Scaling Up HIV Testing and Counselling in Asia and the Pacific

Report of a Technical Consultation
Phnom Penh, Cambodia
4–6 June 2007
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### Acronyms

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<th>Acronym</th>
<th>Description</th>
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<tr>
<td>ANC</td>
<td>Antenatal care</td>
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<tr>
<td>ART</td>
<td>Antiretroviral therapy</td>
</tr>
<tr>
<td>ICTC</td>
<td>Integrated Counselling and Testing Centres</td>
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<tr>
<td>IDU</td>
<td>Injecting drug user</td>
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<tr>
<td>MARP</td>
<td>Most-at-risk populations</td>
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<tr>
<td>MSM</td>
<td>Men-who-have-sex-with-men</td>
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<tr>
<td>PITC</td>
<td>Provider-initiated testing and counselling</td>
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<tr>
<td>PLHIV</td>
<td>People living with HIV</td>
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<tr>
<td>PMTCT</td>
<td>Prevention of mother-to-child transmission</td>
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<tr>
<td>PPTCT</td>
<td>Prevention of parent-to-child transmission</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually transmitted infection</td>
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<tr>
<td>SW</td>
<td>Sex worker</td>
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<tr>
<td>TB</td>
<td>Tuberculosis</td>
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<tr>
<td>VCCT</td>
<td>Voluntary confidential counselling and testing</td>
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<td>VCT</td>
<td>Voluntary counselling and testing</td>
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Executive Summary

In response to concerns over low coverage of HIV testing and counselling in the Asia Pacific region, a “Joint WHO/UNICEF/UNAIDS technical consultation on scaling up HIV testing and counselling in the Asia Pacific” was held in Phnom Penh, Cambodia from 4 to 6 June 2007. The aim of the meeting was to discuss how to scale up HIV testing and counselling services, discuss core public health approaches, ethical principles and human rights values to guide the expansion of HIV testing and counselling, and identify and agree on key actions for follow-up at the regional and country level for policy and programme implementation.

The percentage of the adult population who have received HIV testing in the region is estimated to be around 0.1%.

Increasing the coverage of testing and counselling services can enhance access to AIDS treatment, improve treatment outcomes and expand HIV prevention, including prevention of mother-to-child transmission. However, any scale-up of testing must be done in strict adherence to the principles of voluntary participation, confidentiality, counselling, informed consent, and access to services for those in need.

Participants recognized and agreed that there is an urgent need to scale up access to HIV counselling and testing in countries of the region as a means of enhancing access to comprehensive HIV prevention, care and treatment. Existing models of voluntary counselling and testing (client-initiated HIV testing and counselling) need to be strengthened, scaled up and complemented by approaches that can best fit the local epidemiological and social context and build on the potential of health services to offer HIV counselling and testing (provider-initiated HIV testing and counselling). A set of key conclusions and recommendations was agreed on by the consultation participants.

From 4 to 6 June 2007, 73 participants from 13 countries met in Phnom Penh, Cambodia, to discuss critical actions required to scale up access to HIV testing and counselling towards universal access in Asia and the Pacific. Participants represented civil society, affected communities, governments, international development partners, academic institutions, the World Health Organization (WHO), the United Nations Children's Fund (UNICEF), the Joint United Nations Programme on HIV/AIDS (UNAIDS) and other United Nation agencies.

1. Introduction

In spite of HIV treatment becoming more widely available, few people living with HIV are aware of their status due to limited availability and coverage of HIV testing and counselling services. Multiple factors have impeded efforts to increase coverage of HIV testing and counselling services. Implementing HIV testing and counselling strategies, in particular among high-risk and vulnerable populations, in an ethical manner that respects their human rights, remains a challenge.

With the overall goal of increasing availability and coverage of HIV testing and counselling services, WHO and UNAIDS have published two policy statements on HIV testing and counselling in 2004 and 2006, and are in the process of introducing guidance for the provider-initiated testing and counselling approach to complement the existing client-initiated, voluntary, confidential, counselling and testing services.

Client-initiated HIV testing and counselling, also known as Voluntary Counselling and Testing (VCT), involves individuals actively seeking HIV testing and counselling at a facility that offers these services. VCT usually emphasizes individual risk assessment and management by counsellors, addressing issues such as the desirability and implications of taking an HIV test and the development of individual risk reduction strategies. VCT is conducted in a wide variety of settings including health facilities, stand-alone facilities outside health institutions, through mobile services, in community-based settings and even in people’s homes.

Provider-initiated HIV testing and counselling (PITC) refers to HIV testing and counselling which is recommended by health care providers to persons attending health care facilities as a standard component of medical care. The major purpose of such testing and counselling 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. PITC is neither mandatory nor compulsory.
2. Meeting participants and objectives

From 4 to 6 June 2007, 73 participants met in Phnom Penh, Cambodia, to discuss critical actions required to scale up access to HIV testing and counselling towards Universal Access in Asia and the Pacific. Participants reviewed HIV testing and counselling policies and practices in different settings and contexts in Asia and the Pacific. Participants included technical experts from 12 countries, representatives from civil society and self-support organizations, development partners and institutions, government representatives, the South Asia Association for Regional Cooperation, the Secretariat of the Pacific Community, the World Health Organization, the United Nations Children’s Fund, the Joint United Nations Programme on HIV/AIDS, the United Nations Population Fund, the United Nations Office for Drug and Crime, the International Labour Organization and the International Office for Migration.

