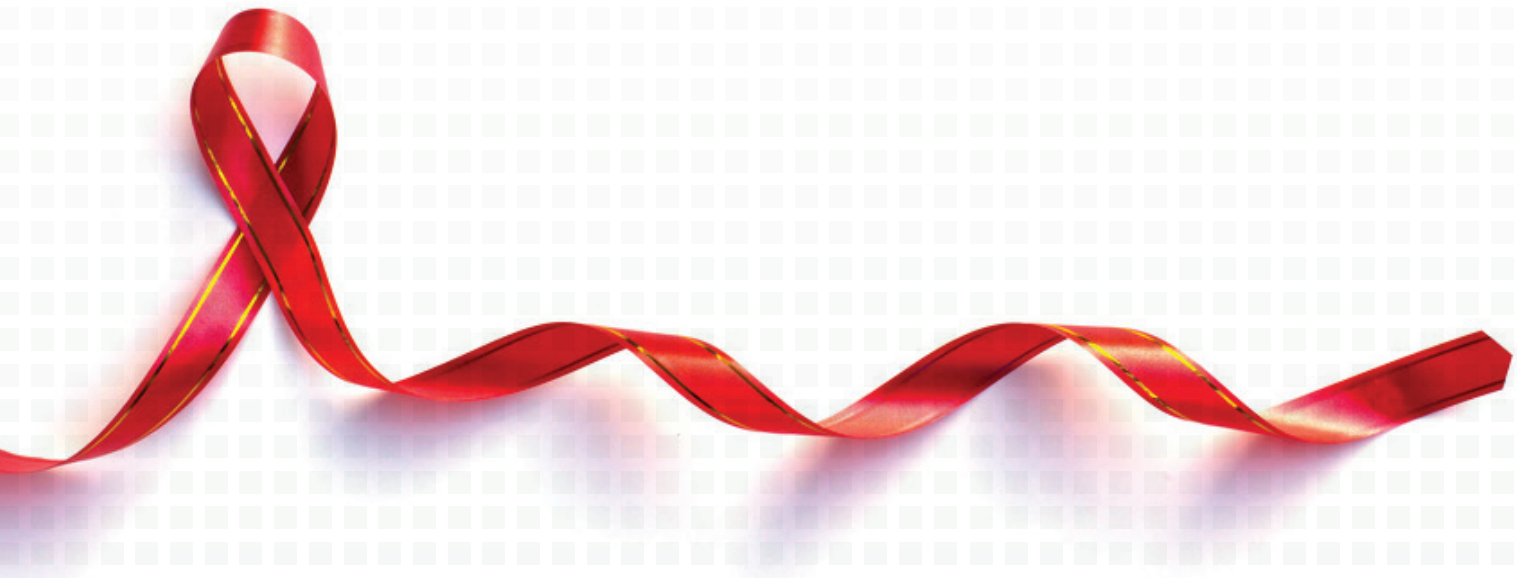
Approved November 2009

Assessment Report on the Status of HIV Testing and Counselling Policies in the SADC Region



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ACRONYMS AND ABBREVIATIONS

AIDS	Acquired immune deficiency syndrome
BAIS	Botswana AIDS Impact Survey
CBO	Community-based organisation
FTA	Free trade agreement
HIV	Human immunodeficiency virus
HSRC	Human Sciences Research Council
HTC	HIV testing and counselling
IDU	Injecting drug user
M&E	Monitoring and evaluation
MSM	Men who have sex with men
NGO	Non-governmental organisation
PITC	Provider-initiated counselling and testing
PLWHA	People living with HIV and AIDS
PMTCT	Prevention of mother-to-child transmission (of HIV)
SADC	Southern African Development Community
STI	Sexually transmitted infections
UN	United Nations
UNAIDS	United Nations Joint Programme on AIDS
VCT	Voluntary counselling and testing
WHO	World Health Organization

GLOSSARY

Confidentiality: The right to have one's medical information, including HIV status, kept private.

Counselling: A confidential dialogue between a client and a trained counsellor, which is aimed at enabling the client to understand and take appropriate decisions related to HIV and AIDS. Counselling may be provided by a professional or a lay counsellor.

High-risk behaviour: Unprotected sexual intercourse with more than one partner, or sharing contaminated injecting equipment.

Hyper-endemic: A situation where at least 15% of adults (15-49 years) are living with HIV.

Pre-test counselling: Counselling given to an individual before an HIV test, to ensure that the individual has sufficient information to make an informed decision about taking an HIV test.

Post-test counselling: Counselling provided when an individual receives his or her HIV test result. Post-test counselling involves at least one session.

HIV testing: Obtaining and use of a bodily fluid sample for the purpose of performing 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.

EXECUTIVE SUMMARY

Southern Africa is the epicentre of the global AIDS epidemic. It accounts for almost one third (32%) of all new HIV infections and AIDS deaths, with national adult HIV prevalence exceeding 15% in seven Member States in 2007. Among the interventions that can play a pivotal role in treatment and prevention, HIV testing and counselling (HTC) is paramount, and has become increasingly important in national and regional prevention and care efforts.

An assessment of HIV testing and counselling policies in the SADC region was necessary to inform the development and implementation of harmonised minimum standards for HTC. These would constitute the harmonisation framework for southern Africa.

The process 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; field assessments; and policy discussions with major stakeholders in the Member States. A consensus-building workshop was held where all stakeholders reviewed, endorsed and adopted the proposed regional minimum standards.

It transpired that all but one SADC Member State have approved national HTC policies and guidelines. Most Member States are offering HTC services at public health facilities, and multiple approaches to HTC are being used. They include provider-initiated testing and counselling (PITC) or routine HIV testing and voluntary counselling and testing (VCT).

Most Member States, however, do not have functional and effective monitoring and evaluation systems specifically for HTC services. Most of them have adapted monitoring and evaluation frameworks that were developed for other HIV and AIDS services in order to monitor and evaluate HTC services.

1. INTRODUCTION

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 harmonisation and coordination, and the 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 citizens. AIDS is a major obstacle to the achievement of this objective, and it threatens 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 great potential for trade, economic growth and employment creation. The FTA may also lead to the increased movement of people, which has implications for the spread of communicable diseases, including HIV.

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

- The *Maseru Declaratio*n (2003) on HIV, which prioritised prevention and social mobilisation among other regional priorities for the SADC region;
- The *Maputo Declaration* (2005) of African Ministers of Health, which proposed efforts to strengthen national HIV prevention programmes;
- The *Brazzaville Commitmen*t (2006), which called on countries to scale up efforts towards universal access to HIV prevention, treatment, care and support by 2010;
- The *Abuja Declaration* (2001 and 2006), which 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 specified targets for HIV prevention.

The SADC 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*. The Business Plan identifies key intervention and priority areas, activities and performance indicators. Among its priorities are policy development and harmonisation.

