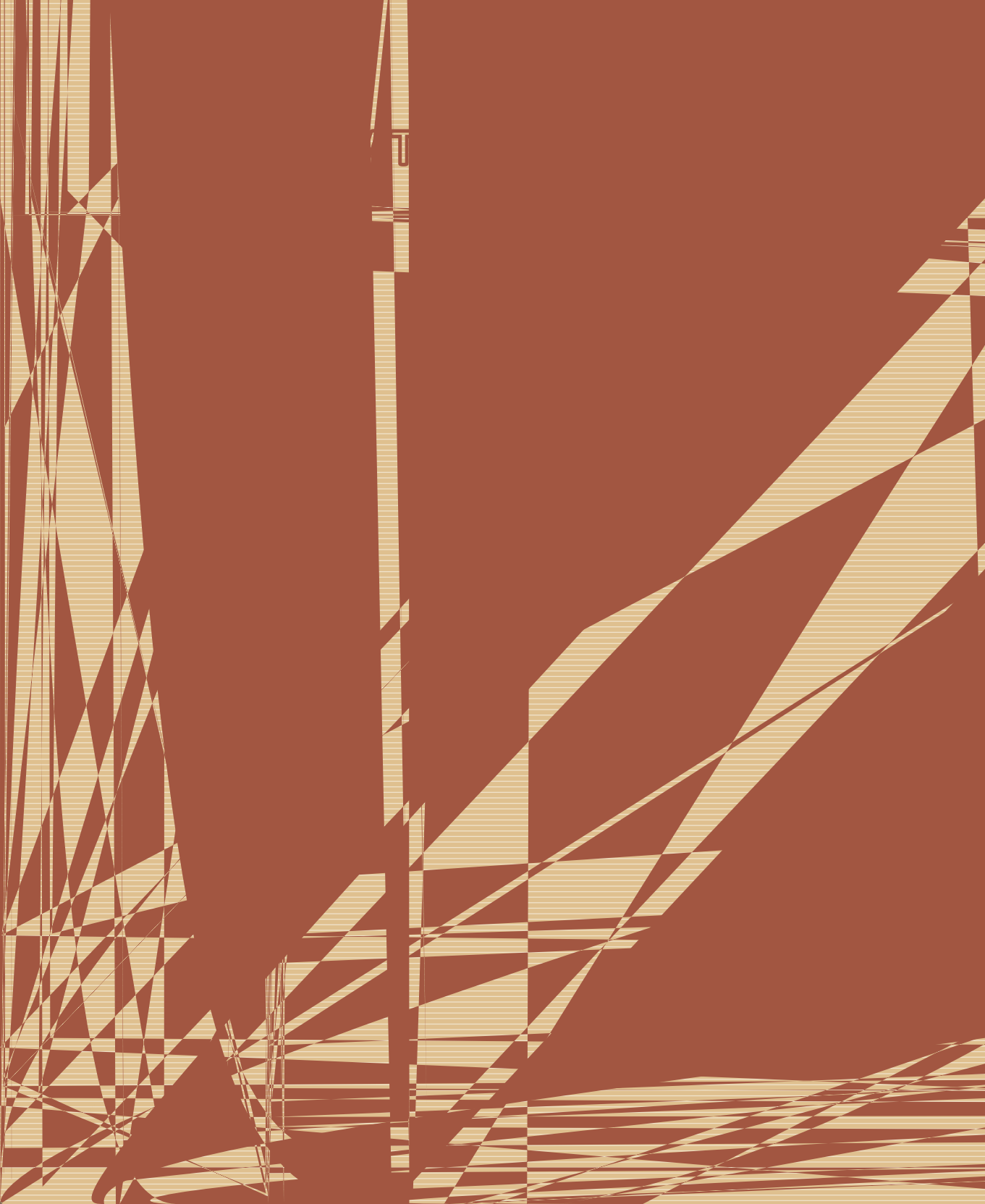

HIV TESTING AND COUNSELING SERVICES IN THE WHO AFRICAN REGION

A Survey of the East and Southern Africa Subregion

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CONTENTS

ABBREVIATIONS

ABC	Abstinence, Be Faithful, Condomize
AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Clinic
ART	Antiretroviral Therapy
ARVs	Antiretroviral drugs
BCC	Behaviour Change Communication
CBCG	Community-based Care Giver
CBO	Community-based Organization
CSO	Civil Society Organization
CSW	Commercial Sex Worker
DOTS	Directly-observed Treatment Short Course
EQA	External Quality Assurance
FBO	Faith-based Organization
HIV	Human Immunodeficiency Virus
HTC	HIV Testing and Counseling
IEC	Information, Education and Communication
IMAI	Integrated Management of Adolescent and Adult Illness
IST-ESA	Intercountry Support Team for East and Southern Africa
KYS	Know Your Status
MOH	Ministry of Health

NGO	Nongovernmental Organization
OI	Opportunistic Infection
PITC	Provider-initiated HIV Testing and Counseling
PLWH	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission (of HIV)
QA	Quality Assurance
RHT	Routine HIV Testing
SOP	Standard Operating Procedure
SSA	Sub-Saharan Africa
STI	Sexually-transmitted Infection
TA	Technical Assistance
TB	Tuberculosis
TOT	Training of Trainers
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

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FOREWORD

Eastern and Southern Africa remains the epicentre of the HIV epidemic, with more than 40% of those infected globally living in this subregion. HIV/AIDS is one of the leading causes of mortality in the African Region which has seen the gains made in life expectancy in the early 1980s reversed.

In order to mitigate the impact of HIV and AIDS in the subregion there is need for accelerated scaling up of HIV prevention, treatment, care and support interventions towards achievement of universal access. To this end, HIV testing and Counseling play critical roles in knowledge about HIV status. The interface between HIV testing and Counseling provides an opportunity to access information about prevention and other services. Those who are infected can also access treatment, care and support services.

Scaling up HIV testing and Counseling is imperative for an effective response to the HIV epidemic. However, the levels of knowledge about HIV status are unacceptably low and hinder access to appropriate services. The challenges to scaling up services include high levels of stigma and discrimination and limited availability of HIV testing and Counseling services in the subregion.

This situation analysis was undertaken to assess the level of implementation of HIV testing and Counseling services in the subregion as well as identify challenges and opportunities for scaling up technical support to countries.

This report is targeted at countries, United Nations agencies, nongovernmental organizations and community-based organizations. It is expected to contribute to the knowledge base critical for addressing the challenges faced by countries in the subregion as they mount an effective response to the HIV/AIDS scourge.