The aim of the meeting was to discuss ways to scale up HIV counselling and testing services. Four main objectives were set, including:

1. To review HIV testing and counselling policies and practices in different settings and contexts in Asia and the Pacific;
2. To discuss the role of provider-initiated testing and counselling (PITC) in complementing existing voluntary counselling and testing services (VCT);
3. To emphasize the need for HIV testing and counselling to be grounded in public health methods, ethical principles and human rights values;
4. To identify and agree on key actions for follow-up at the regional and country level for policy and programme implementation.
3. HIV/AIDS in the Asia Pacific Region

Several countries in the Asia Pacific Region face concentrated HIV epidemics, with HIV prevalence over 5% among most-at-risk populations, e.g. injecting drug users (IDU), sex workers (SW), men-who-have-sex-with-men (MSM). Three countries in Asia currently have generalized epidemics with prevalence rates over 1% among the adult population: Cambodia (1.6%), Myanmar (1.3%) and Thailand (1.4%). There is also one country in the Pacific – Papua New Guinea – with a generalized (1.8%) and still growing epidemic.

In the UNAIDS 2006 Report, it was estimated that 8.6 million adults and children in Asia and the Pacific were living with HIV (this figure will be less based on India’s new estimates of 2.5 million—about half of previous estimates)** and that the region accounted for one million new cases and over half a million deaths from AIDS-related illness.

Figure 1. HIV prevalence in adults in Asia, 1990—2005^2

The major characteristics of the epidemic and the responses in Asia and the Pacific are:

- Driven by risk behaviours among most-at-risk populations. Most HIV epidemics in the region have been fuelled by IDU, SW, clients of SW and/or MSM and the partners of these high-risk and often marginalized groups.

- Low level of HIV awareness. Low level of awareness and understanding of HIV, its transmission, its consequences and treatment is common in the region, particularly among most at risk populations and young people.


* This report cites data published in the UNAIDS (2006) Report on the Global AIDS Epidemic to maintain consistency. Cambodia’s 2006 HIV estimate is currently 0.9% based on the recent national consensus meeting held in June 2007

** New estimate from India National AIDS Control Organisation (NACO) with the endorsement of WHO and UNAIDS released in 2007
• Wide spread stigma and discrimination. Lack of understanding about HIV often leads to stigma and discrimination, which is one of the greatest obstacles to a successful response in many Asian countries. For instance, high levels of HIV-related stigma and discrimination deter many individuals from accessing the services they need. Surveys in India, Indonesia, the Philippines and Thailand indicate that more than one in four people with HIV have experienced HIV discrimination in health-care settings. More than one third have had confidentiality about their HIV status breached, and 15% have been refused medical treatment once health care staff learnt they were HIV-positive.4

• Limited service coverage. An estimated 1 500 000 people are in need of antiretroviral therapy (ART) in the East, South and South-East Asia regions, yet only 280 000 or 19% currently receive treatment.

In most South East Asian countries, coverage of prevention of mother-to-child transmission (PMTCT) is largely inadequate, except for Thailand which has coverage of more than 90%.5 In other Asian countries, this intervention has very low coverage (see Figure 3, 2005 data). Further, coverage of services for most-at-risk populations is low across the region: among IDU only 8% access harm reduction and other HIV prevention services; 26% of SW have contact with outreach programmes and only 8% of MSM are reached by HIV prevention programmes.6

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3 UNGASS Country Report 2005
4 AIDS-related discrimination in Asia, S.Paxton AIDS Care, May 2005, survey conducted in India, Indonesia, Philippines and Thailand
In Asia and the Pacific, there is limited data to show coverage of HIV testing. A few surveys indicate that the proportion of adult population who have been tested and counselled is as low as 0.5% in India\(^7\) (8.8 million tested out of 579 million adult population between 15 and 49 years of age), 0.5% in the Lao People’s Democratic Republic, and 0.1% in Malaysia. This leads to an estimate that overall only 0.1% of people in the region may have ever been tested and counselled.\(^1\) However, this does not indicate what proportion of people most in need of testing are actually receiving this service.

Data are urgently needed on coverage of people in need of testing and counselling, and also on proportions of those accessing HIV testing that receive the result, appropriate counselling, and are eventually referred to specialized services for management of HIV infection.

**Figure 3. Percentage of pregnant women who received an HIV test and percentage of HIV-infected pregnant women receiving ARV for PMTCT, selected countries, 2005\(^8\)**

Increasing coverage of HIV testing and counselling in low-level and concentrated epidemics:

- HIV testing and counselling services should be targeted where they matter most, so that they are readily available in a non-discriminatory manner to those in greatest need. These would comprise people with symptoms indicative of HIV including with tuberculosis, spouses/partners of those known to be HIV-positive, infants born to HIV-positive mothers, malnourished children who do not respond to appropriate

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7 National AIDS Control Organization, Ministry of Health and Family Welfare India and WHO Regional Office for South-East Asia.
nutritional therapy, those presenting at health services with a sexually transmitted infection, and specific populations such as sex workers and their clients, men-who-have-sex-with-men, injecting drug users, prisoners and migrants. Accessible and user-friendly services will help such populations to receive necessary treatment, care and specific prevention/intervention services.

- Services often do not reach those who would benefit from and need them the most (Figure 4). Specific population groups in Asia and the Pacific are at higher risk for HIV and have difficulty accessing quality health services. Strategies are needed to increase access to and uptake of HIV testing and counselling for these groups, including most-at-risk population friendly VCT and outreach services.

- Expanding the coverage of services to the general population may not be making the best use of already limited resources and may result in partial or inadequate coverage of most-at-risk populations.

**Figure 4. Current coverage of testing and counselling services in Asia and the Pacific**
4. Testing and Counselling in the Region

Encouraging progress in preventing HIV transmission has been made in several countries with decreasing HIV prevalence such as Cambodia, Tamil Nadu State in India, and Thailand. Most countries in Asia and the Pacific are providing client-initiated and provider-initiated HIV counselling and testing services or a mix of both approaches. Yet, less than 10% of people living with HIV are aware of their status.