In line with the above commitments, SADC Member States have developed policies, guidelines and protocols to address various aspects of the HIV and AIDS epidemic. Harmonisation of regional policies and strategies ranks among the major priorities in the SADC region. The *SADC Protocol on Health* is legally binding and highlights the response to communicable diseases, including HIV and AIDS, among its priorities.

Article 10 of the *Protocol* calls for the harmonisation of policies for the prevention and control of HIV infection. It also calls for the implementation of HIV and AIDS programmes in a coherent, comparable, harmonised and standardised manner. A policy agenda to develop regional minimum standards as a framework for harmonisation of approaches to HIV testing and counselling (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 needed to inform the development and implementation of harmonised minimum standards for (HTC).

The interconnectedness of the region and the similarities in the challenges countries face demand a common regional approach, notwithstanding some variations in the epidemics of Member States. The *SADC Protocol on Health* calls for the harmonisation and standardisation of regional policies. The development of minimum standards as a harmonisation framework for HTC policies and protocols is therefore vital.

2. OVERVIEW OF HIV AND HIV TESTING AND COUNSELLING IN THE SADC REGION

2.1 Overview of HIV and AIDS in the SADC region

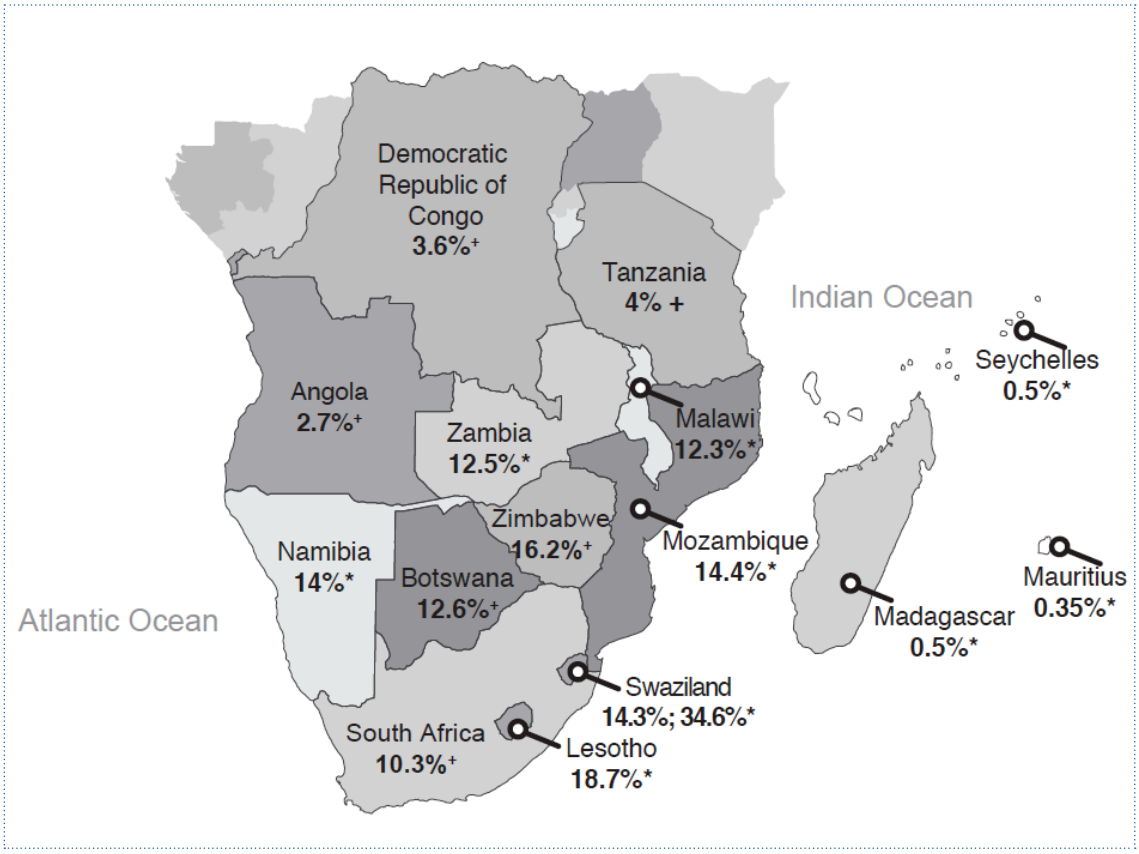
There were an estimated 33.4 million people living with HIV in 2008 globally. (1) SADC is the region most affected by AIDS. (2) The SADC Member States contained about 2% of the world's population, but were home to 35% of all HIV-infected persons and 33% of all AIDS deaths in 2007. (3)

Adult national adult (25-49 years) HIV prevalence in 2007 exceeded 15% in seven Member States; in three of them, HIV prevalence exceeded 30%. By contrast, prevalence was under 6% in a further three Member States. (2)

HIV prevalence among young people (15-24 years) in 2007 ranged from 0.4% to 19% (see Figure 2.1 below). The burden of disease in Member States therefore differs considerably in this population sub-group. Almost all people infected with HIV will progress naturally to AIDS, and will require treatment for the rest of their lives, thus contributing to a heavy burden on Member States as a whole. Island states such as Mauritius, Madagascar and Seychelles have low-level epidemics, with adult HIV prevalence of less than 1%, while Angola, the Democratic Republic of Congo and Tanzania have generalised epidemics with comparatively moderate HIV prevalence (2.7% to 4%).

Most of the other Member States are experiencing hyper-endemic HIV situations, with national adult prevalence of 10% or more. They include Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe. (2)

Figure 2.1: HIV prevalence among 15-24 year-olds in the SADC region, 2007



Source: SADC Epidemic Update 2007, and various 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, in only one Member State did more than 10% of women report that they had had sex with more than one partner in the previous 12 months.

Levels of HIV knowledge are still relatively low. For example, in only three out of 11 Member States could more than 50% of men and women aged 15-24 years correctly identify ways for preventing the sexual transmission of HIV, and reject major misconceptions about HIV transmission. (2)

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 distinguishes between three categories of HIV epidemics: low-level, concentrated and generalised. Each category calls attention to the nature (most- affected populations), dynamics (patterns of change over time) and characteristics (severity of impact) of the respective epidemics. The typology facilitates more strategic and locally appropriate planning and programming:

- In low-level epidemics, HIV has not spread to significant levels in any sub-population. Infections occur largely among individuals with higher risk behaviour (for example, sex workers, injecting drug users, and men who have sex with men). Generally, HIV prevalence has not consistently exceeded 5% in any of those sub-populations. (4)

- In concentrated epidemics, HIV has spread rapidly in certain sub-populations, but is not well established in the general population. HIV prevalence is consistently over 5% in at least one such sub-population, but is below 1% among pregnant women. (4)

- In generalised epidemics, HIV is firmly established in the general population. Sub-populations at high risk may contribute disproportionately to the spread of HIV, but sexual networking in the general population is sufficient to sustain the epidemic. HIV prevalence is consistently over 1% among pregnant women. (4)

A *hyper-endemic* scenario describes a situation in which HIV is well established in the general population and HIV prevalence exceeds 15% among adults. Botswana, Lesotho, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe all fit the hyper-endemic scenario. Madagascar and Mauritius provide a sharp contrast, with national adult HIV prevalence of less than 1%, thus fitting the low or concentrated scenarios. In these countries, HIV is concentrated in certain sub-populations. In Mauritius, for example, adult prevalence is estimated at 0.6% but among prison inmates, sex workers and injecting drug users (IDUs) it ranges between 15% and 25%. (2) Mauritius estimates that 93% of all new HIV infections occur among IDUs and their sexual partners (mainly through the sharing of contaminated injecting equipment and unprotected sex). All the other Member States (Angola, the Democratic Republic of Congo, Malawi and Tanzania) have generalised epidemics.

