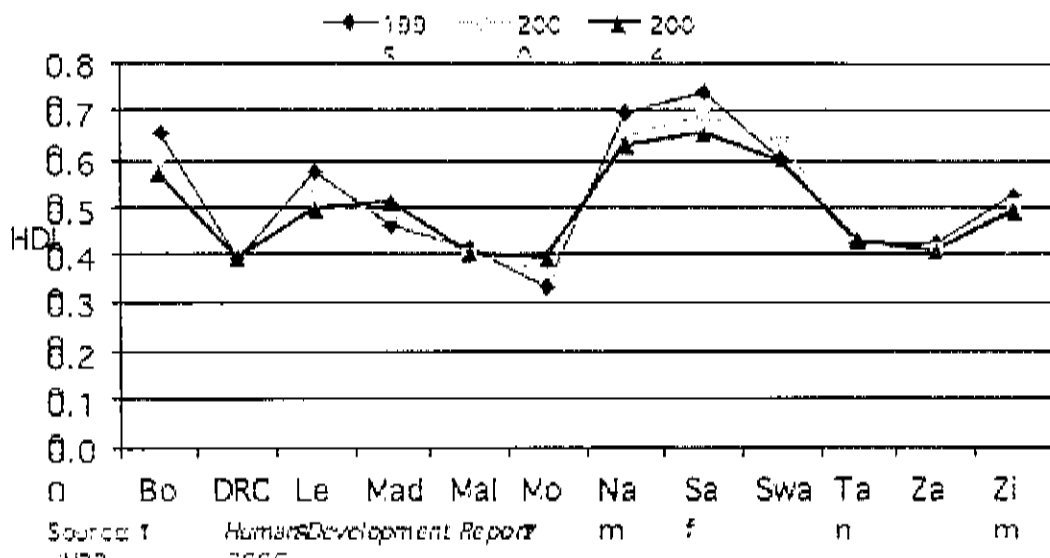
The epidemic continues to surpass efforts to contain it, eroding gains in all sectors of development such as health, education, food security and quality of life. HIV has diverted national resources from investments in development to tackling the resultant crises. At the individual level, family systems have begun to weaken under the strain of care and support to increasing numbers of people debilitated or orphaned by AIDS, and children and old people have been forced to provide care and economic support for younger children and sick family members. However, the most pernicious impact of the epidemic is the long-term nature of its destructive influence. It has left an estimated 6.3 million children⁸ without one or both parents, and many more vulnerable to extreme poverty, neglect and infection.

⁶ HDI is a composite measure of development based on longevity (life expectancy), knowledge (literacy and years of schooling) and standard of living (purchasing power).

⁷ World Bank, 2006. *Africa Development Indicators, 2006*. World Bank, Washington DC

⁸ UNAIDS estimates of children orphaned due to AIDS in 13 of the 14 SADC countries for 2005.

Figure 4: HDI trends within SADC, 1995 - 2004



2.5. Overview of HIV Testing and Counseling

HTC Commitment by Member States

Increasing acceptance of testing by preventing stigmatization and discrimination of our population in the region affected by HIV and AIDS (Maseru Declaration, 2003)

By 2005 ensure expanded access to voluntary and confidential counselling and testing (UNGASS, 2001).

At least 80% of target population access VCT by 2010 (Abuja 2006)

2.5.1. Importance of HIV Testing and Counseling in HIV prevention and treatment

Among the interventions which play a pivotal role both in treatment and prevention, HTC stands out as paramount, and has become increasingly important in national and regional prevention and care efforts. It is a critical point of entry for both HIV and AIDS prevention and care. HTC is necessary because:

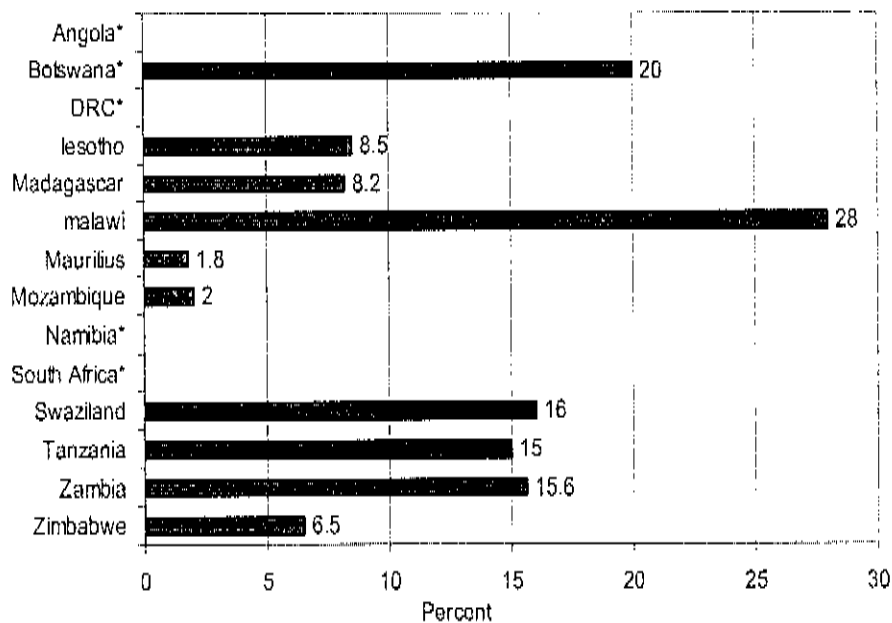
- It is an effective strategy for HIV prevention and care;
- Knowing one's HIV status alerts one to the need to seek medical care to prevent or delay life-threatening illness, and assists health care providers in determining the cause and best treatment of the various illnesses that may develop;
- Knowing one's HIV status can be a motivating force for HIV-positive or HIV-negative people alike to adopt safer sexual behaviour. This enables sero-positive people to prevent their sexual partners from getting infected and those who test sero-negative to remain negative;
- Knowing one's HIV status helps one to plan for the future (e.g. making informed decision

- on whether or not to have children);
- Knowing one's HIV status (even for those who are HIV-positive) may be less stressful for some people than the anxiety of thinking that one is infected but not knowing.

A 2005 United States Agency for International Development (USAID) survey in 12 high-burden sub-Saharan African countries confirmed the findings that only 12% of men and 10% of women in the general population have both been tested for HIV and received their test results⁹. This implies that the majority of people who are HIV positive are not aware of their status and continue to unknowingly infect others, and are unaware of the need to access treatment. The task for HTC, therefore, is to get more people to make use of HTC services.

An HTC indicator that is part of the SADC HIV and AIDS core indicators is “percentage who took an HIV test in the last 12 months and who know their results”. Figure 2 below shows that a low proportion of women and men in the SADC region know their HIV status. Among the ten Member States who provided data on this indicator, the range for those who had a test and know their results was 1.8% to 28%. More than half of these Member States have less than 10% of their adult population who know their HIV status.

Figure 5: Percent who took an HIV test in the last 12 months who know the results, 2007



Source: SADC HIV and AIDS Epidemic Report, 2007

* Means data for this Member State is not available

Qualitative reports from SADC Member States show that HTC programmes are expanding in the region. Most of Member States are offering HTC services at all public health facilities with a view to increasing access. It is also important to note that multiple approaches to HIV testing and

⁹ Denison (2004) in Setswe G (2006) Systematic reviews of behavioural interventions for reducing the risk of HIV and AIDS: Are we getting the evidence. SAHARAJ 3(2), August 2006

counseling are being used in the region. These include provider-initiated testing and counseling; routine testing; voluntary counseling and testing (VCT); and in selected cases mandatory testing¹⁰. For example most of the military services require mandatory testing for either serving in the defence force or for being posted on foreign missions.

2.5.2. Impact of VCT on behaviour change

A systematic review of the impact of VCT in developing contexts shows that evidence exists for VCT as an effective behaviour change strategy, but that weak study designs and limited replication mitigate the strength of evidence. Several studies indicate that VCT is most effective in promoting behaviour change (i.e. reports of less unprotected sex, fewer multiple sex partners and casual partners) between couples tested together and among HIV-positive individuals, particularly with their non-primary partners¹¹. The efficacy of VCT as a primary prevention strategy for HIV-negative people, as well as the long-term effects of VCT for HIV-negative and HIV-positive individuals is less certain¹².

There are indications that VCT assists people to cope with a range of psychosocial problems associated with an HIV-positive diagnosis¹³. A study completed in 2004 highlighted the fact that VCT in the context of PMTCT implementation was vital in helping women manage potentially negative reactions of spouses or family members, but also in encouraging partner support, co-counseling and HIV testing¹⁴.

A few studies from sub-Saharan Africa reveal that high-quality VCT is an effective strategy for reducing HIV sexual risk behaviours among adults, but little is known about VCT for youth, especially among adolescents 14 to 19 years. Experiences in several African countries indicate that youth actively seek out and receive VCT, even when services have not been designed specifically for them. However, youth frequently express concerns about confidentiality, cost, access, and lack of trust in their sexual partners¹⁵.