Country presentations

Cambodia. Voluntary confidential counselling and testing (VCCT) first started in 1995 and expanded from 12 sites in 2003 to 162 sites in early 2007 with the scale up of ART services. A training curriculum was standardized in 2003. Provision of ART is currently widely available and VCCT is integrated within the Continuum of Care for HIV/AIDS. The demand for HIV testing was increased through a range of demand creation strategies, including through mass media, outreach activities at the village level and referral through the INTHANOU—a unique free, anonymous and confidential telephone counselling service in Cambodia. Some VCCT sites employ trained people living with HIV (PLHIV) as counsellors. Quality assurance of counselling is conducted through counsellor networks at the regional level and regular monitoring and quality control of HIV tests are performed. PITC was approved by the Ministry of Health and started in 2006. A one day orientation workshop is conducted to encourage health providers to offer HIV testing at antenatal care (ANC) clinics, tuberculosis (TB) services, sexually transmitted infection (STI) clinics, skin care services, and paediatric wards. Patients are offered the test and with their consent they (or their blood) are referred to the nearby VCCT site for testing. Post test counselling is given by a trained counsellor. More than 200 000 people accessed VCCT in 2006. With same day test results, 97.7% of people returned for post test counselling in 2006. However, there are still challenges. The workload of health staff involved in testing and counselling is increasing and the referral of patients within the continuum of care is slow with health staff competing for incentives. Further, there is a lack of harmonization between partners.

China has had a policy document for VCT since 2004. The objective of the National Action Plan is to have two to three VCT sites available in each county by the end of 2007. VCT is free of charge and voluntary. There are four models of testing and counselling: (1) the CDC based or hospital-based independent VCT; (2) VCT services integrated into ANC and STI clinics; (3) counselling integrated into ANC and STI clinics where lab services are absent; (4) following this, patients are referred to CDC for testing and outreach VCT services for high-risk groups and prisoners.

Initially, the drop out rate for return for test results was high, likely due to the one week delay in obtaining results. The programme is currently moving to rapid testing with same day test results. In 2005, only 28% of the estimated number of PLHIV in China knew their HIV status. In 2006, 1.2 million people were tested in VCT sites. But with 3037 VCT sites in June 2006, the goal of two to three VCT sites in each county has not been achieved. There are still many counties with no VCT site, or only one, especially in some remote areas. In June 2007, the China AIDS centre introduced PITC guidance. Members of the Joint United Nation team are exploring ways to better support China in its efforts to develop a comprehensive testing and counselling policy. There has been a pilot of PITC protocols in
three cities, performed by CDC Global AIDS Program (GAP) and in five urban and six rural sites under the China Comprehensive AIDS Response (CARES) project.

**India.** The National AIDS Control Programme of India initiated VCT and Prevention of parent-to-child transmission (PPTCT) programmes in 1992. Operational guidelines for VCT and PPTCT were designed in 2001 and revised in 2004. In 2006, VCT and PMTCT were merged under heading of Integrated Counselling and Testing Centres (ICTC) – HIV testing at ANC and out patient departments at hospitals. The new operational guidelines for ICTC are being introduced with several new initiatives such as PITC. The 2011 targets are to establish 4955 ICTC and conduct 12 million tests per year. As of December 2006, the Government of India had established 4219 ICTC centres in 611 districts. The cumulative number of people tested during 2002—2006 amounted to 8.8 million (Table 1). Testing increases were highest in areas where ART services are also available. The national ART programme has expanded from eight operational centres in April 2004 to 101 centres in December 2006. A total of 68 461 patients have started ART in these centres.

**Table 1: Select Indicators of ICTC performance in India, 2002—2006**

<table>
<thead>
<tr>
<th>Year</th>
<th>Number ICTC</th>
<th>Number Pre-Tested</th>
<th>Number HIV Tested</th>
<th>Number Received Post-Test Counselling</th>
<th>Number tested HIV Positive</th>
<th>% of those tested positive</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>409</td>
<td>452 078</td>
<td>279 351</td>
<td>261 677</td>
<td>61 960</td>
<td>22%</td>
</tr>
<tr>
<td>2003</td>
<td>576</td>
<td>723 478</td>
<td>504 055</td>
<td>465 760</td>
<td>91 049</td>
<td>18%</td>
</tr>
<tr>
<td>2004</td>
<td>720</td>
<td>1 085 638</td>
<td>795 197</td>
<td>660 500</td>
<td>116 947</td>
<td>15%</td>
</tr>
<tr>
<td>2005</td>
<td>1386</td>
<td>2 669 754</td>
<td>2 127 723</td>
<td>1 396 837</td>
<td>142 380</td>
<td>7%</td>
</tr>
<tr>
<td>2006</td>
<td>3623</td>
<td>3 932 723</td>
<td>3 402 304</td>
<td>2 788 887</td>
<td>192 508</td>
<td>6%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>3623</td>
<td>8 863 671</td>
<td>7 108 630</td>
<td>5 573 661</td>
<td>604 844</td>
<td>9%</td>
</tr>
</tbody>
</table>

Excluding pregnant women, 55% of HIV testing was client-initiated and 25% provider-initiated in 2006. The consent rate at ICTC has increased from 62% in 2002 to 86% in 2006. The HIV positive yield decreased from 22% in 2002 to 5.7% in 2006. TB-HIV cross referral exists in 14 states. HIV testing of TB patients has doubled from 2005 to 2006. However, HIV testing is recommended only for TB patients who do not respond to TB treatment. The TB programme is awaiting the results of a HIV prevalence survey among TB patients with plans to eventually recommend HIV testing for all TB patients.