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, sex workers, prison inmates, and their sexual partners) should be targeted with 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-populations (for example, people with multiple sexual partners), as well as general prevention campaigns for the population as a whole, are recommended. (2)

Sound epidemiological and behavioural information is needed to describe the dynamics of each epidemic and design appropriate responses. Understanding the characteristics of the various epidemics is vital for designing effective prevention programmes.

In concentrated epidemics, most-at-risk populations are key. Injecting drug use, for example, plays a critical role in Mauritius' HIV epidemic, while sex work is instrumental in the spread of HIV in Madagascar. Member States have made commitments to put people affected by the AIDS epidemics, including most-at-risk populations, at the centre of their AIDS responses. Unfortunately, there is limited data available in the SADC region on these sub-populations. Collecting accurate data and information on most-at-risk populations should be prioritised in the Member States.

2.3 Key drivers of the HIV and AIDS epidemic in the SADC region

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 epidemics in these countries.

Other key factors contributing to the AIDS epidemics include: high levels of other sexually transmitted infections (STIs); 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 impact negatively on vulnerability and sexual health.

2.4 Impact of the epidemic in the SADC region

Limited implementation of effective prevention strategies has had a devastating impact, resulting in lower life expectancy, a marked decline in the Human Development Index (HDI), and increasing poverty for most Member States. (The HDI is a composite measure of development, based on life expectancy, literacy and years of schooling), and standard of living.) The HDI in some countries has fallen to pre-independence levels. (5)

The AIDS epidemic continues to exceed 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. The most pernicious impact of the epidemic, however, is the long-term nature of its destructive influence. It has left an estimated 6.3 million children without one or both parents, and many more vulnerable to extreme poverty, neglect and infection.

2.5 Overview of HIV testing and counselling

Member States have made several commitments pertaining to HIV testing and counselling. In the Maseru Declaration (2003), for example, they committed to achieve greater acceptance of testing by preventing stigmatisation and discrimination against populations affected by HIV and AIDS. (6) At the 2001 UNGASS gathering, they agreed to ensure expanded access to voluntary and confidential counselling and testing. (7)

2.5.1 Policy, legal and social issues of HIV testing and counselling

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

The *Declaration of Commitment* (agreed to at the United Nation General Assembly Special Session on HIV/AIDS in June 2001) highlighted the pressing need to either develop or scale-up VCT services. (7) At the first global VCT consultation convened by WHO in Harare, in June 2001, the participants issued a statement that recognised VCT as:

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

2.5.2 Importance of HIV testing and counselling in HIV prevention and treatment

Among the interventions that can 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. HTC is necessary because:

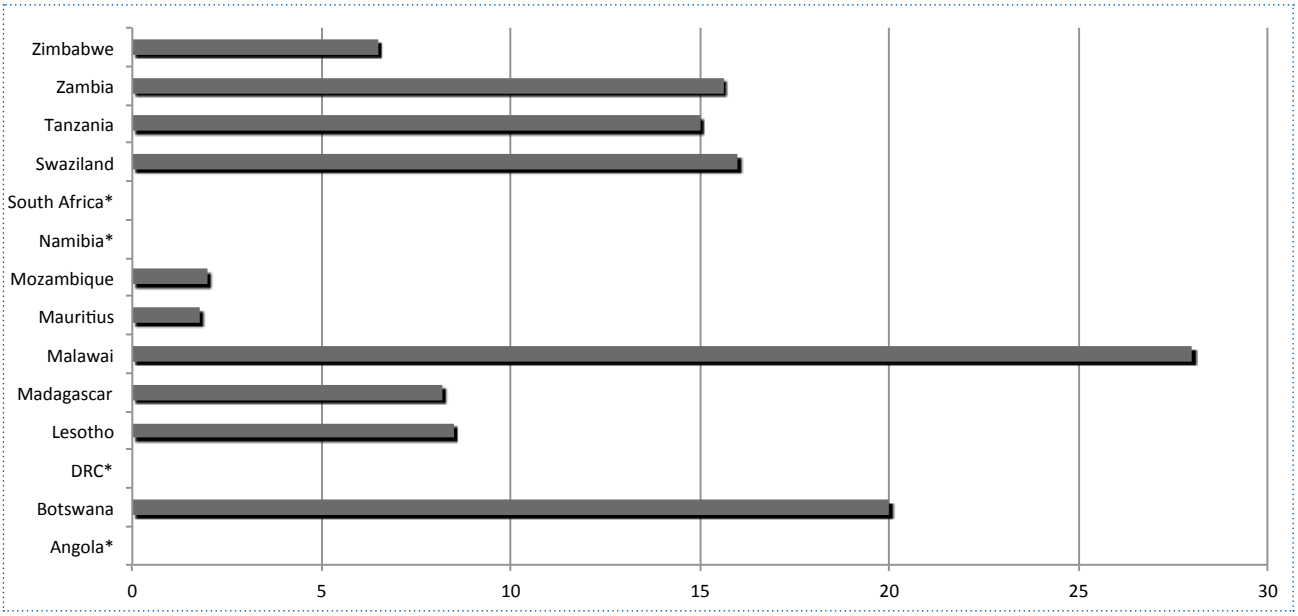
- It is a critical point of entry for both prevention and care;
- Knowing one's HIV status alerts one to the possible need to seek medical care to prevent or delay life-threatening illness, and can assist health care providers in determining the best treatment for illnesses that may develop;
- Knowing one's HIV status can be a motivating force for avoiding HIV risks and thereby reducing the risk of HIV infection; and
- Knowing one's HIV status helps one plan for the future (for example, making informed decision on whether or not to have children).

A 2005 United States Agency for International Development (USAID) survey in 12 high-burden sub-Saharan African countries found that only 12% of men and 10% of women in the general population have both been tested for HIV and received their test results. (8) HTC efforts have expanded subsequently, but it is almost certainly still true that the majority of people who are HIV-positive are not aware of their status, continue to unknowingly infect others, and are unaware of the need to access treatment. The challenge remains to get more people to make use of HTC services.