Voluntary Counseling and Testing is an important gateway to care and support; however the biggest challenge is to bridge the gap between people who know of VCT services and people who decide to make use of the services.

¹⁰ SADC AIDS Epidemic Update, 2007

¹¹ Metcalf CA, Douglas JM, Jr., Malotte CK, et al (2005). Relative efficacy of prevention counseling with rapid and standard HIV testing: a randomized, controlled trial (RESPECT-2). *Sex Transm Dis*. Feb 32(2):130-138.

Kamb ML, Fishbein M, Douglas JM, Jr., et al (1998). Efficacy of risk-reduction counseling to prevent human immunodeficiency virus and sexually transmitted diseases: a randomized controlled trial. Project RESPECT Study Group. *Jama*. 280(13):1161-1167.

Voluntary HIV-1 Counseling and Testing Efficacy Study Group (2000). Efficacy of voluntary HIV-1 counseling and testing in individuals in Kenya, Tanzania and Trinidad: A randomized trial. *The Lancet*, 356, 103_112.

¹² Weinhardt, L.S., Carey, M.P., Johnson, B.T., & Bickham, N.L. (1999). Effects of HIV counseling and testing on sexual risk behaviour: A meta-analytic review of published research, 1985_1997. *American Journal of Public Health*, 89(9), 1397_1405.

¹³ Lie GT, Biswalo PM (1996). HIV-positive patients choice of a significant other to be informed about the HIV test result: findings from an HIV/AIDS counseling Programme in the regional hospitals of Arusha and Kilimanjaro, Tanzania. *AIDS Care*; 8: 285-296.

¹⁴ Chopra M, Jackson D, Ashworth A, Doherty T (2004). In Strodo, A., van Rooyen, H., Heywood, M., Abdool Karim, Q. (2005). Scaling up HIV testing in resource-constrained settings: debates on the role of VCT and routine opt-in or opt-out HIV testing. *South African Journal of HIV Medicine* (20): 45 - 49.

¹⁵ Family Health International (2002). *Voluntary Counseling and Testing and Young People: A Summary Overview*.

Community-based VCT in South Africa showed strong evidence of reaching people in rural and peri-urban settings. Project Accept, based in rural KwaZulu-Natal and Soweto in South Africa, has demonstrated that mobile VCT can reach relatively equal number of males (47%), females (53%) and 75% of youth in the 16-32 year age group. The generally low uptake of VCT in African countries suggests the absence of social norms promoting knowledge of HIV status. However, national promotional campaigns can alter these norms.

A summary of behavioural randomized controlled trials (RCTs) with biological (STI or HIV) outcomes shows that six behaviour change RCTs (mostly among youth) were conducted in Africa. Three found changes in (self-reported) behaviour; none actually reduced STIs or HIV. Two studies were of VCT, while the others employed a mix of VCT, condom promotion, information, education and communication (IEC), sex education in schools, etc. However, none focused primarily on promoting the avoidance of multiple (and concurrent) partnerships in adults.

However, a meta-analysis of the effect of VCT on behaviour change found little overall effect, especially in people who tested HIV-negative. Some studies found some effect on those who tested positive, and also in sero-discordant couples when the male is HIV-negative.

2.5.3. Reasons for the poor uptake of HTC

Despite the evidence that VCT “works” and the increasing availability of VCT in African countries, uptake of VCT remains low. Recent studies indicate that an estimated 18 to 19% of the South African population have been tested for HIV and, in fact, know their serostatus. Other studies suggest that only one in five South Africans who are aware of VCT, have actually used the VCT services that are available.

There are many reasons for the low uptake of VCT services – at the individual level, as well as at the broader institutional and structural levels that shape individual behaviour. Individual factors include fear of testing positive for HIV and the ramifications of a positive test, as well as fears of stigmatization, disease and death.

System factors that limit VCT uptake include perceptions of a lack of confidentiality of VCT services, breaches of confidentiality by health care workers, fear of being discriminated against by health care workers, general lack of trust in the health care system, and fear of disclosure of one’s HIV-positive status to sex partners. An additional barrier to VCT implementation is real and perceived fears of adverse consequences, particularly for women, following VCT. There is evidence that among many HIV positive women, fear of violence is a major barrier to testing and disclosure of HIV status to sexual partners¹⁶.

Provider-initiated testing and counselling (PITC) is fairly new and as such there is inadequate information on the uptake of this form of testing.

2.5.4. Policy, legal and social issues of HTC

The key principles underpinning HTC are **confidentiality** accompanied by **counselling** and **informed consent**, which should be **voluntary**.

¹⁶ Van Rooyon H and Richter L (2007). Background Paper: HIV Testing Strategies. National Consensus Meeting, 11-12 May 2007

The *Declaration of Commitment*, which resulted from the UNGASS on HIV/AIDS in June 2001, highlighted the pressing need for Member States to either develop or scale up voluntary HIV testing and counseling services. At the first global VCT consultation convened by WHO in Harare in June 2001, the participants issued a statement that recognized VCT as a:

- public health and developmental priority and human rights imperative
- cost-effective preventive measure, particularly in high prevalence communities
- central element in interventions, such as PMTCT, access to care and support, and reduction of harm from injecting drug-use
- way to provide individuals with an opportunity to plan for the future and gain access to appropriate health and support services
- means to de-stigmatize and normalize HIV and to empower HIV-positive people in the community
- mechanism that enhances the capacity of health systems to deliver appropriate services.

3. METHODOLOGY

3.1. Process for reviewing HTC policies and programmes

The process was coordinated by the SADC Secretariat in collaboration with the SADC Member States and international cooperating partners, and involved the following:

- A review of regional, continental, and global literature on HTC practices and emerging issues.
- A review and analysis of HTC policies, protocols and guidelines of the SADC Member States.
- Development of an inception report outlining the major issues from the literature and the initial assessment of documents from the Member States. The inception report also outlined the data collection instruments and plans for fieldwork. A technical meeting was held in Gaborone on 15-16 December 2008 with Member States and international cooperating partners to review the inception report, discuss and share experiences on current national policies and programmes for HTC, and to give guidance on the approach to this project. Member States provided guidance on how the assessment process should be conducted and how the minimum standards should be developed.
- Field assessments and policy discussions were conducted with major stakeholders. Policy discussions were conducted by project focal points with small groups of representatives from Ministries of Health, National AIDS Authorities, and local and international stakeholders in 14 SADC Member States (Angola, Botswana, DRC, Lesotho, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland, Tanzania, Zambia, and Zimbabwe). The aim of these policy discussions was to identify major achievements, challenges and good practices that would inform the development of the regional minimum standards on HTC. It was not possible at the time of the project to conduct policy discussions in Madagascar because of riots and political instability. Based on information collected from the Member States, country HTC reports were developed for each of the Member States. These were subsequently sent back to the Member States for verification.
- A consensus-building workshop was held in Victoria Falls, Zimbabwe on 25-27 May 2009, where all major stakeholders reviewed the assessment report and the proposed regional minimum standards. Agreement was achieved on broad areas for this assessment report and the minimum standards on HTC.

3.2. Identifying HTC good and best practices in SADC

The SADC framework for developing and sharing best practice on HIV/AIDS (2006)¹⁷ defines a best practice on HIV and AIDS as a body of knowledge about an aspect of HIV prevention, treatment or care that is based on practical experiences and lessons learnt in a maturing field. This

¹⁷ The SADC framework for developing and sharing best practice on HIV/AIDS (2006)

can be replicated to improve the quality of an intervention that has as its objective the mitigation of one aspect of the HIV epidemic, such as HTC.

The SADC framework also identified the following as essential criteria for best practice:

- Effectiveness
- Cost-effectiveness
- Relevance
- Replicability
- Innovativeness
- Sustainability

These criteria were used to identify interventions as good or best practices. An HTC intervention was identified as a best practice if it complied with four or more of the six criteria above. An HTC intervention was described as a good practice if it complied with two or three of the six criteria above.

4. FINDINGS: ASSESSMENT OF HTC IN SADC

Elements that were considered in the assessment of HTC in SADC Member States include:

- Approaches to HTC
- Availability of HTC policies, protocols and guidelines
- Accessibility of HTC services
- Quality assurance issues
- Monitoring and evaluation.

4.1. Approaches to HIV testing and counseling in SADC

There are two main models or approaches to HTC in SADC, namely:

- Client-Initiated HIV Testing and Counseling, commonly referred to as Voluntary Counseling and Testing (VCT);
- Provider-Initiated Counseling and Testing (PITC).