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EXECUTIVE SUMMARY

In 2007, about 66% of all people living with HIV were living in sub-Saharan Africa where it is estimated that between 2005 and 2007, a median of 9.5% of women and 7.9% of men had ever received an HIV test and test results.[1] This emphasizes the need to rapidly expand HIV testing and Counseling (HTC)[2] services which are a key entry point to other HIV prevention, treatment, care and support services. WHO and UNAIDS issued guidance on HIV testing and on provider-initiated HIV testing[3] and Counseling (PITC) in health facilities.[4] With WHO technical and normative guidance, countries have developed guidelines and training tools and are scaling up HTC services.

Using a standardized data collection tool, a situation analysis was conducted to determine the status of HTC service provision in the WHO East and Southern African subregion (IST-ESA) at the end of 2008. The general objective of the situation analysis was to obtain an overview of the level of implementation and scaling up of HTC services in the IST-ESA subregion.

Findings

Thirteen countries have HTC guidelines which address both VCT and PITC as approaches to HTC service provision and 12 have incorporated WHO/UNAIDS guidance on HTC; four countries have VCT guidelines only while one country has PITC guidelines only. Three countries have HTC guidelines for children while 17 have rapid HIV testing guidelines.

All 18 countries[5] allow nurses to conduct rapid HIV testing and 14 allow trained counsellors to conduct rapid HIV tests as part of task shifting. Only eight countries have the basic HTC training package. All 18 countries have counsellors trained in VCT and other personnel trained in rapid HIV testing. A total of 11 countries have personnel trained in PITC. All 18 countries have facilities that provide PITC services with only five having at least one facility providing PITC services in all districts in the country.

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1. *Towards Universal Access – scaling up priority HIV/AIDS interventions in the health sector. Progress Report 2008, WHO, UNAIDS, UNICEF.*
2. *HTC encompasses both provider-initiated HIV testing and Counseling (PITC) and client-initiated HIV testing and Counseling commonly known as VCT.*
3. *UNAIDS/WHO Policy Statement on HIV Testing, Geneva, WHO, June 2004.*
4. *Guidance on provider-initiated HIV testing and Counseling in health facilities. WHO, UNAIDS. May 2007.*
5. *Botswana, Comoros, Eritrea, Ethiopia, Kenya, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland, Tanzania, Uganda, Zambia, Zimbabwe.*

All 18 countries utilize antenatal clinics (ANC); over half utilize TB, STI, maternal and child health, paediatric and adult outpatient clinics and medical wards; and about half utilize home-based care settings and family planning clinics as entry points for identifying HIV positive individuals.

All 18 countries have VCT facilities: 12 have at least one VCT facility in all districts. All 18 countries have VCT facilities integrated in health facilities; 15 have stand-alone VCT facilities; 14 have VCT outreach services; 10 utilize fully-equipped mobile vehicles to provide VCT services; and 6 provide home-to-home VCT services.

Thirteen countries provided data on number of clients accessing PITC services; seven had sex-disaggregated data while four provided data on number of children accessing PITC services. Eleven countries provided VCT data, with seven providing sex-disaggregated data.

Sixteen countries shared innovative and good practices for scaling up HTC services. These included HTC campaigns; different HTC service delivery models; task shifting; partnerships; and scaling up PITC in health facilities.

Seventeen countries shared the following challenges: inadequate human resource capacity; inadequate funding; limited HTC access for vulnerable groups; high levels of stigma and discrimination; weak systems for monitoring and evaluation of HTC services; and standardization of training of service providers.

All 18 countries detailed the opportunities they have for scaling up HTC. These included: political commitment and leadership; financial and technical support from development partners and global health initiatives; scaling up of PITC services; and good infrastructure for HTC service provision.

Conclusion

IST-ESA countries have made significant progress in ensuring that HTC services are available and accessible to their citizens. The majority of countries are in the process of standardizing HTC service provision with the development of guidelines, training materials, training of medical and non-medical personnel with the aim of scaling up PITC services. A number of challenges still exist and will need to be addressed. However, countries have a number of opportunities that they can exploit to counteract these challenges.

Recommendations

Countries

(a) All countries should ensure: (i) standardization of HTC services through development or updating of HTC guidelines to ensure the incorporation of WHO and UNAIDS global guidance on both VCT and PITC; (ii) access to HTC services for children and adolescents while also ensuring that there are adequate prevention, treatment, care and support services for them.

(b) All countries should have rapid HIV testing guidelines.

(c) All countries should address policy and other impediments to task shifting of rapid HIV testing especially to lay counsellors so as to increase access to and availability of HTC services.

(d) All countries should have the basic HTC training package.

World Health Organization (WHO)

(a) WHO should develop a database of HTC training manuals available in different countries and encourage countries to access these manuals as the need arises.

(b) WHO IST-ESA should continue to assist all countries: (i) to scale up availability of PITC services; (ii) to implement national External Quality Assurance (EQA) schemes for rapid HIV testing; (iii) to scale up access to HTC services through utilization of currently ignored entry points; (iv) to strengthen data collection for HTC services by ensuring collection of sex-disaggregated and age-disaggregated data; (v) with technical expertise as requested.

1. INTRODUCTION

In 2007, an estimated 33.2 million people were living with HIV, with approximately 2.1 million (6%) being children less than 15 years of age. About 2.5 million people were newly infected, with 2.1 million dying from AIDS. About 66% of all people living with HIV (PLWH) were living in sub-Saharan Africa (SSA) where it is estimated that between 2005 and 2007, a median of 9.5% of women and 7.9% of men had ever received an HIV test and test results.[1] This emphasizes the need to rapidly expand HIV testing and Counseling (HTC)[2] services which are a key entry point to other HIV prevention, treatment, care and support services.

Client-initiated HTC, the traditional voluntary Counseling and testing (VCT), has been difficult to scale up in SSA because of poor availability and accessibility of services, high levels of stigma and discrimination, and the time-consuming nature of VCT. In the majority of health facilities and in communities in SSA, HTC services are limited as the majority of health-care providers and community-based volunteers have inadequate capacity to provide HTC services to patients and clients who need them.

By the end of 2007, almost 3 million people were receiving antiretroviral therapy (ART), despite an estimated 9.7 million PLWH who were in need of treatment.[3] The number of people who need to be tested for HIV (in order to identify others needing services) can be drastically reduced by scaling up both VCT in the community and provider-initiated HIV testing and Counseling in health facilities.