SADC's HIV and AIDS core indicators included an HTC indicator for the *"percentage [of people] who took an HIV test in the last 12 months and who know their results"*. Figure 2.2 shows that a small 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 percentage of people who had been tested and knew their results ranged from about 2% in Mauritius and Mozambique to 28% in Malawi. In more than half of those ten Member States, under 10% of the adult population knew their HIV status.

Figure 2.2: Percentage of adults who took an HIV test in the last 12 months and who know the results, SADC Member States, 2007



Source: 2007 SADC HIV and AIDS Epidemic Report
** Data for this Member State was not available*

Qualitative reports from SADC Member States show that HTC programmes are expanding in the region. Most Member States are now offering HTC services at all public health facilities. It is also important to note that multiple approaches to HIV testing and counselling are being used in the region. These include provider-initiated testing and counselling, routine testing, VCT, and, in selected cases, mandatory testing. (2) For example, most military services conduct mandatory tests on personnel who serve in the Defence Force or are being posted on foreign missions.

2.5.3 Impact of voluntary counselling and testing on behaviour change

A systematic review of the impact of VCT in 'developing' countries suggests that VCT can be an effective behaviour change strategy. (9) However, weak study designs and limited replication mitigate the strength of the evidence. Several studies indicate that VCT is most effective in promoting behaviour change (such as less unprotected sex and fewer multiple sex partners and casual partners) in couples who were tested together, and among HIV-positive individuals, particularly with their non-primary partners. (10-12) The efficacy of VCT as a primary prevention strategy for HIV-negative people, as well as the long-term behaviour change outcomes of VCT for HIV-negative and HIV-positive individuals are less certain. (13)

On the other hand, a systematic review of the effect of VCT on behaviour change found little overall effect, especially in people who tested HIV-negative. (14) Some studies found some effect on those who tested HIV-positive, and also in sero-discordant couples when the male is HIV-negative. (15)

There are indications that VCT also helps people cope with a range of psychosocial problems associated with an HIV-positive diagnosis. (16) A 2004 study highlighted the importance of VCT in the context of programmes for preventing mother-to-child transmission of HIV (PMTCT) for helping women manage the potentially negative reactions of spouses or family members. It also encouraged partner support, co-counselling and HIV testing. (17)

While some studies from sub-Saharan Africa show that high-quality VCT can be an effective strategy for reducing HIV sexual risk behaviours among adults, little is known about VCT for young people, especially among adolescents. (18) Experiences in several African countries indicate that youth actively seek out 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 partners. (19)

VCT is an important gateway to care and support. The biggest challenge, however, is to bridge the gap between knowing VCT services are available and using those services.

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. Community-based VCT in South Africa has shown strong evidence people in rural and peri-urban settings can be reached. Project Accept, based in rural KwaZulu-Natal and Soweto (20), has demonstrated that mobile VCT can reach relatively equal number of males (47%), females (53%), as well as 75% of youth in the 16-30 year age group.

2.5.4 Reasons for poor uptake of voluntary counselling and testing

Despite the increasing availability of VCT in African countries, uptake of VCT remains low. Recent data indicate, for example, that fewer than 20% of adults in the SADC region have been tested for HIV and know their serostatus.

There are many reasons for the low uptake of VCT services, and these operate at the individual level, as well as at the broader institutional and structural levels. Individual factors include anxiety about testing positive for HIV and the ramifications of a positive test, as well as fears about stigmatisation, disease and death. (21)

Systemic factors that limit VCT uptake include concerns about a lack of confidentiality, actual breaches of confidentiality by healthcare workers, fear of being discriminated against by those workers, a general lack of trust in the healthcare system, and a fear of disclosing one's HIV-positive status to sex partners. Fears of possible adverse consequences, particularly for women, pose an additional barrier to VCT implementation. 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 partners. (22)

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

3. METHODOLOGY

3.1 Process for reviewing HIV testing and counselling policies and programmes

The process for reviewing HIV testing and counselling policies and programmes was participatory including Member States, the SADC Secretariat and various stakeholders. The process was also informed by internationally-recognised best practice.

Firstly, a desk review of the current national, regional and global policies relevant to HIV testing and counselling was conducted. This was followed by individual country assessments in each Member State, during which key informants within the respective programs, including development partners, civil society organizations and the private sector were consulted to provide information on the state of programmes and policies. The respondents also shed light on some challenges and best practices. Each visit culminated in a country level assessment report which was reviewed and validated by officials from Ministry of Health of each Member State.

The country reports were then compiled to inform a regional picture of the situation and response analysis. The draft regional assessment report was used as a basis for Regional Minimum Standards. Both the draft Regional assessment report and the draft regional minimum standards were then reviewed by a technical team for technical soundness. The team comprised Member States, Technical Partners, Civil society Organizations and the SADC Secretariat. The purpose of the review team was to strengthen the quality of the documents.

Following the technical review and the incorporation of the comments, the documents were then presented to a regional workshop for validation of the situation and response analysis report. All Member States and major stakeholders including regional partners and civil society organisations were invited to the validation and consensus building workshop. The workshop was held on 25-27 May. The meeting made recommendations on the draft report.

The revised reports were reviewed by the SADC National AIDS Authorities in their meeting of October 2009 for technical soundness and recommendation for finalisation.

3.2 Identifying HIV testing and counselling good and best practices in SADC

The *SADC framework for developing and sharing best practice on HIV and AIDS* (2006) defines a best practice 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. (23) This can be replicated to improve the quality of interventions aimed at mitigating particular aspects 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, and
- 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.

4. FINDINGS ASSESSMENT OF HIV TESTING AND COUNSELLING IN THE SADC REGION

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; and
- Monitoring and evaluation.

4.1 Approaches to HIV testing and counselling in the SADC region

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

- Client-initiated HTC, commonly referred to as VCT; and
- Provider-Initiated Counselling and Testing (PITC).

4.1.1 Voluntary counselling and testing

VCT (or client-initiated HIV testing and counselling) is the process by which people seek HTC services to enable them to make informed choices about learning about their status and taking appropriate actions. Counselling for VCT consists of pre-test, post-test and follow-up counselling. During pre-test counselling, the counsellor gives an individual (or a couple or group) the opportunity to assess their situation, and consider being tested for HIV. After enough information and support to understand what is involved, each person makes an informed decision whether or not to take the HIV test.

VCT is effective for promoting knowledge of one's HIV status. It is provided in many settings (such as at free-standing sites) or it is 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 has been on VCT. However, VCT has several limitations and bottlenecks that can lead to poor coverage and slow uptake. It is time-consuming, since it requires a lot of time for counselling. Exclusive reliance on VCT has inhibited timely identification of people living with HIV. There is a need, therefore, to use different testing and counselling approaches to access different groups of people.