4.1.1. Voluntary counseling and testing (VCT)

VCT or client-initiated HIV testing and counseling is the process by which an individual seeks out HTC services to enable them to make an informed choice about learning about their status and to take appropriate action. Counseling for VCT consists of pre-test, post-test and follow-up counseling. During pre-test counseling, the counselor gives an individual (or a couple or group) the opportunity to explore and analyze their situation, and consider being tested for HIV. Each individual makes an informed decision of whether or not to take the HIV test after they have been given information and supported to reach an understanding of what is involved.

VCT is effective for promoting knowledge of one's HIV status. It is provided in many settings, such as free-standing sites, and is also integrated with other services (such as existing reproductive health services). It is also provided in the workplace, and in the community through home-to-home services.

In all SADC Member States, the main emphasis was on VCT. VCT has several limitations and bottlenecks leading to poor coverage and slow uptake. It is time-consuming as it requires a lot of time for counseling. The sole reliance on VCT has inhibited timely identification of people living with HIV and AIDS (PLWHA). There is, therefore, a need to use different testing and counseling approaches to access different groups of people.

Recent 'know your status' campaigns, in Lesotho, South Africa and other countries, have tested large numbers of people over a relatively short period. Although other SADC Member States have developed programmes for encouraging citizens to get tested for HIV/AIDS, Lesotho's "Know Your Status" campaign is identified as a best practice VCT initiative because it meets at least four of the six criteria in the SADC framework of best practices¹⁸. The initiative is:

¹⁸ United Nations Population Fund, (2001)

- i. *relevant* as it started by targeting all public servants in the country. It also uses local people and resources;
- ii. *innovative* and very ambitious as it was the first campaign in the world where health officials targeted every household in an entire country with an offer of an HIV test and counseling;
- iii. *effective* as all urban and rural communities can be reached using various means of transport and local resources;
- iv. *cost-effective* as the country has been able to use resources obtained from international organizations to implement the initiative.

The initiative has not yet been *replicated* in any other country and its *sustainability* cannot be guaranteed as it is mainly depended on the generosity of donor funds. The “*Know Your Status*” campaign is described in **case study 2**.

UNAIDS identified five VCT projects in SADC, which had varying capacities, targeted different populations, and provided a range of services following testing. Although UNAIDS identified them as best practice VCT interventions, they qualify only as good practices according to the SADC framework on best practices as they met only two or three criteria at the time of this project.

The five good practice VCT projects are:

- i. The Demonstration of Antiretroviral Therapy (DART) project in Soweto, South Africa,
- ii. Ndola Demonstration Project (NDP) in Zambia,
- iii. TB/HIV Pilot Project in the Western Cape, South Africa,
- iv. Kara Counselling and Training Trust (KCTT) in Lusaka and Choma, Zambia
- v. Zimbabwe AIDS Prevention and Support Organisation (ZAPSO) in Harare and Chitungwiza, Zimbabwe.

The five good-practice VCT projects are briefly described in **case study 3** in the appendices.

4.1.2. Provider-initiated HIV testing and counseling (PITC)

PITC is a form of HIV testing and counselling recommended by health care providers to persons attending health care facilities as a standard component of medical care. Its main purpose is to enable specific clinical decisions to be made and/or specific medical services to be offered that would not be possible without knowledge of the person’s HIV status. In PITC, an HIV test is recommended:

- i. for all patients whose clinical presentation might result from underlying HIV infection from all epidemic types;
- ii. as a standard part of medical care for all patients attending health facilities in generalized epidemics; and
- iii. more selectively in concentrated and low-level epidemics. Individuals must specifically decline the HIV test if they do not want it to be performed.

Provider-initiated models have only recently been promoted. In **Appendix 2**, seven of the Member States indicate that their governments took the bold and deliberate step of pronouncing the strategy of routine offer of HIV testing as early as 2005. However, the policy statement has not

been followed by swift implementation. A few Member States have started to describe provider-initiated HIV testing and counseling (PITC) in their guidelines.

HTC officials believe that routine testing is a good way to advance prevention programmes and to lessen the burden on hospitals by helping people to access treatment at an earlier stage of disease.

Botswana and Malawi have gone beyond VCT, and have started implementing PITC by ensuring that health care providers offer HIV tests to all clients visiting health services, unless a client opts out. Botswana was the first country in Africa in 2004 to implement Provider Initiated Testing and Counselling, which they call routine HIV testing (RHT)¹⁹.

Botswana's routine HIV testing initiative is described as a best practice because it meets at least four of the six criteria in the SADC framework of best practices²⁰. The initiative is:

- i. *effective* as it has increased access to PMTCT to 95% in 2008,
- ii. *cost-effective* as the country has been able to afford it and to meet the demand,
- iii. *relevant* as it uses local people and resources,
- iv. *innovative* in the way it involves men and people living with HIV and AIDS.

The initiative has not yet been *replicated* in any other country and its *sustainability* cannot be guaranteed in the changed global economic climate. Although the initiative looks good on paper, there are ethical challenges in implementing it in real-life situations as an offer of an HIV test at a health service may be interpreted as some form of coercion. Botswana's initiative is described in **case study 1** in the Appendices.

4.2. Availability of HTC policies, protocols and guidelines

An analysis of national HTC policies and guidelines (see **Appendix 2**) indicates that all but one SADC Member State (Namibia) indicated that they had approved national HTC policies and guidelines. The policies were approved at different times ranging from 2001 to 2009.

In all the 12 SADC Member States that participated in policy discussions, there was a consultation process for developing the HTC policy. All respondents said that the policies/guidelines were easily available, and that there is an HTC implementation plan.

Availability of HTC policies, protocols and guidelines indicates there is recognition in SADC that:

- HTC is central to HIV prevention, treatment, care and support.
- HTC scale-up supports prevention.
- Member States, with partners' support, need to modify their HTC policies, strategies and programmes for rapid HTC scale-up.
- ART access will be scaled up if opportunities for accessing HIV testing are dramatically increased.
- HTC recommendations guide minimum standards at Member State level.

¹⁹ Rennie S and Behets F (2006). Desperately seeking targets: the ethics of routine HIV testing in low-income countries. Bulletin of the WHO, Jan, 84 (1) 52-55

²⁰ United Nations Population Fund, (2001)

4.3. Accessibility of HTC Services

Access to HTC services has increased tremendously in SADC Member States in the past few years. For example, Zambia had 405 sites in 2005, 883 in 2006 and 1023 in 2007. The average number of clients per site was 22 in 2006 and 37 in 2007. If each site were to see 8 clients per day - operating on a 22 month day - the average should be around 176 clients (which would be over 2.1 million tests a year in Zambia rather than the under 600,000).

The pattern in most SADC Member States seems to be that, whilst most individuals found HIV testing acceptable, this has not been converted into high HIV testing rates.

Eight Member States in SADC include pre-test (individual) counseling, while at least ten Member States conduct group pre-test education. About seven Member States in SADC do not specifically have HIV retesting in late pregnancy, and about six Member States have nothing or very little on male involvement, involvement of PLWHA and gender violence. Counseling is provided by health workers, such as doctors and nurses in health services and by trained lay counselors who are referred to as primary counselors (PCs) in Zimbabwe.

At least five SADC Member States said they were developing protocols that allow qualified and registered counselors, volunteers and nurse assistants to offer and conduct HIV tests. The protocols are being amended to allow these staff to be able to facilitate the processing of patients through the entire process, from pretest information/counseling, to performing the test, to post-test counselling.

At least seven Member States stated that they are starting to cover family testing and couple counselling in their policies and guidelines. This is encouraged as long as counselors are sure that no family member or partner is being forced to test or may be harmed as a result.

Generally, the common procedures in HTC service delivery in the SADC Member States include the following:

1. Pre- and post-test counseling is part of the services provided at all sites.
2. Services are **voluntary**, and are used by clients who have already decided that they want to take a HIV test.
3. **Confidentiality** is recognized as an essential component of all services while, at the same time, openness towards partners and family about the HIV status is promoted.
4. Services are **anonymous** and results are never given over the telephone or disclosed to another person.
5. Counseling sessions are **tailored to the individual or couple** attending. Although there are common elements in the content of the counseling sessions, the counselors note that HIV testing is often only one of a number of important issues that are covered in counseling sessions. Relationship difficulties and family problems are also often underlying factors in the wish to obtain VCT.
6. **Continuity of counseling** is also emphasized, with the majority of clients seeing the same counselor for pre- and post-test counseling.

4.4. Quality assurance issues

HTC quality assurance is a way of monitoring and evaluating the quality of services provided in accordance with established national guidelines, policies and standards. In general, it entails

standardization through national HTC guidelines, accreditation of HTC facilities and supervision and support. Approaches for assessing HIV counseling services includes the training of service providers, the use of qualified trainers; standardised training tools; certification; and the use of HTC aids.

All components of quality assurance (QA), such as the pre-analytical, analytical and post-analytical phases, include:

- adherence to laboratory protocol;
- quality control of samples;
- internal quality control such as expiry date and integrity of test kits;
- external quality control (using known positive and negative reference specimens);
- quality control of test kits and supplies.