In June 2004, UNAIDS/WHO issued a Policy Statement on HIV Testing which detailed the following types of HIV testing:

(a) *Voluntary Counseling and testing (VCT);*
(b) *Diagnostic HIV testing* for persons who show signs or symptoms of HIV-related disease or AIDS, including HIV testing for all tuberculosis (TB) patients;
(c) *Routine offer of HIV testing by health-care providers* in sexually transmitted infection (STI) clinics, prevention of mother-to-child transmission of HIV (PMTCT) programmes and clinical settings;

1. *Towards Universal Access – scaling up priority HIV/AIDS interventions in the health sector. Progress Report 2008. WHO, UNAIDS, UNICEF.*
2. *HTC encompasses both provider-initiated HIV testing and Counseling (PITC) and client-initiated HIV testing and Counseling commonly known as VCT.*
3. *UNAIDS/WHO Policy Statement on HIV Testing, Geneva, WHO, June 2004.*

(d) *Mandatory HIV testing* of donors, for example, prior to procedures involving transfer of bodily fluids or body parts such as blood transfusion and organ transplant.

By end of January 2006, the WHO Regional Office for Africa had developed and disseminated the regional voluntary HIV Counseling and testing guidelines and draft regional normative tools for HTC to all 46 Member States in English, French and Portuguese. The draft documents listed below incorporate guidance from the 2004 UNAIDS/WHO Policy Statement on HIV Testing:

(a) HTC training course for counsellors: Trainee's manual;
(b) HTC training course for counsellors: Facilitator's manual;
(c) HTC training course: Manual for training facilitators;
(d) HTC training course for health workers: Facilitator's manual;
(e) HTC training course for health workers: Trainee's manual;
(f) WHO regional process guide for developing or updating national HIV testing and Counseling guidelines.

A number of countries have since adapted the various draft normative tools for training counsellors and health workers, while also developing training materials to address their own country-specific needs.

The draft WHO regional process guide is a simplified guide for countries to use in developing or adapting their HTC guidelines. Some countries successfully used this document to develop or update HTC guidelines, while others requested technical assistance from the WHO Regional Office.

In May 2007, WHO/UNAIDS issued a global guidance document on provider-initiated HIV testing and Counseling[4] for all epidemic settings. The document recommended the use of the expression "provider-initiated HIV testing and Counseling" (PITC) in place of previous expressions issued in the 2004 WHO/UNAIDS Policy Statement on HIV Testing; these included "diagnostic HIV testing", "routine offer", "HIV screening" and "opt-out". The 2007 document suggests that in all epidemic settings, HTC should be recommended in all health facilities to the following patients or clients:

4. *Guidance on provider-initiated HIV testing and Counseling in health facilities. WHO, UNAIDS, May 2007.*

(a) Adults, adolescents or children who present in clinical settings with signs and symptoms or medical conditions that could indicate HIV infection, including tuberculosis;
(b) HIV-exposed children or children born to HIV positive women;
(c) Children with suboptimal growth or malnutrition or malnourished children who are not responding to appropriate nutritional therapy;
(d) Men seeking circumcision as an HIV prevention intervention.

By the time the 2007 global guidance on PITC was released, some countries had already developed their HTC guidelines based on guidance from the 2004 UNAIDS/WHO Policy Statement on HIV Testing. Other countries were still in the process of developing or finalizing their guidelines and therefore managed to incorporate the 2007 recommendations. Some countries, however, still needed to develop guidelines so that they could standardize their HTC service provision.

In 2008, a process guide for developing national guidelines for HIV testing and Counseling in children was prepared to assist countries in developing HTC guidelines for children. A few countries have developed or are in the process of developing HTC guidelines for children.

In view of the above, countries are at different stages of the guidelines development process. Some have VCT guidelines only; some have VCT guidelines and PITC guidelines as separate documents; some have HTC guidelines which incorporate both VCT and PITC; and some have HTC guidelines for children.

A situation analysis was conducted to determine the status of HTC service provision in the WHO East and Southern Africa subregion (IST-ESA) at the end of 2008. This report details the findings from the analysis.

1.1 Objectives

The *general objective* of the situation analysis was to obtain an overview of the level of implementation and scaling up of HTC services in the IST-ESA subregion.

The *specific objectives* were to:
(a) Determine the status of client-initiated and provider-initiated HTC service delivery in countries of the subregion;

(b) Document innovative approaches and good practices in the provision of HTC services;
(c) Identify and document challenges and opportunities faced in scaling up HTC;
(d) Identify gaps in service provision and country needs for technical assistance;
(e) Recommend actions to support countries to scale up HTC services.

1.2 Methodology

A standard data collection tool (Annex 1) was sent to all 18 countries in IST-ESA[5] to collect data in the following areas:

(a) Guidelines for HIV testing and Counseling;
(b) HIV testing and Counseling training;
(c) HIV testing and Counseling service delivery;
(d) Innovative approaches and good practices;
(e) Challenges in providing HIV testing and Counseling services;
(f) Opportunities for scaling up HIV testing and Counseling services;
(g) Technical assistance (TA) needs.

Feedback was received from all 18 countries in the subregion.

[5] *Botswana, Comoros, Eritrea, Ethiopia, Kenya, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland, Tanzania, Uganda, Zambia, Zimbabwe.*

2. FINDINGS AND DISCUSSION

2.1 Guidelines for HIV testing and Counseling

2.1.1 Comprehensive HTC guidelines

HTC guidelines assist in ensuring a standardized approach to HTC service provision in the subregion. As shown in Table 1, 13 countries have HTC guidelines which address both VCT and PITC as approaches to HTC service provision.

Table 1: Countries with HTC guidelines by date of development and status of incorporation of WHO/UNAIDS guidance on PITC

Country	Date developed	Incorporation of WHO/ UNAIDS guidance on PITC
Comoros	June 2007	Yes
Eritrea	2005	Yes
Ethiopia	July 2007	Yes
Kenya	2008	Yes
Lesotho	April 2004	No
Madagascar	2004	Yes
Malawi	December 2007	Yes
Mozambique	Date not stated	Yes
Swaziland	June 2006	Yes
Tanzania	2007	Yes
Uganda	Date not stated	Yes
Zambia	2006	Yes
Zimbabwe	October 2005	Yes

It is encouraging to note that 12 of the 13 countries have incorporated the WHO/UNAIDS guidance on PITC, although some of the countries incorporated the guidance in the 2004 UNAIDS/WHO Policy Statement on HIV Testing. Only one country (Lesotho) has not incorporated the global guidance on PITC because the country's guidelines were developed before the release of the WHO/UNAIDS Policy Statement on HIV Testing in June 2004. However, the country plans to revise the guidelines so that they conform to the global standards.