However, the quality of counselling services has to be strengthened, especially at sub-district level and discrimination by health care providers is of particular concern in some areas. In future, India plans to expand ICTC to primary health care centres and sub-centres with use of rapid tests on whole blood by nurses, strengthening partnerships with the private sector, and promoting PITC and conducting a media campaign to increase demand for HIV testing and counselling.
Pakistan. The National HIV testing strategy states that HIV testing should be voluntary, confidential and accompanied by pre-and post-test counselling. Testing for diagnosis uses three different tests. There are currently 16 VCT centres (both community-based and hospital-based) for the general population and VCT is integrated as part of 20 projects for most at risk populations (IDU, SW, MSM, truck drivers and prisoners). ART is available at nine sites. Challenges still exist in scaling up testing and counselling to most-at-risk populations.

Indonesia. While there has been a large expansion of testing and counselling services, there has also been under-utilization of testing and counselling services by the population. The objective of Indonesia’s national programme is to have VCT services available in all districts and cities by 2010. National guidelines and training curriculum have existed since 2005. Currently, 290 VCT sites offer HIV testing and counselling. In 2006, 15 facilities started to offer HIV testing and counselling at ANC as part of PMTCT services. Testing of TB patients was initiated at the end of 2006 and guideline development is ongoing. PITC is still being discussed to avoid missed opportunities but there are concerns about poor utilization of PITC by health staff and limited human resources. For Indonesia, the challenge is to expand coverage at current VCT services.

Papua New Guinea. Testing and counselling is integrated into ANC services using an “opt out” strategy, although follow-up after testing is limited. Within reproductive health services (family planning, gynaecology), PITC is implemented. ART and support services are not widely available and early infant testing is not available, despite the fact that Papua New Guinea now faces a generalized epidemic and heavy burden of disease. Challenges for scale-up testing and counselling in Papua New Guinea include: stigma and discrimination; gender inequality and domestic violence against women; low attendance at ANC services; limited human resources and lack of staff capacity; logistical difficulties, such as geographical isolation of communities and difficult terrain; and lack of a simple testing algorithm for use at the provincial health centre level.

Thailand. HIV voluntary counselling and testing started in 1991 through anonymous clinics in government hospitals. PITC was introduced in the late nineties with the PMTCT programme and recently as part of the national TB directly observed treatment short-course (DOTS) programme. PITC includes group pre-test information giving and if requested individual pre-test counselling is accompanied by informed consent and gives the option to opt out, depending on the type of health services. The PITC was a key to the success of the national PMTCT programme. Out of a total of 672,035 deliveries in 2005, 98% attended ANC and out of those, 99.7% had an HIV test.
The high coverage of PITC and ART prophylaxis did result in a decrease of reported paediatric AIDS cases.

In 2003, the Office of Disease Prevention and Control Region 7 (ODPC 7), Ministry of Public Health in Ubon Ratchathani, in north-eastern Thailand, started provider-initiated voluntary HIV testing and counselling for patients with active TB disease with the purpose of providing access to HIV care and ART. All newly registered TB patients are offered voluntary HIV testing and counselling. If they test HIV-positive, clients undergo a CD4 count measurement, and are accordingly offered HIV care, including ART. Retrospective data analyses from all hospitals showed that the proportion of newly registered TB patients who underwent HIV testing increased from 33% in 2003 to 84% in 2007. Out of 468 TB/HIV patients diagnosed during the period October 2006 to March 2007, 74% (346) had a CD4 count and of those, 78% had a CD4 count of less than 250 cells/mm³ and were in need of ART. The success of this activity led Thailand’s Ministry of Public Health to adopt a national TB/HIV action plan in late 2005. Under the plan, more than 90% of TB patients receive HIV-testing, over 75% of HIV-infected persons would be screened for TB, and all TB patients with HIV would have access to ART. The plan now covers every province in Thailand.
PAKISTAN:
Adult HIV prevalence: 0.1% concentrated in IDU and male SW (2005).
Testing and counselling: 162 VCT centres (both community and hospital based) for general population and VCT integrate as part of 20 projects for most-at-risk populations.

INDIA:
Adult HIV prevalence: 0.9% (2006)
Testing and counselling: In 2006 there were 4129 VCT sites (at least one per district) and 3.9 million people were pre-tested, 3.4 million had an HIV test, and 2.8 million received the test result. In 2006, VCT and PMTCT integrated to create ICTC (Integrated Counselling and Testing Centres).

CHINA:
Adult HIV prevalence: 0.1% (2005)
Testing and counselling: China has achieved the National Action Plan goal of two to three VCT sites existing in each county by 2007 and has 3037 VCT sites as of June 2006. In 2005, only 28% of estimated PLHIV knew their status; in 2006, 1.2 million people tested. In 2007, China is revising T&C policy to include PITC which is currently being piloted.

INDONESIA:
Adult HIV prevalence: 0.1-0.2% (2005) generalized epidemic in Papua and concentrated epidemic in IDU.
Testing and counselling: Counselling and testing services provided in 290 services in all 19 provinces, however VCT services are under-utilized. Low coverage of PMTCT and TB/HIV testing.

PAPUA NEW GUINEA:
Adult HIV prevalence: 1.8% (2005)
Testing and counselling: Integrated into ANC services using opt-out strategy, although follow-up after testing is limited. PITC is implemented within reproductive health services. Early infant testing is not available.

CAMBODIA:
Adult HIV prevalence: 1.6% (2005)

THAILAND:
Adult HIV prevalence: 1.4% (2006)
Testing and counselling: VCT first offered in 1991, PITC introduced in late 1990 within PMTCT programme. In 2003 PITC was introduced for patients with active TB. This has led to a substantial increase in both the percentage of ANC women and TB patients who are tested and treated.