4.4.1. Accreditation of staff and facilities

Responsibility for the accreditation of staff working in HTC lies with health professions organisations such as the medical council, nursing council or health professions council in all SADC Member States. The main criteria for accreditation require training at an approved institution, done by trained professionals for a stipulated period of time. In most instances training should be for at least one year.

All the criteria above exclude lay counsellors. Their training ranges from a few days to several weeks in most SADC Member States. The accreditation of lay counsellors to do counselling and testing requires that different criteria be established for their training and acceptance as *de facto* HTC practitioners. Zimbabwe has developed a curriculum for the training of lay counsellors.

Most SADC Member States leave the responsibility of accreditation of facilities to officials in the Department of Health. The minimum requirements that Departments of Health use for accreditation of facilities are staff, space, equipment and supplies. Most Member States have developed guidelines that indicate how many staff members, the size of space, the type of equipment and the amount of supplies that are required for an HTC site.

Table 1 shows minimum requirements that are used for accreditation of voluntary counselling and testing (VCT) sites while **Table 2** shows minimum requirements that are used for accreditation of PITC sites, which are mainly linked to health services.

Table 1: Minimum requirements for accreditation of VCT sites

	Large VCT facility	Small VCT centre
Staff	<ul style="list-style-type: none"> ○ Minimum of two counsellors ○ Minimum one counsellor supervisor ○ Laboratory staff for QA for all HIV testing in the facility ○ CT coordinator 	<ul style="list-style-type: none"> ○ Minimum of two counsellors ○ Arrangement for supervision can be made with a supervisor from another facility
Space	<ul style="list-style-type: none"> ○ Dedicated CT rooms with good ventilation and privacy 	<ul style="list-style-type: none"> ○ Any room with auditory and visual privacy and good ventilation
Equipment	<p>Each CT room to have :</p> <ul style="list-style-type: none"> ○ 3 chairs, ○ one desk, ○ one lockable cabinet for documents, ○ one lockable cabinet for storage of HIV test kits and supplies, ○ testing table with sharps disposal bin, ○ hand washing facility ○ bench in waiting area 	<ul style="list-style-type: none"> ○ 3 chairs, ○ one desk, ○ one lockable cabinet for documents, ○ one lockable cabinet for storage of HIV test kits and supplies, ○ testing table with sharps disposal bin, ○ hand washing facility
Supplies	<ul style="list-style-type: none"> ○ HIV test kits ○ Gloves and other supplies ○ Disinfectant ○ Counselling registers and monthly summation forms, other required stationary 	<ul style="list-style-type: none"> ○ HIV test kits ○ Gloves and other supplies ○ Disinfectant ○ Counselling registers and monthly summation forms, other required stationary

Table 2: Minimum requirements for accreditation of PITC sites

	Large PITC facility	Small PITC facility
Staff	<ul style="list-style-type: none"> ○ Adequate number of health workers ○ Adequate number supervisors for health workers ○ Laboratory staff for QA for all HIV testing in the facility ○ PITC coordinator 	<ul style="list-style-type: none"> ○ Acceptable number of health workers including lay counsellors ○ Arrangement for supervision can be made with a supervisor from another facility
Space	<ul style="list-style-type: none"> ○ Dedicated CT rooms with good ventilation and privacy 	<ul style="list-style-type: none"> ○ Any room with auditory and visual privacy and good ventilation

Equipment	Each CT room to have :	
	<ul style="list-style-type: none"> ○ chairs, ○ desks, ○ lockable cabinets for documents, ○ lockable cabinets for storage of HIV test kits and supplies, ○ testing tables with sharps disposal bin, ○ hand washing facilities ○ benches in waiting area 	<ul style="list-style-type: none"> ○ 3 chairs, ○ 1 desk, ○ one lockable cabinet for documents, ○ one lockable cabinet for storage of HIV test kits and supplies, ○ testing table with sharps disposal bin, ○ hand washing facility
Supplies	<ul style="list-style-type: none"> ○ HIV test kits ○ Gloves and other supplies ○ Disinfectant ○ Counselling registers and monthly summation forms, other required stationary 	<ul style="list-style-type: none"> ○ HIV test kits ○ Gloves and other supplies ○ Disinfectant ○ Counselling registers and monthly summation forms, other required stationary

4.4.2. Standard operating procedures

All Member States said they have developed standard operating procedures, as part of their guidelines, to address pre-test, testing and post-test counseling.

Some of the standard operating procedures of Member States indicate that during pre-test counseling the following minimum information must be included:

- the nature of HIV and of AIDS;
- the nature and purpose of an HIV test;
- the clinical and prevention benefits of testing, and the potential risks, such as discrimination, abandonment or violence;
- the services that are available in the case of either an HIV-negative or an HIV positive test result, including whether antiretroviral treatment is available;
- the fact that the test result will be treated confidentially and will not be disclosed;
- the fact that the patient has the right to decline the test;
- the fact that declining an HIV test will not affect the patient's access to services that do not depend upon knowledge of HIV status;
- in the event of an HIV-positive test result, encouragement of disclosure to other persons who may be at risk of exposure to HIV; and
- an opportunity to ask the health care provider questions.

For group pre-test education, the same basic information provided in individual sessions is offered, although the individual session does offer an opportunity to discuss more in-depth personal issues.

Standards for post-HIV test counseling in most Member States clearly indicate that post-test HIV counseling must be provided after every HIV test. Where the test is positive, the person providing treatment, care or counseling services is expected to follow standard operating procedures outlined for this stage.

4.5. Monitoring and Evaluation (M&E)

Successful M&E systems are simple, include a standardised core set of tools to collect and analyse data, involve both internal self assessment and external verification, and are built into the design of a programme (not retro-fitted into implementation stages of the programme).

Most SADC Member States said they do not have functional and effective M&E systems for HTC services. None of the SADC Member States have developed specific M&E frameworks for evaluating different aspects of their HTC programmes. However, most Member States have adapted M&E frameworks developed for other HIV and AIDS services to monitor and evaluate HTC services.

5. DISCUSSION

The table below gives a summary of achievements and challenges with HTC in SADC:

Achievements	Challenges
Uptake and availability of testing and counselling Innovative and increased campaigns to promote testing - universal testing in Lesotho and provider-initiated testing in Botswana	Record-keeping — 6 MS have no data on testing and counselling uptake Low-uptake — in reporting countries uptake is below 35% Treatment — limited availability of ARVs for people in need

5.1. Opportunities for HTC

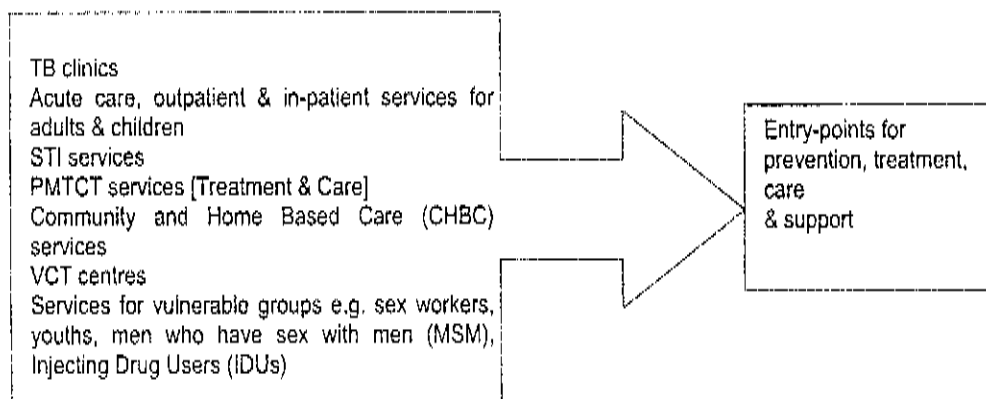
HTC is a key entry point to care and support services for those who are HIV-infected. In order to ensure access to HTC for larger populations, and to facilitate access to ARV treatment, most SADC Member States use many settings, particularly in services where those most likely to benefit from knowledge of their HIV status can be reached. Almost all Member States use their primary health care services, where they diagnose and treat tuberculosis (TB) and sexually transmitted infections (STI), as an entry point for HIV testing and counseling.

Most Member States also provide services linked to PMTCT to encourage pregnant women to get tested for HIV.

About ten SADC Member States use community- and home-based care services (including door-to-door services) to encourage people to get tested for HIV.

About four SADC Member States are using services for vulnerable groups such as sex workers, youths and men who have sex with men, to encourage people in these target groups to get tested for HIV. Almost all SADC Member States are using general medical settings where providers encourage patients presenting with various health problems to be tested for HIV.

Figure 6 summarizes the different entry points or opportunities available for HTC.