Tanzania has both VCT guidelines and PITC guidelines but these are separate documents. The PITC guidelines were developed less than two years after publishing the VCT guidelines, and, therefore, it was decided that there should be two separate documents. The country, however, has made plans to merge the two documents.

2.1.2 VCT and PITC guidelines

As shown in Table 2, one country has PITC guidelines only, while four countries have VCT guidelines only. This highlights the urgent need for the five countries to have HTC guidelines that incorporate both VCT and PITC.

Table 2: Countries with either VCT or PITC guidelines by type of guideline

Country	VCT guidelines (Date developed)	PITC guidelines (Date developed)
Botswana	No	Yes (2004)
Mauritius	Yes *(date not stated)*	No
Namibia	Yes *(Aug 2006)*	No
Seychelles	Yes	No
South Africa	Yes *(date not stated)*	No

Botswana has had PITC guidelines since January 2004. These were referred to as "Routine HIV testing (RHT) guidelines". RHT is implemented in all health facilities in the country in accordance with the 2004 presidential directive to routinely offer HIV testing to all patients visiting health facilities in the country. The country is in the process of developing HTC guidelines which incorporate both VCT and PITC.

2.1.3 HTC guidelines for children

It is important that children have access to HIV testing so that those who are HIV positive can access prevention, treatment, care and support services. Only three countries (Malawi, Uganda and Zimbabwe) have HTC guidelines for children while two countries (Botswana, Zambia) are in the process of developing HTC guidelines for children and adolescents.

2.1.4 Rapid HIV testing guidelines

Seventeen countries have separate Rapid HIV testing guidelines to standardize HIV testing procedures in the country. Mauritius is the only country that does not have these guidelines.

2.2 Task-shifting of rapid HIV testing

One major obstacle to scaling up HTC is the inadequate availability of laboratory staff to conduct HIV testing. However, with the wide availability of rapid HIV testing methods, WHO recommends task-shifting the conduct of HIV rapid testing to non-laboratory health providers and lay service providers who are adequately trained and supervised. The conduct of rapid HIV testing by nurses and lay counsellors[6] was therefore assessed by country.

2.2.1 Rapid HIV testing by nurses

It is encouraging to note that all 18 countries allow nurses to conduct rapid HIV testing.

2.2.2 Rapid HIV testing by lay counsellors

Fourteen countries (Botswana, Eritrea, Ethiopia, Kenya, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Swaziland, Tanzania, Uganda, Zambia) have gone a step further in ensuring that task-shifting takes place among other levels of service providers by allowing all trained counsellors to conduct rapid HIV tests. This practice ensures greater HTC service accessibility and availability. Since May 2008, Zambia has been piloting the use of lay counsellors to conduct rapid HIV testing. Comoros, Seychelles, South Africa and Zimbabwe do not allow lay counsellors to conduct rapid HIV testing. This may be an indication of the existence of policy or other impediments that need to be addressed before task-shifting takes place in these countries.

[6] *Lay counsellors include all non-health workers providing HTC services in the various countries.*

2.3 HIV testing and Counseling training

2.3.1 HTC training tools

Health workers and lay counsellors who provide HTC services need to be trained in order for them to provide a quality service. Countries need to develop country-specific training materials. This can be done through adaptation of WHO generic training tools. The basic HTC training package consists of the following:

(a) VCT training manual;
(b) VCT participant's manual;
(c) PITC training manual;
(d) PITC participant's manual;
(e) Rapid HIV testing training manual.

With this package in place, countries would have the tools to support the training of both health and non-health workers, including lay counsellors.

Only eight countries (Ethiopia, Kenya, Mozambique, Namibia, Swaziland, Tanzania, Uganda, Zambia) have the basic HTC training package. Fifteen countries have Rapid HIV testing training manuals which serve to standardize the training of cadres who are allowed to conduct rapid HIV tests. Comoros, Mauritius and Zimbabwe do not have rapid HIV testing training manuals.

2.3.2 Additional training tools

Twelve countries have additional training tools as detailed in Table 3.

Table 3: Countries with additional training tools by type of training tool

Country	Type of training tool
Botswana	Couple Counseling training manual and participants' manual Lay counsellors training manual and participants' manual Palliative Care Training Manual Generic HIV Counseling Manual
Eritrea	BCC training manual Home-based care training manual PMTCT training manual
Lesotho	Community based care givers (CBCG) training manual
Madagascar	Training manual in basic concepts in case management of PLWH Training curriculum for management of HIV in mothers and children with congenital syphilis
Malawi	HTC supervision training guide
Mozambique	Training of trainers manual
South Africa	Mentorship training manual
Swaziland	Psychological care and support manual Community-based care and support training manual
Tanzania	Home-based care training manual and guidelines
Uganda	Stress management module Positive prevention for counsellors: facilitator's and participant's manuals Positive prevention peer educators manual Home-based HIV Counseling and testing trainer's and participant's manuals
Zambia	Diagnostic HIV Counseling and testing manual
Zimbabwe	Primary counsellor's trainer's and participant's manuals

The existence of the additional training tools in the different countries makes it possible for other countries to tap into these training resources.

2.3.3 Personnel trained in HTC

All countries have counsellors trained in VCT and other personnel trained in rapid HIV testing as detailed in Section 2.2 above.

Eleven countries have personnel who have received training in PITC as shown in Table 4. Among these, 11 countries have trained nurses; nine countries have trained doctors; nine countries have trained other cadres besides doctors and nurses. Kenya did not indicate the other cadres who have received training in PITC.

Table 4: Personnel trained in PITC by type of cadre

Country	Doctors	Nurses	Other *(type of cadre)*
Botswana	Yes	Yes	Yes *(lay counsellor, midwife, social worker, psychologist)*
Comoros	Yes	Yes	-
Ethiopia	Yes	Yes	Yes *(health officer)*
Kenya	-	Yes	Yes *(?)*
Lesoth	-	Yes	Yes *(community care-giver)*
Seychelles	Yes	Yes	Yes *(dentist, psychologist, physiotherapist, laboratory technician)*
Swaziland	Yes	Yes	Yes *(dental hygienist, health inspector)*
Tanzania	Yes	Yes	Yes (*laboratory technician, pharmacist)*
Uganda	Yes	Yes	Yes *(midwife, clinical officer, dentist, surgeon, nursing assistant, laboratory assistant)*
Zambia	Yes	Yes	-
Zimbabwe	-	Yes	Yes *(primary counsellor)*

The training of personnel in PITC has ensured that these countries scale up this approach to access HTC services.