Figure 6. Selected reports from the region on testing and counselling
Consequences of low coverage

Knowledge of HIV status is essential for:

- Expanding access to HIV/AIDS treatment, care, and support
- Improving HIV/AIDS treatment outcomes
- Enhancing HIV prevention, including PMTCT.

The number of people receiving ART continues to increase globally. However, many PLHIV remain untreated. Increasing coverage of testing and counselling could increase the number of people treated, but only if those who are HIV positive, rather than low risk individuals come forward for testing, and there is adequate availability and linkage between testing and counselling and treatment and care services.

Without timely testing and counselling, HIV infection may not be detected at early stages of HIV disease and treatment outcomes will be poor. Studies show that earlier enrolment in pre-ART and eventually on ART is associated with decreased mortality and overall a more favourable prognostic outlook.

There remains a substantial gap in the number of women attending ANC services who are tested for HIV, and this low coverage carries dramatic implications with regards to preventable paediatric HIV infections. It also represents many missed opportunities for counselling them and their partners on HIV prevention, especially male sexual behaviours and HIV risk during pregnancy.

Some countries face substantial human and financial constraints, weak health infrastructures (in particular at the community level), inadequate use of HIV testing technologies (e.g. rapid testing), limited knowledge of HIV in the community and among health care workers, and stigma and discrimination. Commonly, laws and policies inhibit the implementation of interventions targeting people most-at-risk such as SW and their clients, IDU and MSM. Various countries have different experiences with HIV testing and counselling in closed settings such as rehabilitation centres, prisons, camps and juvenile institutions. These include mandatory HIV testing on entry, release, or during the period of detention with voluntary counselling and testing exceptional and often not accompanied by access to appropriate prevention or care-related services.
5. Highlights and key messages

Countries in Asia and the Pacific have had varying success with scale-up of testing and counselling services, and employ different practices and policies. However, it is recognized that there is an urgent need to scale up access to and uptake of testing and counselling services in the region. This is a necessity for the achievement of universal access targets by 2010. However, the scale-up of testing and counselling must be done with careful consideration of the possible consequences on affected populations.

There is consensus that the principles of voluntary participation, counselling, confidentiality, informed consent and access to services are fundamental to effective testing and counselling but there is concern that in some settings, these principles are not being followed.

The experience of some of the most-at-risk-populations in the region show that in general, there appears to be little understanding of the guiding principles and patients’ rights. There are clear examples of hospitals testing patients without their consent. Compulsory testing is practised in a number of settings, for instance, among IDU and migrant workers. Similarly, the requirement of confidentiality is not strictly observed in the region. The understanding of consent and the legal requirements for informed consent vary in different countries.

It is recognized that people may seek HIV testing only if they can see its benefits. In the region, discrimination against people infected with HIV and limited availability and accessibility of treatment services discourage people from seeking HIV testing and counselling.

It is clear that any scale-up of testing and counselling needs to be linked to improved provision of other services such as high quality treatment and treatment monitoring, positive prevention, care and support for people living with HIV.

The rapid disease progression of infants makes early diagnosis very important. Across the region there are significant challenges surrounding the consent of adolescents and young people to HIV testing and other services, and limited experience and tools for guiding disclosure of HIV status, both of parents to children and the child’s individual sero-status.

Given the nature of the epidemic in the region, that is, several countries with concentrated high-risk groups, not all interventions will take place in health settings. Furthermore, marginalized most-at-risk populations may not readily access health services and may be better reached through community-based interventions and services. Careful consideration needs to be given to creating linkage between non-health and health settings, and improving the quality of service in all settings.
6. Summary of working group sessions

On day two of the consultation, participants split into three working groups to discuss key issues, concerns and challenges for HIV testing and counselling in different settings. The groups identified ways to improve the quality and coverage of HIV testing and counselling which are inline with recommended international standards and practices, with the aim to improve access to prevention, treatment and care services.

Group 1: testing and counselling in health settings

Group 1 recognised that a mix of VCT and PITC approaches are used across the region, although uptake and quality of VCT is low in most countries. They also highlighted that PITC implementation in some programmes, such as ANC and TB services, has resulted in higher uptake of HIV testing. However, availability and linkages to HIV/AIDS treatment, care and support are critical and many of the most-at-risk-populations are currently being coerced into testing.

Group 1 recommended:

- further research to identify and understand the reasons for low uptake of testing and counselling and ongoing sensitization and training of health care providers;
- national consultations with all stakeholders to revise guidelines, policies and strategic planning related to testing and counselling and further clarification of the roles of providers in both VCT and PITC in health settings;
- an assessment of the type of services or programmes where PITC could be implemented;
- mobilization of resources for the scale-up of testing and counselling;
- for health settings where the needs of most-at-risk populations are addressed, VCT should be expanded and be the preferred option if the patient has no signs or symptoms of HIV;
- further definition of a minimum services package (ART, plus CD4 counts, ongoing care and support, PMTCT and cotrimoxazole) and linkages between testing and counselling services and treatment and care.

The way forward involves high-level advocacy, mass promotion of HIV testing and counselling, a strong monitoring and supervision system and ongoing quality assurance. Group 1 also called for legal protection of HIV infected people and an abolishment of anti-sodomy laws in the region. Further, group 1 called for legislation which allows for harm reduction services to be scaled up.
Group 2: testing and counselling in outreach and community settings

Group 2 recognized that many effective responses for engaging with marginalized populations have been developed but the nexus with government services has seldom been well managed. Tension exists between community organization’s ability to engage with populations and the responsibility of governments to ensure quality of testing and counselling.

Group 2 highlighted the importance of active partnership between governments, communities and other stakeholders to optimize services. Also important is “ownership” of services by community organizations in order to ensure their credibility within communities and to empower them to engage as active partners.