Implementing HTC at the Member State level is informed by:

- The type of epidemic. The HIV epidemic may be described as endemic in some Member States or hyper-endemic in others.
- Policy, legal and social environment for implementing HTC programmes;
- Available resources such as human and financial resources;
- Infrastructure such as clinics, hospitals and other community services for implementing the programme.

5.2. Challenges in implementing HTC services

All SADC Member States said that there is a need for infrastructural improvements for the delivery of HTC and follow up services. Geographical distribution of services between urban and rural areas in most Member States is skewed. Access to HTC for children and adolescents needs to be improved in many Member States.

Other key challenges identified by SADC Member States in the implementation of HTC policies, protocols and guidelines in SADC include the following (as detailed in **Appendix 4**):

- Inadequate financial resources, which are often narrowly earmarked by donors;
- Inadequate human resources, including problems with lay counselors;
- Poor partner and sectoral coordination and donor support resulting in verticalisation of programmes and poor implementation of national policies;
- Stigma and discrimination against people living with HIV/AIDS;
- Unequal emphasis on the needs of women, their children, partners and families, and insufficient follow-up within a continuum of care;
- Insufficient integration of HTC services and insufficient linkages with other health and social services;
- The need to decentralize implementation and service delivery, and focus on developing and strengthening of community structures and systems to include HTC;
- Programme monitoring, recording and reporting;
- Quality assurance and impact assessment;

- Inadequate efforts to ensure male engagement in HTC;
- Impact of gender inequality and of gender-based violence;
- Lack of capacity to cost HTC plans;
- Slow scale-up of provider-initiated testing and counseling services, where appropriate, and the limited creation of demand for these services.

Table 3 provides a summary SWOT analysis of the strengths, weaknesses, opportunities and threats to HTC in SADC. The analysis points to some of the key issues that were considered in the development of SADC regional minimum standards.

Table 3: Summary of strengths, weaknesses, opportunities and threats to HTC in SADC

STRENGTHS

- Existence of HTC policies and guidelines
- Training and use of Primary Care Counsellors (PCs) to provide counselling services in health facilities
- Use of peer counsellors living with HIV to provide HTC services
- Use of integrated services in HTC
- Introduction of treatment literacy for PLWHA, covering nutrition, adherence, secondary prevention and stress management
- Media campaigns on HTC, TB, HIV and AIDS treatment and care

OPPORTUNITIES

- Development of HTC guidelines for children that stipulates the age of consent
- Possibility of establishing HTC services in youth centres or colleges to encourage youth participation
- Comprehensive communication strategy being developed
- Media promotions

WEAKNESSES

- Limited male involvement
- Limited follow-up and care and support for HIV positives
- Inadequate psychosocial support structures
- Incomplete and late reporting
- Inadequate infrastructure
- Poor M&E
- Limited space for confidential counselling and for on-site rapid testing within clinics
- Failure to maintain an integrated referral system

THREATS

- Financing HTC programme improvement and implementation

5.3. HTC policy issues in SADC Member States

Member States identified some policy issues that impact on the abilities of health care facilities in SADC to scale up and make testing and counseling widely available. These policy issues include:

- **Rapid HIV testing task shifting.** Most Member States are trying to include training for assistant nurses, environmental health officers, TB officers, rehabilitation officers and lay counselors to conduct rapid HIV testing. Some Member States such as Malawi and Botswana allow lay counselors to conduct testing

- **Policy on child counselling, age of consent and testing of minors:** The current age of consent for HIV testing in SADC ranges from 12 years to 18 years and above. However, there is evidence of early sexual debut and teenage pregnancy. There is, therefore, a need to look at circumstances under which children should be tested and the age of consent.
- **Delay in translating the PITC policy into action (routine offer).** While some Member States have realised the need to implement provider-initiated testing and counselling, they have not been able to move swiftly to enact this as a policy or to implement the policy, where one has been developed.
- **Serial and parallel testing.** Parallel rapid HIV testing is currently recommended in most HIV testing protocols. Most Member States are considering introduction of serial rapid HIV testing, in line with WHO recommendations for generalised HIV epidemics.
- **Minimum standards:** Minimum standards have not been set for all types of HIV testing in most Member States— since PITC still constitutes only a small portion of all HIV testing. All Member States say the current testing policies are more broadly disseminated and enforced in the private sector.
- **Testing in special circumstances.** Most Member States said they are instituting counselling as an integral component of testing, and are determining conditions for potential opt-out versus opt-in options. Some Member States are considering introducing mandatory counselling followed by an HIV test, with the client having the option to opt out of the test, rather than to opt in, during pregnancy or with positive test results for TB or STIs. They are suggesting that this would be similar to the current process of testing for syphilis.
- **Conducting HIV tests:** Several Member States have not decided on who should administer tests in different settings, and under what conditions. The main options in most Member States are nurse counsellors or lay counsellors administering HIV rapid tests, given the shortage of laboratory personnel.
- **HIV disclosure:** Confidentiality should not be breached under any circumstances in HIV testing and counselling. Most Member States said that counsellors prepare clients to disclose when they are ready and health services create environments conducive for clients to disclose their HIV status without fear of stigma or discrimination.
- **Involvement of PLWHA:** Most Member States indicated that they have developed mechanisms for involving PLWHA. However, when asked whether these mechanisms are in writing, many of them said no.
- **HIV self-testing:** Although HIV self-tests are not encouraged in most SADC Member States because of concerns such as accuracy, the inability of people to provide adequate samples for testing, possibility of abuse and the lack of pre- and post-test counselling, there are no clear standpoints on this matter in most Member States.

Appendix 3 identifies HTC policy issues in SADC Member States, including policy gaps. These include:

- The need to speed up development, revision and implementation of HTC policies and guidelines in the light of new developments;
- The need to improve M&E by developing and using HTC indicators, registers, etc;
- The need to improve the quality of both counseling and testing;
- Appropriate use of lay counselors in the health care setting;
- The need to improve the integration of HTC into AIDS treatment and care programmes;
- Effective communication on HTC;

- Improve community support for HTC;
- Strengthen quality assurance for HTC services;
- Development, implementation and documentation of good and best practice models in HTC.

REFERENCES

Allen SA, Serufflira J, Bogaerts P, Van de Perre F, Nsengumuremyi C, Lindan SE, Gregorich MD, Sweat MC, Kamenga FA, Plummer, et al., (2003) Efficacy of voluntary HIV-1 counseling and testing in individuals. Voluntary HIV 1 Counseling and Testing Efficacy Study Group. *Lancet* 2003

Amman S, Mbwambo J, Hogan M, Kilonzo G, Sweat M. and Weiss E. (2001). HIV and partner violence. Implications for HIV Voluntary Counseling and Testing programmes in Dar Es Salaam, Tanzania. New York: Horizons/Population Council.

Anderson, B (2006). A Human Rights Approach to HIV Testing: Voluntary, Mandatory or Routine? *AIDS Legal Quarterly*, pp 1-7.

Asante, A.D. (2007). Scaling up HIV prevention: why routine or mandatory testing is not feasible for sub-Saharan Africa. *Bulletin of the World Health Organization*, 85 (8), 644-646.

Bond L, Lauby J and Batson H. (2005). HIV testing and the role of the individual- and structural-level barriers and facilitators. *AIDS Care*, 17 (2), 125-140.

Chopra M, Jackson D, Ashworth A, Doherty T (2004). In Strode, A., van Rooyen H,

Heywood M, Abdool Karim Q. (2005). Scaling up HIV testing in resource-constrained settings: debates on the role of VCT and routine opt-in or opt-out HIV testing. *Southern African Journal of HIV Medicine* (20): 45 - 49.

Coovadia HM. (2000). Access to voluntary counseling and testing for HIV in developing Member States. *Annals of the New York Academy of Sciences*, 918, 57-63.

Day J, Miyamura K, Grant A, Leeuw A, Munsamy J, Baggaley R. and Churchyard G. (2003). Attitudes to HIV voluntary counseling and testing among mineworkers in South Africa: Will availability of antiretroviral therapy encourage testing? *AIDS CARE*, 15 (5), 665-672.

Economic Commission for Africa. Report of the Commission on HIV/AIDS and Governance in Africa. 2008. Addis Ababa, Ethiopia.

Ellen JM, Liang TS, Claude A, Jacob CA, Erbelding E and Christmyer C. (2004). Post-HIV test counseling of clients of a mobile STD/HIV clinic. *STD & AIDS*, 15, 728-731.

Family Health International (2002). Voluntary Counseling and Testing and Young People: A Summary Overview. Available online at: <http://www.fhi.org>

Frith L, (2007). HIV self-testing: a time to revise current policy. *Lancet* 2007; 369: 243-5.

Gruskin S. (2006). Its time to deliver right! HIV Testing in the Era of Treatment Scale Up: Concerns and Considerations. *AIDS Legal Quarterly*, pp 11-14.