2.4 HIV testing and Counseling service delivery

2.4.1 PITC service delivery

Facilities available for providing PITC services
All 18 countries have facilities that provide PITC services. Only five countries (Kenya, Lesotho, Mauritius, Swaziland, Zimbabwe) have at least one facility providing PITC services in all districts in the country.

Entry points for identifying HIV positive individuals
Entry points or opportunities for identifying people with HIV are utilized to varying levels by countries. As detailed in Table 5, all 18 countries utilize ANC clinics; over half utilize TB, STI, maternal and child health, paediatric and adult outpatient clinics and medical wards; and about half utilize home-based care settings and family planning clinics as entry points for identifying HIV positive individuals.

Table 5: Entry points for identifying HIV positive individuals

Entry point	Number of countries using entry point
Antenatal clinics	18
TB clinics	16
STI clinics	13
Maternal and child health clinics	12
Paediatric clinics	11
Outpatient departments	11
Medical wards	10
Home-based care settings	9
Family planning clinics	9

The other entry points that countries are utilizing to a lesser degree are surgical wards, obstetric wards, well baby clinics, blood transfusion centres, youth centres and private clinics.

PITC data

Thirteen countries provided data on the number of clients accessing PITC services. Seven of these (Comoros, Eritrea, Kenya, Malawi, Mozambique, Namibia, Zimbabwe) have sex-disaggregated data, while four (Kenya, Malawi, Namibia, Zimbabwe) provided data on the number of children accessing PITC services. Most of the countries reported that they had problems accessing the data from their routine data collection systems. This was especially difficult for sex-disaggregated data and children's data.

2.4.2 VCT service availability

VCT facilities

All 18 countries have VCT facilities. Twelve countries (Botswana, Eritrea, Kenya, Lesotho, Malawi, Mauritius, Namibia, Swaziland, South Africa, Tanzania, Uganda, Zambia) have at least one VCT facility in all districts. Although this is not a good measure of service availability, it is important to note that the remaining five countries in the subregion have not been able to meet this basic level of VCT service availability.

VCT service delivery models

VCT services are delivered through a number of models as detailed in Table 6. All 18 countries have VCT facilities integrated in health facilities while 15 countries have stand-alone VCT facilities. Fourteen (14) countries have VCT outreach services, while 10 countries utilize fully-equipped mobile vehicles to provide VCT services. Six (6) countries provide home-to-home VCT services.

Table 6: VCT service delivery models in countries

Entry point	Integrated in health facilities	Stand alone	Outreach	Mobile	Home-to-home
Botswana	Yes	Yes	Yes	Yes	No
Comoros	Yes	No	No	No	No
Eritrea	Yes	Yes	Yes	No	No
Ethiopia	Yes	Yes	Yes	Yes	No
Kenya	Yes	Yes	Yes	Yes	Yes
Lesotho	Yes	Yes	Yes	Yes	Yes
Madagascar	Yes	Yes	Yes	No	No
Malawi	Yes	Yes	Yes	Yes	Yes
Mauritius	Yes	No	Yes	No	No
Mozambique	Yes	Yes	No	No	No
Namibia	Yes	Yes	No	No	No
Seychelles	Yes	Yes	Yes	No	No
Swaziland	Yes	Yes	Yes	Yes	Yes
South Africa	Yes	Yes	Yes	Yes	No
Tanzania	Yes	No	No	Yes	No
Uganda	Yes	Yes	Yes	Yes	Yes
Zambia	Yes	Yes	Yes	Yes	Yes
Zimbabwe	Yes	Yes	Yes	No	No
TOTAL	18	15	14	10	6

Other less commonly used VCT service delivery models utilized by countries include HTC services provided through private doctors, NGOs, CBOs, workplace programmes, mass screening and targeted VCT services for such groups as youth, persons with disabilities and most-at-risk populations.

VCT data

Eleven (11) countries provided VCT data (Comoros, Eritrea, Kenya, Madagascar, Malawi, Mauritius, Mozambique, Seychelles, South Africa, Tanzania and Zimbabwe). Only seven of these had sex-disaggregated data (Comoros, Eritrea, Kenya, Madagascar, Malawi, Mauritius and Zimbabwe).

2.5 Innovative approaches and good practices

Sixteen countries shared what they perceived as the innovative approaches and good practices that they are implementing in order to scale up HTC services. The detailed submissions from countries are included in Annexes 2 and 3. The innovative approaches included:

(a) Use of different HTC service delivery models such as community HTC and door-to-door HTC (11); Campaigns ranging from national scale to those targetting specific population groups (9);

(b) Strengthening partnerships (5); Scaling up PITC in health facilities (5);

(c) Provision of community HTC services (3); Task shifting to lay counsellors (2); Ensuring HTC access for children (1).

The good practices countries wanted to share included:

(a) Use of different HTC models (10); Conducting HTC campaigns (7); Scaling up PITC services including paediatric services (4); Task-shifting of HIV Counseling and HIV testing (4).

(b) Strengthening of partnerships (2); Quality assurance system for community-based HIV testing (1); Supportive legislative framework for HTC service provision (1); Provision of free HTC services (1); Strengthened HTC linkages with other services (1); Campaigns to address stigma (1).

2.6 Challenges in providing HIV testing and Counseling services

Seventeen countries shared the challenges they face in providing HTC services as detailed in Annex 4. The challenges included:

(a) Inadequate human resource capacity (12); Limited access to HTC services especially for vulnerable groups such as children (9);

(b) High levels of stigma and discrimination (5); Weak systems for monitoring and evaluation of HTC services (4); Standardization of training of service providers (4);

(c) Limited funding for HTC (3); Poor infrastructure for provision of quality services (3); Weak supervision, burn-out and stress management for service providers (3); Weak referral and linkages between HTC and other HIV and AIDS services (2); Ineffective coordination of partners supporting HTC services (1).