Recent "Know Your Status" campaigns in Lesotho, South Africa and other SADC Member States have tested large numbers of people in relatively short periods of time. Lesotho's "Know Your Status" campaign is considered a best practice VCT initiative because it meets at least four of the six criteria in the SADC framework of best practices. The initiative is:

- *Relevant*, since it started by targeting all public servants in the country. It also uses local people and resources;
- *Innovative* and ambitious as it was the first campaign in the world where health officials targeted every household in an entire country with an offer of HTC;
- *Effective*, since all urban and rural communities can be reached using various means of transport and local resources;
- *Cost-effective*, as the country has been able to use resources obtained from international organisations to implement the initiative;

- But the initiative has not yet been *replicated* in any other country, and its *sustainability* cannot be guaranteed because it relied heavily donor funds.

The "Know Your Status" campaign is described in Case Study 2 (in Appendix, below).

4.1.2 Provider-initiated HIV testing and counselling

PITC (also referred to as "routine testing") entails healthcare providers recommending HTC to persons attending healthcare 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:

- To all patients whose clinical presentation might result from underlying HIV infection;
- As a standard part of medical care for all patients attending health facilities in countries with generalised epidemics; and
- More selectively in concentrated and low-level epidemics.

Individuals must specifically decline the HIV test if they do not wish it to be performed. Provider-initiated models have been introduced relatively recently. HTC officials believe that routine testing is a promising way to advance prevention programmes and to reduce the burden on hospitals by helping people access treatment at earlier stages of disease.

Botswana and Malawi have begun implementing PITC by ensuring that healthcare providers offer HIV tests to all clients accessing health services. Botswana was the first country in Africa in 2004 to implement PITC (which it refers to as routine HIV testing). (24)

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 practices. The initiative is:

- *Effective*, as it has increased access to PMTCT to 95% in 2008;
- *Cost-effective*, because the country has been able to afford it and to meet the demand;
- *Relevant*, since it uses local people and resources; and
- *Innovative* in the way it involves men and people living with HIV.

Botswana's initiative has not yet been *replicated* in any other country. The initiative is described in Case Study 1, below.

As shown in Appendix 1, seven of the Member States indicate that their governments adopted the strategy of routine offer of HIV testing as early as 2005. Those policy commitments, however, have not yet been followed by implementation.

5. AVAILABILITY OF HIV TESTING AND COUNSELLING POLICIES, PROTOCOLS AND GUIDELINES

An analysis of national HTC policies and guidelines indicates that all but one SADC Member State (Namibia) have approved national HTC policies and guidelines. The policies were approved at different points, dating back to 2001.

Each of the 12 SADC Member States that participated in policy discussions staged a consultation process for developing the HTC policy. All respondents said that the policies or guidelines were easily available, and that HTC implementation plans existed.

The availability of HTC policies, protocols and guidelines in SADC Member States indicates recognition 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; and
- HTC recommendations guide minimum standards at Member State level.

5.1 Accessibility of HIV testing and counselling services

Access to HTC services has increased significantly in SADC Member States in the past few years. Zambia, for example, had 405 sites in 2005, 883 in 2007 and 1023 in 2007. The average number of clients accessing each site per month rose from 22 in 2006 to 37 in 2007. If each site were to see eight clients per day (assuming a 22-day month), then the average should be around 176 clients per month at each site. This would add up to more than 2.1 million tests a year in Zambia, rather than the current 600 000. The pattern in most SADC Member States seems similar. A majority of individuals find HIV testing acceptable, but this has not translated into high HIV testing rates.

Eight Member States in SADC include individual pre-test counselling, while at least 10 Member States conduct group pre-test education. About seven Member States do not specifically have HIV retesting in late pregnancy, and six offer nothing or very little by way of involving men, involvement of persons living with HIV, and gender violence. Counselling is provided by health workers, such as doctors and nurses in health services and by trained lay counsellors (referred to as primary counsellors in Zimbabwe).

At least five SADC Member States said they were developing protocols that would allow qualified and registered counsellors, volunteers and nurse assistants to offer and conduct HIV tests. The protocols are being amended to enable these staff to guide patients through the entire process, from pre-test information/counselling, 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 counsellors are confident that no family member or partner is being forced to test, or may suffer harm as a result.

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

- Pre- and post-test counselling is part of the services provided at all HTC sites;
- Services are *voluntary*, and are used by clients who have already decided that they want to take a HIV test;
- *Confidentiality* is recognised as an essential component of all services while, at the same time, openness towards partners and family about the HIV status is promoted;
- Services are *anonymous*, and results are never given over the telephone or disclosed to another person;
- Counselling sessions are tailored to the individual or couple attending. Although there are common elements in the content of the counselling sessions, the counsellors note that HIV testing is often only one of a number of important issues that are covered in counselling sessions. Relationship difficulties and family problems are often underlying reasons for wishing to obtain HTC; and
- *Continuity of counselling* is also emphasised, with the majority of clients seeing the same counsellor for pre- and post-test counselling.

5.2 Quality assurance issues

HTC quality assurance monitors and evaluates the quality of services provided in accordance with established national guidelines, policies and standards. In general, it entails standardisation through national HTC guidelines, accreditation of HTC facilities, and supervision and support. Approaches for assessing HIV counselling services include the training of service providers, use of qualified trainers, standardised training tools, certification, and use of HTC aids.

Components of quality assurance, such as the pre-analytical, analytical and post-analytical phases, include:

- Adherence to laboratory protocols;
- 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); and
- Quality control of test kits and supplies.

5.2.1 Accreditation of staff and facilities

Responsibility for the accreditation of staff working in HTC rests with health organisations such as medical councils, nursing councils or health professional councils in each of the SADC Member States. The main criteria for accreditation involve training at an approved institution, by trained professionals, and for a stipulated period of time. In most instances training should last at least one year.

Lay counsellors are an exception. In most SADC Member States, their training ranges from a few days to several weeks. The accreditation of lay counsellors to perform 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 their respective Departments of Health. The minimum requirements of the Departments of Health that are used for accreditation of facilities include adequate and appropriately trained staff, adequate space, as well as adequate, appropriate and functioning 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 5.1 shows the minimum requirements that are used for accreditation of VCT sites, while Table 5.2 shows the minimum requirements that are used for accreditation of PITC sites (which are mainly linked to health services).