Joint Civil Society Monitoring Forum (2006). Scaling up HIV Voluntary Counseling and Testing in South Africa: Time for New Models. 9th National Meeting, 5 October 2006

Kalichman S and Simbayi L. (2003). HIV testing attitudes, AIDS stigma, and voluntary HIV counseling and testing in a black township in Cape Town, South Africa. *Sexually Transmitted Infections*, 79, 442- 447.

Kamb ML, Fishbein M, Douglas JM, Jr., et al (1998). Efficacy of risk-reduction counseling to prevent human immunodeficiency virus and sexually transmitted diseases: a randomized controlled trial. Project RESPECT Study Group. *Jama*, 280(13):1161-1167.

Kamenga C and Sangiwa G. (2008.) Premarital HIV Counseling and Testing for Couples: A Neglected Opportunity. Presented at the International HIV CT Workshop, Lusaka, Zambia.

Lie GT, Biswalo PM (1996). HIV-positive patients' choice of a significant other to be informed about the HIV test result: findings from an HIV/AIDS counseling Programme in the regional hospitals of Arusha and Kilimanjaro, Tanzania. *AIDS Care*; 8: 285-296.

Matovu JKB, Gray RH, Makumbi F, Wawer MJ, Serwadda D, Kigozi G, Sewankambo NK and Nalugoda, F. (2005). Voluntary HIV counseling and testing acceptance, sexual risk behavior and HIV incidence in Rakai, Uganda. *AIDS*, 19, 503-511.

Metcalf CA, Douglas JM, Jr., Malotte CK, et al (2005). Relative efficacy of prevention counseling with rapid and standard HIV testing: a randomized, controlled trial (RESPECT-2). *Sex Transm Dis*. Feb 32(2):130-138.

Morin SF, Khumalo-Sakutukwa G, Charlebois ED, Routh J. et al. (2006). Removing barriers to knowing HIV status: same-day mobile HIV testing in Zimbabwe. *J Acquir Immune Defic Syndr*, 41, 218-224.

Ncube B (2008) Recommendations on HIV testing and counseling. Presentation at the Meeting to Develop Regional Minimum Standards for PMTCT and HIV Counseling and Testing in Gaborone, Botswana on 15 - 16 December 2008

Perez F, Zvandaziva C, Engelsmann B and Dabis F. (2006). Acceptability of Routine HIV Testing (Opt-Out) in ANC services in two rural districts of Zimbabwe. *AIDS*, 41 (4), 514-520.

Steen, T.W., Seipone, K., Gomez, F.L. et al. (2007). Two and a half years of routine HIV testing in Botswana. *AIDS*, 44 (4), 484-488.

Strode, A., van Rooyen, H., Heywood, M., Abdool Karim, Q. (2005). Scaling up HIV testing in resource-constrained settings: debates on the role of VCT and routine opt-in or opt-out HIV testing. *Southern African Journal of HIV Medicine* (20), 45 - 49.

Swinepoxes, P.H. (2004). Persuading South Africans at risk of HIV/AIDS to voluntarily present themselves for counseling, testing and referral (VCT): Using theory and empirical evidence in formative research for VCT message design. Unpublished Working Paper: University of South Africa.

SADC. AIDS Epidemic Update, 2007. Gaborone, Botswana

UNAIDS. AIDS Epidemic Update. 2006. Geneva, Switzerland: UNAIDS

UNAIDS/WHO, UNAIDS/WHO Policy statement on HIV testing (June 2004). Geneva, Switzerland: UNAIDS.

UNAIDS/WHO. 2008 Report on the Global AIDS Epidemic. Geneva, Switzerland: UNAIDS

UNFPA/IPPF. Integrating HIV Voluntary Counseling and Testing services into reproductive health settings: Stepwise guidelines for programme planners, managers, and service providers. 2004. United Kingdom.

UNICEF/WHO. "Towards Universal Access: Scaling Up Priority HIV/AIDS Interventions in the Health Sector: Progress Report". April 2007. Geneva, Switzerland: UNAIDS

Van Dyk AC and van Dyk PJ. (2003). To know or not to know': Service-related barriers to voluntary counseling and testing (VCT) in South Africa. *Curationis*, 26(1), 4-10.

Voluntary HIV-1 Counseling and Testing Efficacy Study Group (2000). Efficacy of voluntary HIV-1 counseling and testing in individuals in Kenya, Tanzania and Trinidad: A randomized trial. *The Lancet*, 356, 103-112.

Weinhardt, L.S., Carey, M.P., Johnson, B.T., & Bickham, N.L. (1999). Effects of HIV counseling and testing on sexual risk behaviour: A meta-analytic review of published research, 1985_1997. *American Journal of Public Health*, 89(9), 1397_1405.

WHO (2006). Addressing Violence Against Women in HIV Testing and Counseling: Strategies and Recommendations. Meeting Report, Geneva, 16-18 June 2006.

Wolff B, Nyanzi B, Katongole G, Ssesanga D, Ruberantwari A and Whitworth J. (2005). Evaluation of a home-based voluntary counseling and testing intervention in rural Uganda. *Health Policy and Planning*, 20 (2), 109-1

Appendix 1: HIV prevalence estimates in SADC

	ANG	BOT	DRC	LES	MAD	MAL	MAU	MOZ	NAM	SEY	RSA	SWA	TAN	ZAM	ZIM
1. Estimated adult HIV prevalence rate, 2007, 15-49 (MoH, 2007; UNICEF, 2008)	2.1%	23.9%	1.2-1.5%	23.2%	0.1%	12.0%	1.7%	12.5%	15.3%	0.5%	18.1%	26.1%	6.2%	15.2%	15.3%
2. Estimates based on sentinel surveillance data, 2007, 15-24 year-olds (SADC, 2008; SDHS)			4.1%	18.7%	0.5%	12.3%	0.35%	14.4%	14.0%			34.6%		12.5%	
3. Estimates based on population based survey data, 2007, 15-24 year-olds (DHS 2004, NDHS, 2006/7; SADC, 2008; ZDHS, 2007)	2.7%	12.6%	3.6%			6.0%					10.3%	14.3%	4.0%	6.5%	16.2%

Appendix 2: Availability of HTC policies, protocols and guidelines in SADC Member States

	ANG	BOT	DRC	LES	MAD	MAL	MAU	MOZ	NAM	SEY	RSA	SWA	TAN	ZAM	ZIM
Is HTC policy available?	✓	✓	✓	✓	N/C	✓	✓	✓	x	✓	✓	✓	✓	✓	✓
Has HTC policy been approved?	✓	✓	✓	✓	N/C	✓	✓	✓	x	✓	✓	✓	✓	✓	✓
When was it approved?	2009	2009	2002	2006	N/C	2004	2006	2006	2007	2001	2007	2006	2001	2008	2005
Are there HTC guidelines?	✓	✓	✓	✓	N/C	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
When were the guidelines published?	1997	1997	2002	2004	N/C	2004	2008	2008	2006	2008	2007	2006	2005	2006	2005

Was there a consultation process for developing HTC policy?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Are policies/guidelines easily available?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Is there an HTC implementation plan?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Which HTC methods/approaches are used?	VCT,	VCT,	VCT,	VCT,	VCT,	VCT,	VCT,	VCT,	VCT,	VCT,	VCT,	VCT,	VCT,	VCT,	VCT,	VCT,	VCT,	VCT,	VCT,	VCT,	VCT,
	PITC	PITC	PITC	PITC	PITC	PITC	PITC	PITC	PITC	PITC	PITC	PITC	PITC	PITC	PITC	PITC	PITC	PITC	PITC	PITC	PITC
Which types of staff do the counseling?	HW,	HW,	HW,	HW,	HW,	HW,	HW,	HW,	HW,	HW,	HW,	HW,	HW,	HW,	HW,	HW,	HW,	HW,	HW,	HW,	HW,
	LC	LC	LC	LC	LC	LC	LC	LC	LC	LC	LC	LC	LC	LC	LC	LC	LC	LC	LC	LC	LC

N/C = Not Collected; VCT = Voluntary Counselling and Testing; PITC = Provider Initiated Testing and Counselling; LC = Lay Counsellor; HW = Health Worker;

Appendix 3: HTC implementation needs in SADC Member States

	ANG	BOT	DRC	LES	MAD	MAL	MAU	MOZ	NAM	SEY	RSA	SWA	TAN	ZAM	ZIM
Need to speed up development of HTC policies and guidelines	✓	✓	✓		N/C	✓		✓	✓	✓	✓	✓			
Need to improve M & E (HTC indicators, registers)	✓	✓	✓	✓	N/C	✓	✓	✓	X	✓	✓	✓	✓	✓	✓
Need to improve quality of C & T				✓	N/C	✓	✓		✓	✓	✓	✓	✓	✓	✓
Appropriate use of lay counselors in the health care setting	✓	✓	✓		N/C	✓	✓	✓	✓	✓		✓	✓	✓	✓
Improve integration of HTC into AIDS treatment and care activities	✓	✓	✓	✓	N/C	✓	✓	✓	✓	X	✓	✓	✓	✓	✓
Effective communication on HTC	✓	✓	✓	✓	N/C	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Improve community support for HTC	✓	✓	✓	✓	N/C	✓	✓	✓	✓	X	✓	✓	✓	✓	✓