2.7 Opportunities for scaling up HIV testing and Counseling services

All 18 countries detailed the opportunities they have for scaling up HTC as detailed in Annex 5. The opportunities included:

(a) Political commitment and leadership (5); Financial and technical support from development partners and global health initiatives (3); Scaling up of PITC services (3); Good infrastructure for service provision (3);

(b) HTC campaigns (2); Strong partnerships (2); Free ART and other services (2); Task-shifting (2); Standardization of HTC services (2); Rapid expansion of ARV programme (2); Community participation (2);

(c) HTC services for vulnerable groups such as persons with disabilities (1); HTC programme reviews (1); Availability of ARVs (1); High demand for HTC services (1); Integration of services (1); High levels of knowledge of HIV and AIDS (1); Reduced levels of stigma (1); Community leadership and support (1); Acceleration of HIV prevention efforts (1).

3. CONCLUSION

IST-ESA countries have made significant progress in ensuring that HTC services are available and accessible to their citizens. The majority of countries are in the process of standardizing HTC service provision with the development of guidelines and training materials as well as training of medical and non-medical personnel, especially with the aim of scaling up PITC services.

Mauritius still needs to address a number of issues pertaining to standardization of HTC services through development of PITC guidelines, rapid HIV testing guidelines and HTC training tools. The majority of countries still need to develop HTC services for children and adolescents.

A number of challenges still exist and will need to be addressed. However, countries have a number of opportunities that they can exploit to counteract these challenges.

4. RECOMMENDATIONS

Based on the findings of the situation analysis, the following recommendations are made to address the major issues that have been raised:

4.1 Countries

(a) All countries should ensure standardization of HTC services through development or updating of HTC guidelines to ensure the incorporation of WHO and UNAIDS global guidance on both VCT and PITC.

- Lesotho should update its HTC guidelines to incorporate WHO/UNAIDS guidance on PITC.

- Mauritius, Namibia, Seychelles and South Africa should develop HTC guidelines which incorporate both VCT and PITC.

(b) All countries should ensure access to HTC services for children and adolescents while also ensuring that there are adequate prevention, treatment, care and support services for them. HTC guidelines for children and adolescents should be developed in 13 countries, namely Comoros, Eritrea, Ethiopia, Kenya, Lesotho, Madagascar, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland and Tanzania.

(c) Rapid HIV testing guidelines should be developed in Mauritius in order to standardize rapid HIV testing among HTC service providers.

(d) Policy and other impediments to task-shifting of rapid HIV testing, especially to lay counsellors, should be addressed to increase access to and availability of HTC services in Comoros, Seychelles, South Africa and Zimbabwe.

(e) All countries should have the basic HTC training package which should consist of the following training manuals:

- VCT training manual,
- VCT participant's manual,
- PITC training manual,
- PITC participant's manual,
- Rapid HIV testing training manual.

(f) Ten countries (Botswana, Comoros, Eritrea, Lesotho, Madagascar, Malawi, Mauritius, Seychelles, South Africa, Zimbabwe) should ensure that they have developed all the manuals that constitute the basic HTC training package.

4.2 World Health Organization

(a) WHO should develop a database of HTC training manuals available in different countries and encourage countries to access these manuals as the need arises.

(b) WHO IST-ESA should continue assisting all countries to scale up availability of PITC services, with special emphasis on those facing major challenges.

(c) WHO IST-ESA should assist countries to implement the national External Quality Assurance (EQA) schemes for rapid HIV testing.

(d) WHO IST-ESA should assist all countries to scale up access to HTC services by using the entry points that are currently being ignored in identifying HIV positive individuals.

(e) WHO IST-ESA should assist countries in strengthening data collection for HTC services by ensuring collection of sex-disaggregated data and age-disaggregated data.

(f) WHO IST-ESA should provide technical assistance according to countries' requests (see Annex 6).

Annex-1 Data collection tool

HIV Testing and Counseling (HTC) Situation Analysis
for WHO East and Southern Africa subregion

COUNTRY:

Section 1:	Background	(Population: million)
HIV prevalence estimate (15-49 yrs):	Number of PLWH in 2006:	% of adults who know their HIV status:
Number of PLWH needing ARVs in 2007:	Number of PLWH on ARVs by end of June 2007:	Number of children LWH in 2007:
Number of children needing ARVs in 2007:	Number of children on ARVs by end of June 2007:	Number of orphans in 2007:

Number of districts: ☐

Number of health facilities: Central level ☐
District level ☐
Primary level ☐

Section 2: Guidelines for HIV testing and Counseling (HTC)

N.B. Provider initiated testing and Counseling=PITC

- Do you have HTC guidelines which combine VCT and PITC?
  No ☐ Yes ☐ *(Date developed :.....)*

  Under development ☐ *(Expected date of completion:.....)*

  Are there separate guidelines for:
  (i) VCT: No ☐ Yes ☐ *(Date developed: .....)*
  (ii) PITC: No ☐ Yes ☐ *(Date developed.....)*

- Do the guidelines incorporate WHO/UNAIDS global guidance on PITC?
- No ☐ Yes ☐
- Do you have rapid HIV testing guidelines? No ☐ Yes ☐ *(Date developed.....)*

- Which personnel are allowed to conduct rapid HIV testing?
  Laboratory technicians and technologists: No ☐ Yes ☐
  Doctors: No ☐ Yes ☐
  Nurses: No ☐ Yes ☐
  Any counsellor who has received the necessary training: No ☐ Yes ☐

- Do you have separate HTC guidelines for children? No Yes ☐ *(Date developed .....)*

Section 3: Training

3.1 *Training tools* - Are the following training tools available?

- VCT Training manual No ☐ Yes ☐
- VCT Participant's manual No ☐ Yes ☐
- PITC Training Manual No ☐ Yes ☐
- PITC Participant's Manual No ☐ Yes ☐
- HTC Training of Trainers Manual No ☐ Yes ☐
- Stress Management Training Manual No ☐ Yes ☐
- Community-Based Counsellor Training Manual No ☐ Yes ☐
- Child Counseling Training Manual No ☐ Yes ☐
- Child Counseling Participant's Manual No ☐ Yes ☐
- Rapid HIV Testing Training Manual No ☐ Yes ☐
- Do you have any other training manuals? No ☐ Yes ☐
  If Yes, please specify).....

3.2 *Personnel trained in HTC*

- Number of health workers trained in PITC:
  Doctors ☐ *Nurses* ☐ *Other (specify)*... ☐

- Number of counsellors trained in VCT ☐
  Number or % of trained counsellors providing VCT services ☐

- Number of personnel trained in rapid HIV testing ☐

Section 4:Service availability

4.1 PITC

- Number of facilities offering PITC services:
  Central level ☐
  District level ☐
  Primary level ☐

- % of districts with at least 1 health facility providing PITC services: .....