Group 2 recommended:
• that governments play a greater role in the development and adaptation of standards (in laboratory testing procedures, tests, quality assurance and control, counselling, training and supervision), and accreditation mechanisms and thus endorse community organizations who are already performing high quality work;
• governments should monitor the maintenance of these standards and gather local evidence through which the quality of services is judged;
• sensitization of health care workers through engagement with community members;
• consideration of HIV testing must be made in the context of the person’s other health and social needs;
• create linkages between health and community services by:
  o placing peers in government organizations;
  o designate “link workers” to connect community and mainstream services;
  o placing government health care services within community settings.

Group 3: testing and counselling in regulated settings

Members of group 3 chose to focus on only two types of “regulated setting”: drug dependence treatment and rehabilitation centres and pre-or post-migration check-up settings.

Drug dependence treatment and rehabilitation centres:

The group voiced concern that pre-test counselling in drug treatment and rehabilitation centres is difficult since the person is detained, and most often, has no access to HIV prevention tools (condoms, sterile needle/syringes) within the centre. Further, few centres have the capacity to offer HIV treatment and monitoring and therefore linkage to treatment, care and support services do post-test is usually not possible. All members of the group were concerned about confidentiality, consent, links to other services, separation and stigma, and lack of staff capacity to offer testing and counselling.
Group 3 recommend that any policy development should be made after consideration of:

- laws in place and ways they affect the detainees;
- type of treatment/rehabilitation centre—i.e. operated by police, military or another organization;
- current HIV testing protocol;
- availability of prevention measures;
- linkages of testing to other HIV treatment, care and support services.

Pre-or post-migration check-up settings:
The group made the following recommendations:

- **pre-departure**
  - (a) do not promote testing to this relatively low risk group. Instead provide HIV/AIDS knowledge, education and prevention but no mandatory testing;
  - (b) ensure confidentiality;
  - (c) if the patient is HIV positive, design protocols to link patient to AIDS treatment, care and support services in their home country.

- **in host country**
  - (a) develop guidelines for informed consent and confidentiality;
  - (b) develop a repatriation protocol.

- **on return to home country**
  - (a) protocol to link to HIV/AIDS services;
  - (b) no mandatory testing.

- strengthen access to HIV counselling and testing for returning and returnee migrant workers in a broader framework of treatment and care;

- advocate for regional intergovernmental bodies to encourage governments to change policies of mandatory testing and disclosure of status.
7. Conclusions and recommendations

Mandatory and other coercive forms of HIV testing do not serve a legitimate public health goal and jeopardize access to health services, reduce health-seeking behaviours and increases stigma and discrimination.

Participants recognized and agreed there is an urgent need to scale up access to HIV counselling and testing in countries of the region as a means of enhancing access to comprehensive HIV prevention care and treatment. Existing models of voluntary counselling and testing need to be strengthened, scaled up and complemented by approaches that build on the potential of health services to offer HIV counselling and testing. Such an approach to HIV testing, initiated by health providers, should be accompanied by counselling, confidentiality and be conditional upon the person’s informed consent (the “3 Cs”). Guidance published by WHO and UNAIDS in May 2007 provides a useful framework which now needs to be considered by all countries.

In order to scale up voluntary HIV counselling and testing and achieve universal access to prevention treatment and care services, participants recommended:

1. Countries need to review national HIV testing policies, and approaches and practices to embrace existing guidance on VCT, and consider the new PITC guidance.

2. National consideration needs to be a participatory and transparent process.

3. HIV counselling and testing, irrespective of settings, must be accompanied and linked to a nationally agreed minimum package of defined services and linked to HIV prevention, including harm reduction services, treatment and care, including ART.

4. Additional attention is required to clearly define terms used locally, and to reinforce the voluntary nature of HIV testing and the requirements of consent, counselling and confidentiality (“3 Cs”).

5. Countries need to optimize the use of newer HIV testing technologies, including rapid tests, to allow same day access to results, and virological testing for infants.

6. Countries will need to define, revise and apply standards, guidelines and training tools for HIV testing and counselling, including internal and external quality assurance schemes to support quality service delivery.

7. Countries need to review and amend laws and policies which criminalize practices like sex work, drug use, and sex between men, with a view to facilitating access to HIV counselling and testing, prevention, treatment care and support (including ART and harm reduction).

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8. Countries need to review laws, policy and practice to prohibit mandatory testing of persons in closed settings (such as rehabilitation centres, prisons, detention centres and immigration lock-ups) to facilitate access to voluntary HIV testing and counselling, prevention, care and treatment and support (including ART and harm reduction).

9. Countries should ensure increased access to HIV testing and counselling, HIV prevention, treatment and care, including ART for infants, children and adolescents.

10. Countries should prioritize where and how testing services should be scaled up based on national and sub-national epidemiological patterns and at risk populations (including the need for HIV counselling and testing in STI, TB and ANC services). This should be reflected in agreed benchmarks and targets.

11. In order to scale up quality, accessible, equitable and acceptable HIV testing and counselling services, countries will need to revise existing costed plans and mobilize additional resources.

12. Scaling up community response requires broad-based advocacy, greater collaborative interactions between community and health facilities, and specific steps to support and facilitate referrals.

13. Codes of conduct and mechanisms for receiving, examining and responding to complaints are needed for HIV services, including HIV testing and counselling in health facilities, closed settings and in the context of labour and migration.

14. Countries need to review and revise national policies and laws to prohibit mandatory HIV testing for migrant workers and ensure access to HIV prevention, treatment, care and support, and referral services in both home and host countries, and advocate for this through regional and intergovernmental mechanisms.