Strengthen quality assurance for HTC services																✓			✓	
Good or best practice models in HTC																	✓			✓

Appendix 4: HTC implementation challenges in SADC Member States

	ANG	BOT	DRC	LES	MAD	MAL	MAU	MOZ	NAM	SEY	RSA	SWA	TAN	ZAM	ZIM
Inadequate financial resources, which are often narrowly earmarked by donors	✓	✓	✓	✓	N/C	✓		✓	✓	✓	✓		✓	✓	✓
Inadequate human resources: problems with lay counsellors	✓	✓	✓	✓	N/C			✓	✓	✓	✓	✓	✓	✓	✓
Poor partner and sectoral coordination and donor support resulting in verticalisation of programmes and poor implementation of national policies		✓	✓	✓	N/C	✓	✓			✓	✓				
Stigma and discrimination	✓				N/C		✓	✓	✓	✓		✓	✓	✓	✓
Unequal emphasis on the needs of women, their children, partners and families, and insufficient follow up within a continuum of care	✓	✓	✓	✓	N/C	✓	✓	✓	✓	✓		✓	✓	✓	✓
Insufficient integration of HTC services and insufficient linkages with other health and social services;	✓	✓	✓	✓	N/C	✓	✓	✓	✓		✓	✓	✓	✓	✓
The need to decentralize implementation and service delivery, and focus on developing and strengthening of community structures and systems to include HTC	✓				N/C	✓		✓	✓	✓	✓	✓	✓	✓	✓

Programme monitoring, recording and reporting	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Quality assurance and impact assessment:		✓	✓	✓	✓	✓	✓	✓	✓	N/C	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Inadequate efforts to ensure male engagement in HTC;	✓	✓	✓	✓	✓	✓	✓	✓	✓	N/C	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Impact of gender inequality and of gender-based violence	✓	✓	✓	✓	✓	✓	✓	✓	✓	N/C	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Lack of capacity to cost plans		✓	✓	✓	✓	✓	✓	✓	✓	N/C	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Slow scale-up of PITC services, where appropriate, and the limited creation of demand for these services.	✓	✓	✓	✓	✓	✓	✓	✓	✓	N/C	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Case study 1: Botswana's Routine HIV Testing (RHT) programme as a best practice HTC intervention

Background

Botswana had a population of 1.7 million people with an HIV prevalence of 32.4% among pregnant women in 2006. This was down from 37.4% in 2003. The HIV prevalence is 17.1% in the general population and 25% among the 15-49 age-group (BAIS II). There is strong political leadership and a comprehensive HIV prevention and treatment, care and support programme which includes HIV/AIDS education, routine HIV testing (RHT), voluntary counseling and testing (VCT), antiretroviral therapy (ART), prevention of mother to child transmission (PMTCT), Isoniazid Prophylaxis Treatment (IPT), and behaviour change communication (BCC).

The Routine HIV Testing (RHT) or Provider Initiated Testing and Counseling (PITC) programme

Approximately 50% of Botswana knew their HIV status. The other half of the population who did not know their HIV status could not maximise the existing government programmes such as PMTCT, ARV, IPT, etc.

Botswana was the first Member State in the SADC region to introduce RHT in January 2004 because there was a need to expand counseling and testing and increase access to HIV-related services. RHT was introduced in all public health facilities in the Member State.

Routine HIV Testing (RHT) means making HIV testing an integral part of the clinical services provided at the health facilities. It implies a default (opt-out) policy of testing, where testing will not be performed if the client/patient declines to have the test (opt-out). It is not compulsory.

The main criteria for RHT include:

- Clinical symptoms suggestive of HIV/AIDS;
- Pregnancy;
- Sexually transmitted Infections;
- Tuberculosis (TB);
- Attendance for medical examinations;
- Patients aged 16 years and above visiting health facilities.

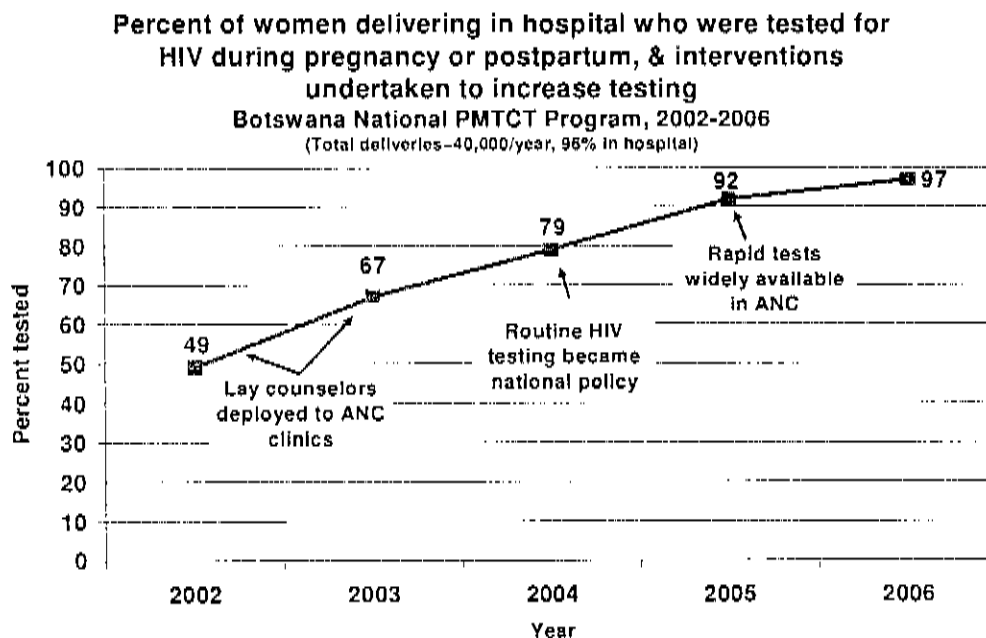
Achievements of the RHT programme

- Acceptance of RHT is high and RHT increased access to HCT
- Improved linkage to prevention, treatment, care and support
- Contribution to reduction of stigma and discrimination
- Introduction of the lay counselor cadre has been accepted and has worked to increase testing.

Number of people tested in Botswana's RHT programme, 2004-2007

Year	Offered	No. Tested (%)		HIV prevalence
		Male	Female	
2004		60,846		41.9%
2005	177,831	157,894 (88.8%)	30.5%	31.5%
2006	187,935	178,176 (94.8%)	30.5%	26.3%
2007 (Jan-Aug)	124,789	117,104 (93.8%)	35.5%	22.3%

A total of 514,020 people were tested in the RHT programme since 2004. Acceptance levels were very high, ranging from 88.8% to 94.8%. More females than males accepted to be tested and the HIV prevalence has been declining among those tested.



Challenges with the RHT programme

- Implementation of the programme was not introduced in a phased way.
- Consulting clinicians are often unable to conduct testing for various reasons such as work overload, lack of training, negative attitude to the RHT programme and logistical challenges such as space for counseling and testing.
- Inconsistent and inadequate offering of RHT in facilities due to inadequate training and guidelines.
- Support from supervisors to ensure quality, especially for the lay counselors.
- Irregular supply of reagents, test kits, etc.
- Late reporting of programme uptake from facilities.

Lessons learnt from the RHT programme

- High acceptance of RHT.
- Involvement of non-professional staff increased CT significantly, e.g. PMTCT.
- Implementation works better when piloted/ phased: e.g. PMTCT .
- Uptake of VCT increased parallel with RHT.

Source: Ntsuape and Kejelepula MT (2008) Four years of routine HIV testing – Botswana's achievements & lessons learned. Presentation at the Inception meeting of the SADC PMTCT and HTC project, 15-17 December 2008

Case study 2: Know Your Status Campaign in Lesotho as a best practice HTC intervention

HTC is an essential component of Lesotho's national response to the HIV and AIDS epidemic. Lesotho supports a comprehensive approach that integrates HIV prevention, treatment, care and support. HTC is the centre point of this strategy, serving as a key entry point to all three services. In particular, counselling provides a critical opportunity for prevention education, behaviour change support, and referral to appropriate services.

In 2004, the Prime Minister of Lesotho, Mr Pakalithi Mosisili, launched a national campaign to encourage Basotho to know their HIV status. On World AIDS Day, December 1, 2005, the Minister of Health and Social Services launched the Know Your Status Campaign to achieve Universal Access to HIV Testing and Counselling by the end of 2007. This plan ensured that the STI/HIV/AIDS Directorate of the Ministry of Health and its many partners in Lesotho put in place all the necessary components to allow all men, women and adolescents in Lesotho to learn their HIV status, and access HIV prevention, treatment, care and support services. The plan was created with input from multiple stakeholders representing various government ministries, NGOs, and international partners. Thus, the plan reflects consensus achieved by the key stakeholders and technical advisors.