Table 5.1: Minimum requirements for accreditation of voluntary counselling and testing sites

	Large VCT facility	Small VCT centre
Staff	- Minimum of two counsellors - Minimum one counsellor supervisor - Laboratory staff for quality assurance for all HIV testing in the facility - Counselling and testing coordinator	- Minimum of two counsellors - Arrangement for supervision can be made with a supervisor from another facility
Space	- Dedicated CT rooms with good ventilation and privacy	- Any room with auditory and visual privacy and good ventilation
Equipment	Each counselling and testing room should have: - 3 chairs - Desk - Lockable cabinet for documents - Lockable cabinet for storage of HIV test kits and supplies - Testing table with sharps disposal bin - Hand washing facility - Bench in waiting area	- 3 chairs - Desk - Lockable cabinet for documents - Lockable cabinet for storage of HIV test kits and supplies - Testing table with sharps disposal bin - Hand washing facility
Supplies	- HIV test kits - Gloves and other supplies - Disinfectant - Counselling registers and monthly summation forms, other required stationery	- HIV test kits - Gloves and other supplies - Disinfectant - Counselling registers and monthly summation forms, other required stationery

Table 5.2: Minimum requirements for accreditation of provider-initiated testing and counselling sites

	Large PITC facility	Small PITC facility
Staff	- Adequate number of health workers - Adequate number of supervisors for health workers - Laboratory staff for quality assurance for all HIV testing in the facility - PITC coordinator	- Acceptable number of health workers including lay counsellors - Arrangement for supervision can be made with a supervisor from another facility
Space	- Dedicated counselling and testing rooms with good ventilation and privacy	- Any room with auditory and visual privacy and good ventilation
Equipment	Each CT room should have: - 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	- 3 chairs, - Desk, - Lockable cabinet for documents, - Lockable cabinet for storage of HIV test kits and supplies, - Testing table with sharps disposal bin, - Hand washing facility
Supplies	- HIV test kits - Gloves and other supplies - Disinfectant - Counselling registers and monthly summation forms, other required stationery	- HIV test kits - Gloves and other supplies - Disinfectant - Counselling registers and monthly summation forms, other required stationery

5.2.2 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 counselling.

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

- 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;
- Services that are available in the case of either an HIV-negative or an HIV-positive test result, including whether ARV treatment is available;
- The fact that the test result will be treated confidentially;
- 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 individual sessions do offer opportunities to discuss more in-depth personal issues.

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

6. MONITORING AND EVALUATION

Successful monitoring and evaluation (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 did not have functional and effective M&E systems for HTC services. None of the Member States has developed specific M&E frameworks for evaluating various aspects of their HTC programmes. However, most Member States have adapted monitoring and evaluation frameworks developed for other HIV and AIDS services to monitor and evaluate HTC services.

7. DISCUSSION

The table 7.1 provides a summary of achievements and challenges in relation to HTC in SADC:

Table 7.1: Main HIV testing and counselling achievements and challenges

Achievements	Challenges
- Uptake and availability of testing and counselling has increased; - Innovative and expanded campaigns to promote testing, such as universal testing in Lesotho, PITC in Botswana.	- Record-keeping: Six Member States 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.

7.1 Opportunities for HIV testing and counselling

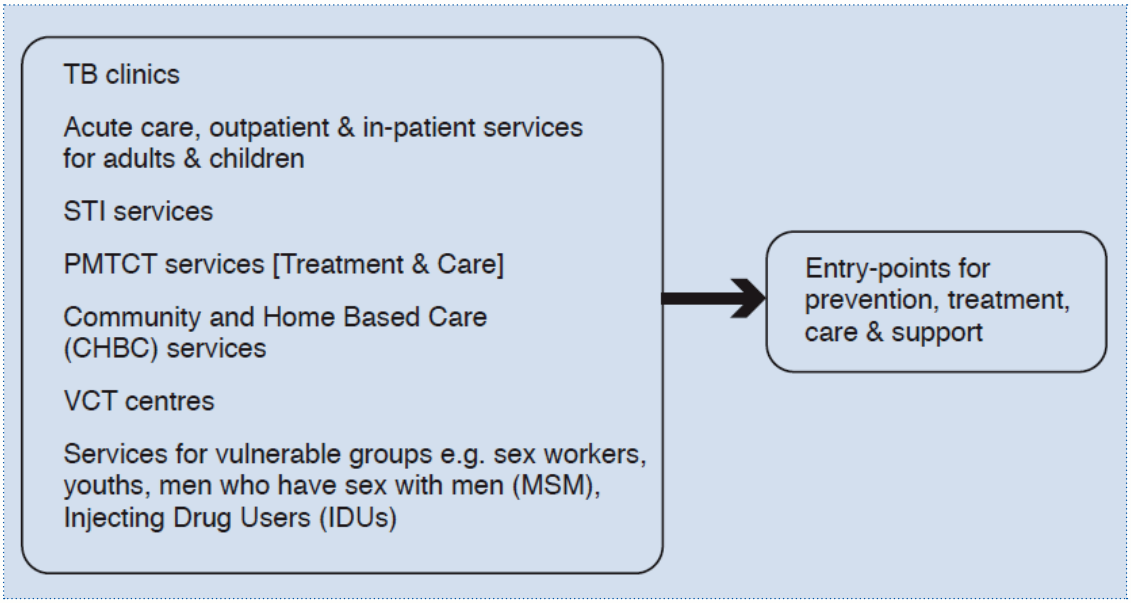
HTC is a key entry point to care and support services for persons who are HIV-infected. In order to ensure access to HTC for larger populations and facilitate access to ARV treatment, most SADC Member States use several settings, particularly where persons most likely to benefit from knowledge of their HIV status can be reached. Almost all Member States use their primary healthcare services, where they diagnose and treat tuberculosis and STIs, as an entry point for HIV testing and counselling.

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

About 10 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 to encourage vulnerable groups, such as sex workers, young people and men who have sex with men, to get tested for HIV. Almost all SADC Member States are using general medical settings where providers encourage patients to be tested for HIV.

Figure 7.1: Entry-points and opportunities for HIV testing and counselling



Implementing HTC at the Member State level is informed by:

- The type of epidemic: Concentrated, generalised, endemic or hyper-endemic;
- 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.

7.2 Challenges in implementing HIV testing and counselling services

All SADC Member States reported 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 include:

- Inadequate financial resources, which are often narrowly earmarked by donors;
- Inadequate human resources, including problems with lay counsellors;
- 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 and 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 decentralise 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; and
- Slow scale-up of PITC services, and the limited creation of demand for these services.

Table 7.2 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 7.2: Summary of strengths, weaknesses, opportunities and threats to HIV testing and counselling in SADC
Strengths Weaknesses

Strengths	Weaknesses
- Existence of HTC policies and guidelines; - Training and use of primary care counsellors 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 people living with HIV, covering nutrition, adherence, secondary prevention and stress management; - Media campaigns on HTC, tuberculosis, HIV and AIDS treatment and care.	- Limited involvement of men; - Limited follow-up and care and support for persons who test HIV-positive; - Inadequate psychosocial support structures; - Incomplete and late reporting; - Inadequate infrastructure; - Poor monitoring and evaluation; - Limited space for confidential counselling and for on-site rapid testing in clinics; - Failure to maintain an integrated referral system.
Opportunities	**Threats**
- Development of HTC guidelines for children that stipulate the age of consent; - Possibility of establishing HTC services in youth centres or colleges to encourage participation by young people; - Comprehensive communication strategy being developed; - Media promotions.	- Financing HTC programme improvement and implementation.