15. Simplified national monitoring mechanisms should be put in place and adapted to reflect progress towards achieving set targets.

16. A working group should be established at the regional level (comprising civil society, people living with HIV/AIDS, global and regional partners, and technical experts) to support the process of scaling up voluntary HIV counselling and testing to secure access to care and prevention at the national level and to monitor progress against these recommendations.

17. Technical support should be extended to countries by global and regional partners to implement the above recommendations.
# Programme of Activities

## Day 1: Monday, 4 June 2007

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Presenter/Announcement</th>
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<tbody>
<tr>
<td>08.00 – 08.30</td>
<td>Registration</td>
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<tr>
<td>08.30 – 09.15</td>
<td>Welcome</td>
<td>Master of ceremony</td>
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<tr>
<td></td>
<td>• Opening statements</td>
<td>Dato’ Dr Tee Ah Sian</td>
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<td>o WHO</td>
<td>Mr Ian MacLeod</td>
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<td>o UNICEF</td>
<td>Mr Prasada Rao</td>
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<td>o UNAIDS</td>
<td>H.E. Dr Mam Bun Heng</td>
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<td>• Ministry of Health, Cambodia</td>
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<tr>
<td>09.15 – 10.00</td>
<td>Introduction of participants</td>
<td>Master of ceremony</td>
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<td>Selection of Chair persons</td>
<td>Dr Massimo Ghidinelli</td>
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<td>Objectives and expected outcomes</td>
<td>UNAIDS</td>
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<td>Administrative announcements</td>
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<tr>
<td>10.00 – 10.15</td>
<td>COFFEE-TEA BREAK</td>
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<tr>
<td>10.15 – 10.40</td>
<td>Global situation on HIV testing and counselling: perspectives towards Universal Access</td>
<td>Dr Kevin DeCock</td>
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<tr>
<td>10.40 – 11.00</td>
<td>The role of HIV testing and counselling in Universal Access in Asia and Pacific countries</td>
<td>JVR Prasada Rao</td>
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<tr>
<td>11.00 – 11.15</td>
<td>Questions and Answers</td>
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<tr>
<td>11.15 – 12.15</td>
<td>Presentations (15’ each)</td>
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<tr>
<td></td>
<td>• Scaling up VCT and PITC in Cambodia</td>
<td>Dr Mean Chhi Vun</td>
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<td>• HIV testing and counselling experiences in China</td>
<td>Dr Ma Wei</td>
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<td>• National programme for HIV testing and Counselling in India: Successful implementation and lessons learnt</td>
<td>Dr Suresh Mohammed</td>
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<td>Questions and Answers (15’)</td>
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<tr>
<td>12.15 – 13.30</td>
<td>LUNCH</td>
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<td>Time</td>
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<tr>
<td>13.30 – 14.30</td>
<td>HIV voluntary counselling and testing services in Indonesia: Challenges and opportunities</td>
<td>Dr Dyah Erti Mustikawati</td>
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<td>HIV testing and counselling in the context of PMTCT expansion in Papua New Guinea</td>
<td>Dr Grace Kariwiga</td>
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<td>Voluntary counselling and testing in Pakistan</td>
<td>Dr Nadeem Ikram</td>
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<tr>
<td>14.30 – 14.45</td>
<td>Highlights on VCT services in Asia and the Pacific</td>
<td>Dr Kathleen Casey</td>
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<tr>
<td>14.45 – 15.00</td>
<td>Questions and Answers</td>
<td>Chairperson</td>
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<tr>
<td>15.00 – 15.15</td>
<td>COFFEE-TEA BREAK</td>
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<tr>
<td>15.15 – 15.30</td>
<td>The community feedback on the current HIV testing and counselling policy and practice in Asia and the Pacific</td>
<td>Mr William O’Loughlin</td>
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<tr>
<td>15.30 – 15.45</td>
<td>Study on mandatory HIV testing for employment of migrant workers in 8 countries of Asia-Pacific Region</td>
<td>Ms Ema Naito/ Dr Maria Nenette Motus</td>
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<tr>
<td>15.45 – 16.00</td>
<td>Questions and Answers</td>
<td>Chairperson</td>
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<tr>
<td>16.00 – 16.15</td>
<td>Review of HIV testing and counselling laws and policies in East Asia and Pacific</td>
<td>Atty Manuel Goyena</td>
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<tr>
<td>16.15 – 16.30</td>
<td>Legal aspects of HIV testing and counselling in South Asian Countries</td>
<td>Mr Anand Grover</td>
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<tr>
<td>16.30 – 16.45</td>
<td>Questions and Answers</td>
<td>Chairperson</td>
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<tr>
<td>16.45</td>
<td>Conclusions of Day 1 and wrap up</td>
<td>Chairperson</td>
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<tr>
<td>18.30</td>
<td>Reception – Mekong II Room</td>
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## Day 2: Tuesday, 5 June 2007

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<tr>
<th>Time</th>
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<th>Speaker</th>
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<tr>
<td>08.30 – 08.45</td>
<td>Testing and counselling for children and adolescents</td>
<td>Dr Suomi Sakai</td>
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<tr>
<td>08.45 – 09.15</td>
<td>Introduction of Global guidance on PITC and fundamental principles</td>
<td>Dr Jos Perriens</td>
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<tr>
<td>09.15 – 09.30</td>
<td>Questions and Answers</td>
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<tr>
<td>09.30 – 09.45</td>
<td>Expanding TB/HIV joint activities: the role of provider-initiated HIV testing and counselling for access to HIV care and treatment</td>
<td>Dr Somsak Akksilp</td>
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<tr>
<td>09.45 – 10.00</td>
<td>PITC in STI settings</td>
<td>Dr Sophaganine Ali</td>
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<tr>
<td>10.00 – 10.15</td>
<td>The role of provider-initiated testing and counselling for scaling up national prevention-of-mother-to-child transmission programme</td>
<td>Dr Siripon Kanshana</td>
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<tr>
<td>10.15 – 10.30</td>
<td>Questions and Answers</td>
<td>Chairperson</td>
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<td>10.30 – 10.45</td>
<td>COFFEE-TEA BREAK</td>
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## OBJECTIVE 3: To emphasize the need for HIV testing and counselling to be grounded in public health methods, ethical principles and human rights values