- Services at which PITC is provided:
  TB ☐ *STI* ☐ *Family planning* ☐ *ANC* ☐ *MCH* ☐ *Medical wards* ☐

  Paediatric wards ☐ *Outpatients department* ☐ *Home-based care* ☐
  Other (specify) .....

- Number or percentage of patients tested for HIV in different health facility points:(*e.g. calculation of percentage for TB patients: number of TB patients tested for HIV through PITC / Total number of TB patients seen)*
  TB ☐ *STI* ☐ *Family planning* ☐ *ANC* ☐ *MCH* ☐ *Medical wards* ☐

  Paediatric wards ☐ *Outpatients department* ☐ *Home-based care* ☐
  Other (specify) .....

- Total number of patients or clients seen through PITC:
  Adult males: ☐
  Adult females: ☐
  Children: ☐

4.2 VCT

- % of districts with at least 1 VCT site: ☐
- Total number of patients or clients seen through VCT:
  Adult males: ☐
  Adult females: ☐
  Children: ☐

- VCT service delivery models used in the country:
  Stand alone No ☐ Yes ☐ *Number of stand alone sites at district level .* ☐

  Integrated health facility sites No Yes
  Number of integrated sites at district level :
  Mobile (using a fully equipped vehicle) No ☐ Yes ☐ *Number of mobile vehicles .* ☐
  Outreach at district level (NOT using a fully equipped vehicle) No ☐ Yes ☐

  Home-to-home No ☐ Yes ☐

Other service delivery models (please specify).....
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Section 5: Innovative approaches to scaling up HTC

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Section 6: Good practices in HTC that can be shared with other countries

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Section 7: Opportunities for scaling up HTC

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Section 8: Challenges in scaling up HTC

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Section 9: What technical assistance do you need from WHO?

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Annex-2

Innovative approaches

Country	Innovative approaches to scaling up HTC
Botswana	*Partnership between MoH and civil society organizations to expand HTC services to hard-to-reach areas by building capacity of civil society; *Public officers HIV Testing Month targeting civil servants through outreach services; *Zebras for Life Test for Life Campaign: national soccer team mobilizes communities throughout the country, targeting men and youth.
Comoros	Nil
Eritrea	*Premarital testing supported by FBOs; *Sensitization of the community by religious leaders and opinion leaders during gatherings and funerals; *HTC service provision in prison settings; *Lay counsellors providing HTC services in health facilities.
Ethiopia	*VCT campaigns in universities; *Outreach VCT services within catchment area of some hospitals.
Kenya	*Use of different HTC models: PITC and home-based HTC; *Sensitization of health service providers at all levels; *Media campaigns with different messages and specific times; *HTC campaigns such as HIV testing days or weeks; *Advocacy for paediatric testing especially among health workers; *Moonlight HTC services.
Lesotho	*Know Your Status (KYS) Camaign.
Madagascar	*Integration of HTC within a minimum package of activities for training providers in the public and private health sectors.
Malawi	*Annual HTC week campaigns.
Mauritius	*Community-based-proximity HTC referral through area health centres and mobile clinics addresses stigmatization.
Mozambique	Community HTC services completely run by trained community workers.
Namibia	*Nil
Seychelles	*Development of IMAI toolkit *Implementation of HIV/AIDS workplace policy; *Outreach activities in all districts and at national level; *Stand-alone sites such as in town; *Use of all means of media to sensitize and inform the population; *Mass sensitization and participation including NGOs, CSOs, FBOs; *Change existing laws or legislation of HTC for those under 18 years needing parental consent; *Developing guidelines; *Routine HIV testing of all patients being admitted to hospital or having blood tests.

Country	Innovative approaches to scaling up HTC
South Africa	*Offering VCT as a routine in selected departments in health facilities e.g. TB, STI, family planning, ANC; *Conducting campaigns to reach the community and men; *Collaborating with international NGOs to strengthen VCT in the country; *Use of mobile units to reach areas where people may not come to health facilities.
Swaziland	*Conducting periodic and structured national campaigns to create increased demand for HTC services e.g. HTC month; *Door-to-door testing in high density population areas; *Conducting male-targeted interventions such as "dip tank outreaches" (Kudla Inhloko Campaign); *HIV and AIDS workplace programmes, including universities.
Tanzania	*National testing campaigns; *Establishment of new models of HTC e.g. PITC, home-to-home testing, to complement VCT; *Public-Private mix working with NGOs, CSOs and FBOs to implement HTC.
Uganda	*Use of index clients; *Home-based HTC *Routine HTC in Ministry of Health regional hospitals etc. *Mobile VCT to hard-to-reach populations by AIDS Information Centre e.g. CSWs, fishermen, prisoners, military forces, *boda-boda* (motor cycle) cyclists; *Asking each person to recommend another person to get tested.
Zambia	*Mobile VCT at national events e.g. traditional ceremonies; *Home-based VCT.
Zimbabwe	*Scaling up of PITC through use of "Learning Sites" as pilot sites before services are provided in health facilities; *Use of primary counsellors, a non-health worker cadre, trained to provide HIV Counseling, PMTCT, ART adherence and psychosocial support; *Training of nurses to perform rapid HIV testing.

Annex-3

HTC good practices

Country	Good practices in HTC that can be shared with other countries
Botswana	*Routine HIV testing; *Public officers VCT campaign every September; *Zebras for Life, Test for Life campaign.
Comoros	Nil
Eritrea	*FBOs support premarital Counseling and testing as a norm before marriage; *Devotion of health workers to support PLWH with their social problems.
Ethiopia	*Development of PITC training package with piloting in TB clinics and eventually expanding to hospitals throughout the country; *Task-shifting of both HIV Counseling and HIV testing from health workers to community (lay) counsellors.
Kenya	*Home-based HTC.
Lesotho	*HIV testing by community health workers; *QA system for community-based HIV testing.
Madagascar	* Rapid Result Initiative approach.
Malawi	*Annual HTC week campaigns; *PITC in paediatric wards; *Door-to-door community-based HTC; *Targeted home-based HTC (a client at a normal HTC site invites counsellors to come to her/his home to test all family members); *HTC integrated into community-based family planning services with community-based distributors providing HTC as an integrated component of family planning at community level.
Mauritius	*Decentralization of services; *Induction programme in prison services; *Outreach sessions with most-at-risk persons.
Mozambique	* Community HTC is integrated in a packaging with community DOTS in same provinces.
Namibia	* Nil
Seychelles	*Outreach activities in all districts for World AIDS Day or other theme days; *HIV testing week; *ABC Safe Sex Week Campaign *Media focal persons of HIV, AIDS, STIs focal persons in workplace areas; *HTC to all pregnant women (and partners) offered twice during pregnancy; *Decentralization of HTC services; *People able to go to any health centre to have their test and not necessarily only in their district; *Availability and accessibility of HTC services in all health centres.