7.3 HIV testing and counselling 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 counselling widely available. The issues include:

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

- *Policy on child counselling, age of consent and testing of minors.* The current minimum age of consent for HIV testing in SADC ranges from 12 years to 18 years. Evidence of early sexual debut and teenage pregnancy points to the need to review circumstances under which children should be tested, as well as the age of consent;

- *Delay in translating the PITC (routine offer) policy into action.* 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;

- *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 report that current testing policies are more broadly disseminated and enforced in the private sector;

- *Testing in special circumstances.* Most Member States reported that 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 tuberculosis or STIs. They suggest that this would be similar to the current process of testing for syphilis;

- *Conducting HIV tests.* Several Member States have not determined who should administer tests in different settings, and under what conditions. The main options in most Member States are nurse counsellors or lay counsellors who administer rapid HIV tests, given the shortage of laboratory personnel;
- *HIV disclosure.* Confidentiality should not be breached under any circumstances in HTC. Most Member States said that counsellors prepare clients to disclose when they are ready, and that health services create conducive environments for clients to disclose their HIV status without fear of stigma or discrimination;
- *Involvement of people living with HIV.* Most Member States indicated that they have developed mechanisms for involving people living with HIV. However, many of them could not share the mechanisms are in writing;
- *HIV self-testing.* Although HIV self-tests are not encouraged in most SADC Member States (due to concerns about accuracy, difficulties in providing adequate samples for testing, the possibility of abuse, and the lack of pre- and post-test counselling), most Member States do not have clear positions on this matter.

HTC policy issues in SADC Member States 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 monitoring and evaluation by developing and using HTC indicators, registers, etc.;
- The need to improve the quality of both counselling and testing;
- Appropriate use of lay counsellors 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; and
- Development, implementation and documentation of good and best practice models in HTC.

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APPENDIX

Case study 1: Botswana's routine HIV testing programme as a best practice HIV testing and counselling intervention Background

Botswana has a population of 1.7 million people, and HIV prevalence was 32% among pregnant women in 2006 (slightly down from 37% in 2003). The HIV prevalence is 17% in the general population and 25% in the 15-49 year age group (BAIS II).

There is strong political leadership and a comprehensive HIV prevention and treatment, care and support programme which includes HIV and AIDS education, routine HIV testing, voluntary counselling and testing (VCT), antiretroviral therapy (ART), prevention of mother to child transmission (PMTCT), Isoniazid Prophylaxis Treatment, and behaviour change communication.

The routine HIV testing, or provider initiated testing and counselling, programme

Botswana was the first Member State in the SADC region to introduce routine HIV testing in January 2004 because there was a need to expand counselling and testing and increase access to HIV-related services. Routine HIV testing was introduced in all public health facilities in the Member State. At the time, approximately 50% of adult Batswana knew their HIV status.

Routine HIV Testing means entails 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 patient declines to have the test (or opt-outs). It is not compulsory.

The main criteria for routine HIV testing include:

- Clinical symptoms suggestive of HIV and AIDS,
- Pregnancy,
- Sexually transmitted Infections,
- Tuberculosis,
- Attendance for medical examinations, and
- Patients aged 16 years and older visiting health facilities.

Achievements of the routine HIV testing programme

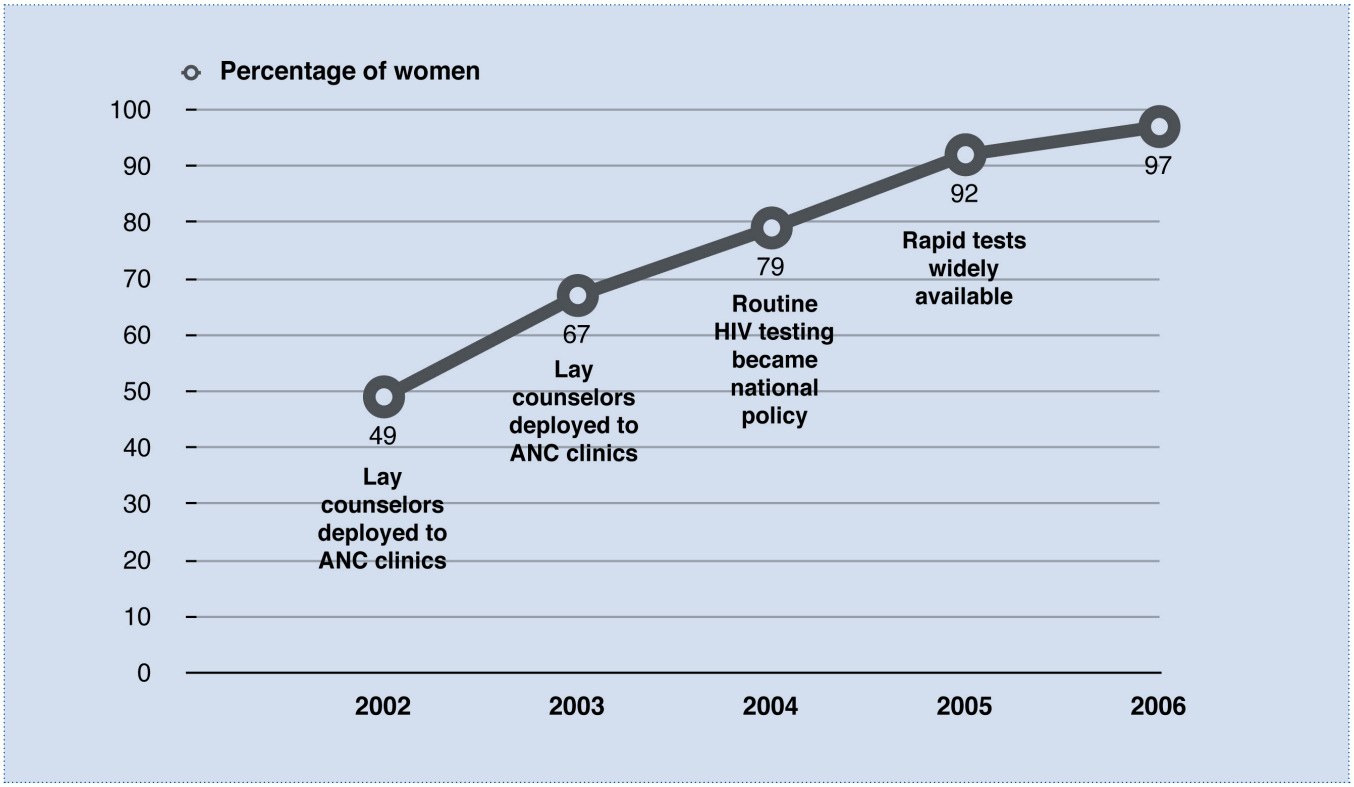
- Acceptance of routine HIV testing is high and routine HIV testing has increased access to HTC;
- Improved linkage to prevention, treatment, care and support;
- Contribution to reduction of stigma and discrimination;
- Introduction of a lay counsellor cadre has been accepted and has helped increase testing uptake.