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
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<tbody>
<tr>
<td>10.45 – 11.00</td>
<td>HIV testing and counselling as a public health strategy and human rights approach</td>
<td>Prof. Daniel Tarantola</td>
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<tr>
<td>11.00 – 11.40</td>
<td>Presentations on experience of HIV testing and counselling by representatives of vulnerable groups:</td>
<td>Mr Bijaya Pandey, Ms Mony Pen, Dr Dede Oetomo, Mr Shiba Phurailatpam</td>
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<tr>
<td></td>
<td>Injection drug users</td>
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<td>Sex workers</td>
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<td>Men who have sex with men</td>
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<td>People living with HIV</td>
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<tr>
<td>11.40 – 12.00</td>
<td>Discussion</td>
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<tr>
<td>12.00 – 13.00</td>
<td>LUNCH</td>
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<td>Time</td>
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<tr>
<td>13.00 – 16.00</td>
<td>Introduction of group-work</td>
<td>Mr Binod Mahanty</td>
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<td>(Break out into 3 groups to identify key issues, concerns and challenges for scaling up HIV testing and counselling)</td>
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<td>• Group 1: Testing and Counselling in health settings</td>
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<td>• Group 2: Testing and Counselling in outreach and community settings</td>
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<td>• Group 3: Testing and Counselling in regulated services</td>
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<td>15.00 – 15.15</td>
<td>COFFEE-TEA BREAK</td>
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<tr>
<td>15.15 – 16.00</td>
<td>Continue with group session</td>
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<tr>
<td>16.00 – 17.00</td>
<td>Feedback from break-out groups and discussion</td>
<td>Chairperson/Rapporteurs</td>
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**Day 3: Wednesday, 6 June 2007**

**OBJECTIVE 4:** To identify and agree on key actions for follow-up at regional and country level for policy and programme implementation

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<tr>
<th>Time</th>
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<tbody>
<tr>
<td>08.30 – 08.45</td>
<td>Highlights of Day 2</td>
<td>Mr Ian MacLeod</td>
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<tr>
<td>08.45 – 10.15</td>
<td>Plenary discussion – draft conclusions and recommendations</td>
<td>Chairperson</td>
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<tr>
<td>10.15 – 10.30</td>
<td>COFFEE-TEA BREAK</td>
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<tr>
<td>10.15 – 11.30</td>
<td>Continuation of plenary discussion</td>
<td>Chairperson</td>
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<tr>
<td>11.30 – 12.00</td>
<td>Closing remarks:</td>
<td>Dr Ying-Ru Lo</td>
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<td>• WHO – Dato’ Dr Tee Ah Sian</td>
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<td>• UNICEF – Mr Ian MacLeod</td>
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<td>• UNAIDS – Mr Prasada Rao</td>
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<td>• Ministry of Health Cambodia – H.E. Dr Mam Bun Heng</td>
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<tr>
<td>12.30</td>
<td>PRESS CONFERENCE</td>
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</tbody>
</table>
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Next Steps Recommended by UN Agencies

For global/regional level:

- Officially notify national authorities on the need for intensified action to provide access to services for HIV testing and counselling in order to achieve Universal Access, accompanied by translated new PITC guidance, and 2004 notes on VCT;
- Develop key communications package for national authorities, Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and donors;
- Adapt and/or modify generic tools;
- Document regional best practises;
- Describe common regional pitfalls;
- Undertake cost effectiveness analysis of PITC for TB, STI and pregnant women;
- Develop regional discussion document on – protection of privacy, criminalization of HIV transmission;
- Update regional guidance note on best use of testing technologies;
- Identify upcoming regional and national opportunities to review national guiding documents e.g. national strategic planning;
- Identify financial resources to support inclusive national review process and adaptation of international guidelines;
- Adapt or develop step by step guide for national adaptation that sets out key elements to increase HIV testing and counselling;
- Articulate regional priorities for expanding access to HIV testing and counselling;
- Document list of key terms used in regions;
- Develop standardized simplified comprehensive monitoring framework and systems for HIV testing and counselling (programme level);
- Provide technical support to national adaptation process.

For national level:

- Plan for national stakeholder review of HIV testing policy and guidance:
  - Mapping existing legal and policy directives;
  - Document existing practice;
  - Listing and clarifying terms;
  - Gap/bottlenecks analysis;
  - Agreeing on priorities for scaling-up (based on epi/resources etc.);
  - Defining who pays for what services;
  - Clarifying roles and responsibilities by cadre and facility;
  - Estimating resource implications (human and financial);
  - Consultation with key partners;
  - Agreeing on targets and monitoring.
• Develop national road map with timelines and budget;
• Agree on essential enabling legal and policy frameworks for HIV testing and counselling (as check list);
• Identify vulnerable populations and articulation of additional protection prerequisites;
• Describe essential package for HIV testing and counselling by settings (pre and post test info/services);
• Advocate and prepare communication pack for opinion leaders, health care providers, NGOs etc.;
• Prepare community mobilization tools and orientation package for health care workers;
• Draft Memorandum of Understanding for service provision (public sector/private/NGO/prison etc.)
• Develop standardized simplified comprehensive monitoring framework and systems for HIV testing and counselling (programme level).