The goal of the campaign is to "contribute to halting and reversing the spread of HIV in Lesotho, in the context of comprehensive HIV and AIDS prevention, care, treatment, and support". The program aims to meet the following broad objective: "All people above the age of 12 years living in Lesotho will know their HIV status by the end of 2007, so that those who are negative remain negative and those who are positive live productive lives." The plan has 11 strategic objectives:

1. Create a policy environment that enables people in Lesotho to know their HIV status;
2. Build widespread national support and community ownership of the Know Your Status Campaign;
3. Build HIV and AIDS knowledge, shift attitudes and influence behaviour on HIV and AIDS, with a focus on HIV testing and counselling;
4. Expand human resource capacity to conduct HIV testing, counselling, and education at the district, health centre and village level;
5. Expand access to HIV testing and counseling, especially at the community level;
6. Strengthen logistics and supply management for HIV testing;
7. Strengthen post-test services for HIV positive and negative people;
8. Strengthen the supervisory system for HIV testing and counselling services;
9. Strengthen the monitoring and evaluation of HIV testing services at local and national level;
10. Assure independent oversight of the HIV campaign to ensure the rights of community members
11. Mobilize the necessary resources to fully implement the Campaign at the national, district and community level.

Broadly, the strategic approach for ensuring universal access to HIV testing and counselling included the following:

- Every household in Lesotho was offered an HIV test and personal counselling following community level education and mobilization;
- The communities chose how HIV testing and counselling was carried out for its members -- they were able to choose among house-to-house counselling by a community health worker from within or outside their community, mobile testing and counselling on fixed dates, and provider initiated testing and counselling in health facilities;
- Every person tested and counselled was referred to post-test services, according to their HIV status; and

- Community level testing and counselling was rolled out at the same time that HIV prevention, care and treatment services were scaled up at the health centre level, ensuring a continuum of services.

To achieve these goals, 3,600 community health workers were trained in HIV testing and counselling; five community members per village, including PLWHA, were trained in on-going counselling and HIV education; and quality of the testing and counselling was assured according to existing national standards. In compliance with national standards, HIV testing and counselling in Lesotho is never mandatory. Finally, testers always obtained informed consent prior to testing.

Overall, to implement the plan, there was a need to: appoint or recruit 12 staff at national level to be dedicated to working on the Campaign; appoint 100 district level dedicated staff; build the capacity of 3,600 community health workers (already in the health system); and train a new cadre of 3,600 community-based counsellors. The total budget for the plan to was estimated to be 75.6 Million Maloti over a 2-year period.

What was unique about this project?

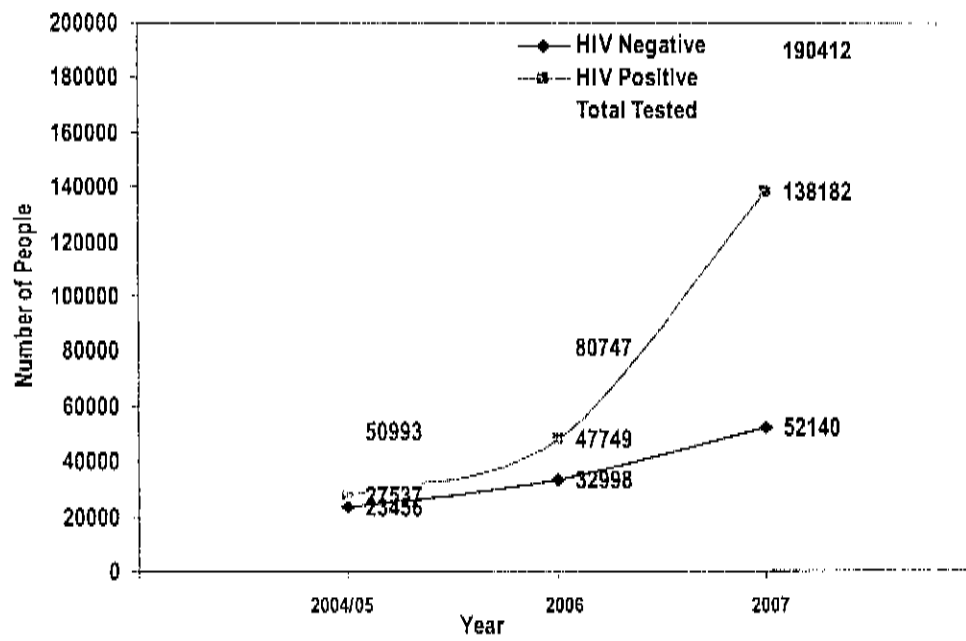
Globally, it was the first plan that aimed to offer every household in an entire country an HIV test and counselling. It was created in a participatory fashion with input from multiple partners. It had built-in mechanisms to ensure that the human rights of citizens were protected. It required that individuals be encouraged to know their status only when HIV prevention, care, and treatment were available locally. It called for an enormous increase in human capacity to carry out testing and counselling across the country, but also to provide on-going counselling support for safer sex and adherence counselling. It required each village to decide how they wanted to receive testing and counselling. It proposed a communications plan that ensured that the people of Lesotho knew about the advantages and disadvantages of being tested and counselled and where to get the service. And finally, it included a resource mobilization component that resulted in Lesotho increasing its human resource capacity and greatly impacting the HIV and AIDS epidemic.

Update (by end of September 2008)

- There is increased access to HTC & post-test services generally.
- By the end of September over 480 000 people accepted HIV testing.
- Acceptance rate for HIV testing was greater than 95% amongst those offered.
- Over 161 sites offering HTC services nation-wide.
- Number of service providers increased with 3,800 community-based carers trained to provide HTC services.

See below for trends in HTC service utilization in Lesotho.

Trends in HTC Service Utilization in Lesotho from June 2004 to December 2007



Case study 3: UNAIDS good practice VCT projects in SADC

1) *Demonstration of Antiretroviral Therapy (DART) project*, is based in Soweto, South Africa and is implemented by the Perinatal HIV Research Unit of the University of the Witwatersrand. All women undergo individual pre-test counselling at their first antenatal visit. At the end of the counselling session, the VCT counselor asks the client to sign a form in the patient folder, indicating if she wants to test and receive the results the same day; test and receive the result later; test another time; not have a test.

Uptake of the HIV test in the DART project was very high. Over 90% of women attending antenatal services in the Chris Hani Baragwanath Hospital, and approximately 88% in the Zola Clinic, decided to have an HIV test

2) *Ndola Demonstration Project (NDP)* is located in the Copperbelt Province of Zambia, implemented by the Ndola District Health Management Team (DHMT), and supported by the USAID-funded LINKAGES Project. The key objectives of the project are to integrate VCT and improved counseling on infant-feeding practices; introduce VCT into MCH as an ongoing service available to pregnant women and their partners, and create an enhanced environment for counseling to ensure privacy and confidentiality.

Pregnant women are invited during antenatal visits and on other occasions to utilize VCT services at any time during pregnancy or afterwards. This invitation also includes their partners. Pre-test counselling is only made available to those who decide to test. VCT counselors distribute the ARV drugs during post-test counseling to women who tested positive and agreed to the intervention. This ensures that women are in possession of the drug at the onset of labour.

3) *TB/HIV Pilot project* uses VCT as a link between HIV/AIDS and TB programmes. The project is located in the Western Cape Province of South Africa and is implemented by the local authority and the provincial government under the guidance of the Department of Health and WHO. The key objectives of the project are to increase access to voluntary counselling and HIV testing, decrease the barriers to VCT, and improve the quality of VCT.

All HIV-positive clients have access to free comprehensive care, including TB treatment, TB preventive therapy, and co-trimoxazole prophylactic treatment.

4) *Kara Counseling and Training Trust (KCTT)* is operating in Lusaka and Choma in Zambia. KCTT works towards increasing young people's utilization of VCT services, including post-test support services. To achieve this, the organization takes the following approaches:

- youth-oriented outreach activities to educate and mobilize young people for VCT;
- access to partner and pre-marital counselling and testing for young couples;
- youth-friendly VCT service provision;
- provision of ongoing counselling and youth-friendly post-test clubs; and
- operational research about VCT and young people.

5) *Zimbabwe AIDS Prevention and Support Organisation (ZAPSO)* operates in Harare and Chitungwiza in Zimbabwe. The three models of VCT delivery used by ZAPSO include a freestanding VCT site in central Harare, which services a population working in the central city; a VCT service attached to a busy primary healthcare clinic in a high-density Harare suburb; and free-standing sites in rural/semi-rural settings.

The ZAPSO services indicate that different models may suit different communities. It highlights the importance of participatory community planning to determine the acceptability and model of VCT service proposed before VCT services are implemented.