Number of people tested in Botswana's routine HIV testing programme, 2004-2007

Year	Offered an HIV test	Percentage of males and females tested	HIV prevalence among those tested
2004		60,846	41.9%
2005	177,831	157,894 (88.8%) 30.5% (males) 69.5% (females)	31.5%
2006	187,935	178,176 (94.8%) 30.5% (males) 69.5% (females)	26.3%
2007 (Jan-Aug)	124,789	117,104 (93.8%) 35.5% (males) 66.5% (females)	22.3%

A total of 514 020 people were tested in the routine HIV testing programme since 2004. Acceptance levels were very high, ranging from 89% to 95%. More females than males agreed to be tested and the HIV prevalence has been declining among those tested.

Figure: Percentage of women delivering in hospital who were tested for HIV during pregnancy or post-partum, and interventions introduced to increase testing in Botswana, 2002-2006



Note: There are about 40,000 deliveries a year, 96% of them in hospitals

Source: Data from the Botswana National PMTCT Programme

Challenges for the routine HIV testing programme

- The programme was not implemented in a phased manner;
- Consulting clinicians are often unable to conduct testing for various reasons, such as work overload, lack of training, negative attitude to the routine HIV testing programme and logistical challenges such as space for counselling and testing;
- Inconsistent and inadequate offers of routine HIV testing in facilities due to inadequate training and guidelines;
- Support is lacking from supervisors to ensure quality, especially for lay counsellors;
- Irregular supply of reagents, test kits, etc.; and
- Late reporting of programme uptake from facilities.

Lessons learnt from the routine HIV testing programme

- There is high acceptance of routine HIV testing;
- Involvement of non-professional staff increased HTC significantly, for example in relation to PMTCT;
- Implementation works better when piloted or phased, for example with PMTCT;
- Uptake of VCT increased parallel with routine HIV testing.

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 HIV testing and counselling 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, and serves 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 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.

The plan ensured that the STI/HIV and AIDS Directorate of the Ministry of Health and its many partners in Lesotho put in place the necessary components to enable 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 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 programme 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 levels;
5. Expand access to HIV testing and counselling, especially at the community level;
6. Strengthen logistics and supply management for HIV testing;
7. Strengthen post-test services for HIV-positive and HIV-negative persons;
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. Mobilise the necessary resources to fully implement the campaign at the national, district and community levels.

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 mobilisation;
- The communities chose how HIV testing and counselling was carried out for their 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 people living with HIV and AIDS, were trained in on-going counselling and HIV education. Quality of the testing and counselling was assured in line with 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.

In order to implement the plan, 12 national-level and 100 district-level staff were appointed to work on the campaign. The capacity of 3,600 community health workers (already in the health system) was developed, and a new cadre of 3,600 community-based counsellors was trained. The total budget for the plan was estimated at 75.6 Million Maloti over a two-year period.

What was unique about this project?

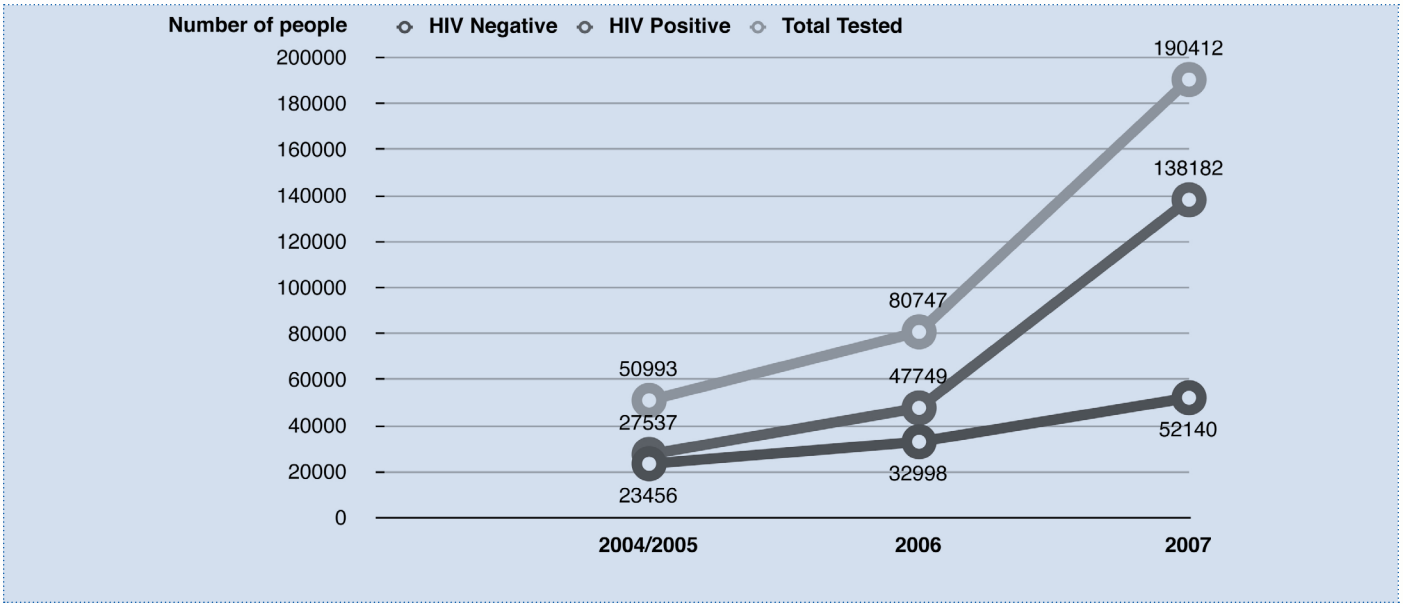
The campaign has several distinctive features:

- Globally, it was the first campaign that aimed to offer every household in an entire country an HIV test and counselling;
- The campaign 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, and 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;
- The campaign required that each village decide how it 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
- It included a resource mobilisation component that resulted in Lesotho increasing its human resource capacity and greatly impacting the AIDS epidemic.

Achievements by September 2008

- There was increased access to HTC & post-test services generally;
- Over 480 000 people had accepted to take an HIV test;
- Acceptance rate for HIV testing was more than 95%;
- There were over 160 sites offering HTC services nation-wide;
- The number of service providers increased, with 3,800 community-based carers trained to provide HTC services.

Figure: Trends in HIV testing and counselling service utilisation in Lesotho, June 2004 to December 2007



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