Country	Good practices in HTC that can be shared with other countries
South Africa	*Supportive legislative framework and respect for human rights to ensure that confidentiality is maintained; *Reduction of stigma through strong IEC campaigns to encourage VCT e.g. Khomanani, Soul City, Love Life.
Swaziland	Partnership with civil society based on their comparative technical advantage in delivering certain aspects of HTC; *Provision of door-to-door HTC; *HTC month campaigns with targeted massages i.e. “Love Test campaign”.
Tanzania	*Political will increases motivation for public to be tested e.g. launching of National Testing Campaign when President and his wife were tested; *Use of mass media to mobilize public for HTC.
Uganda	*Free services to the public or minimal charges by private practitioners; *Follow up of index cases in case of PITC; *Linkage of HTC to other prevention and care services; *Home-based HTC especially for discordant couples; *Scaling up integrated HTC in health-care settings; *Train non-laboratory professionals to conduct rapid HIV testing; *Special HTC providers capacity-building.
Zambia	*PITC in paediatric ward at top National Reference Hospital (acceptance level is over 90%).
Zimbabwe	*Training and utilization of non-health cadres (primary counsellors) to enhance Counseling capacity in health institutions.

Annex-4

Challenges in providing HTC services

Country	Challenges in scaling up HTC
Botswana	*Human resource shortage; *Funding in civil society organizations; *Standardization of training and participants' manuals to use as reference materials.
Comoros	*Incorporating PITC approach within national guidelines *Training of service providers.
Eritrea	*Shortage of skilled human resources; *Fear and stigmatization; *Counsellor burn-out.
Ethiopia	*Venipuncture still the primary method for collecting blood for HCT; *|Few health facilities in country compromise access to HCT services; *Large geographical area with poor infrastructure; *Counseling of children affected by low utilization and coverage rates of PMTCT+ and paediatric HIV/ART services; *Counseling of disabled persons affected by low utilization and coverage rates; *High turnover of both professional health workers and lay/community counsellors affects Counseling quality and service provision.
Kenya	*Occasional shortage of commodities; *Poor infrastructure; *Inadequate testing of children; *Access issues in some remote places.
Lesotho	*Skilled human resources to provide services; *Supportive supervision; *Quality assurance; *Sustained incentives for community-based workers.
Madagascar	*Increasing geographical coverage of the programme.
Malawi	*Human resource capacity; *Monitoring the quality of decentralized HTC training; *HIV test kit logistics.
Mauritius	*Stigma and discrimination in the community as well as from health workers; *Up to 30% of detected cases not attending treatment, care and support services.
Mozambique	*Logistical capacity and quality of HIV testing from both institutional and community HTC; *Training for community agents who provide community HTC.
Namibia	Nil
Seychelles	*Lack of human resources in the AIDS Control and Prevention Programme office (one man show); *Lack of trained counsellors, laboratory technicians, nurses and other health professionals in HTC, rapid HIV testing etc; *Lack of material resources; *Current stock-out of HIV rapid test kits; *Fear of stigmatization for HTC; *Poor monitoring and evaluation system; *Difficulty in identifying or targetting the at-risk groups.
South Africa	*Stigma still a major problem where people are still afraid to go for HIV testing; *Infrastructural challenges: many old facilities not suitable for quality VCT services; *Shortage of health workers as VCT is labour-intensive and time-consuming; *High turnover and shortage of health workers.

Country	Challenges in scaling up HTC
Swaziland	*Limited human resources within the health facilities to support PITC; *Legal framework not supportive in encouraging people to know their HIV status i.e. harassment, gender-based violence, dehumanization and expulsion from work; *Weak referral and linkages for post testing; *Weak monitoring and evaluation system; *Weak support supervision and quality assurance on the provision of HTC; *Weak stress management strategies for HTC providers.
Tanzania	*Erratic supply of test kits; *Human resource shortage; *Lack of supportive supervision *Low morale of counsellors due to lack of motivation.
Uganda	*No access to services for many people who want to be tested; *Inadequate resources to train all health workers in routine HIV testing and Counseling; *Inadequate HIV test kits; *Providers are trained but do not provide services; *Transfer of trained staff to non-HTC sites; *Difficult for MoH to effectively coordinate all HTC partners in both the public and private sectors; *Heavy workload for service providers; *Inadequate modern infrastructure; *HTC funds not flowing easily.
Zambia	*Rolling out HTC training nationally due to financial and technical constraints; *Finger prick HIV testing brings issues of quality control which can be challenging for testing facilities.
Zimbabwe	*Inadequate human resources for testing and Counseling; *Inadequate geographical coverage of HTC services; *Monitoring and evaluation, incomplete data, late submission of data, poor data quality; *Linkages of HTC services to other HIV and AIDS services; *Supply chain management of commodities; *Stigma and discrimination.

Annex-5

Opportunities for scaling up HTC

Country	Opportunities for scaling up HTC
Botswana	*Workplace VCT campaigns; *Involvement of youth organizations in HIV issues; *Churches involvement.
Comoros	*Initial training of 17 counsellors within testing centres and TB units.
Eritrea	*Political commitment of the government; *Free provision of ART; *Free VCT services; *Community participation: voluntary home-based care providers.
Ethiopia	*Millennium AIDS Campaign; *PITC *Task-shifting to lay providers; *New HCT guidelines.
Kenya	*Rapid expansion of ART services; *High level of awareness of HIV and AIDS; *Reducing stigma in the community; *Good international support and guidance e.g. WHO/UNAIDS, HIV testing days, WHO PITC guidelines; *Good political support.
Lesotho	*Ownership by community leadership structures such as Community Councils.
Madagascar	*Existence of structures or networks for continuum of care; *Establishment of regional groups of trainers for HTC and PMTCT; *Effective decentralization of human, material and financial resources; *Integrated care of HIV and STI patients especially during prenatal consultations; *Mobile HTC services.
Malawi	*Community-based home-to-home (village-to-village) HTC.
Mauritius	*Needle exchange programmes and methadone substitution therapy; *STI management at social hygiene clinics.
Mozambique	*Acceleration of HIV prevention efforts provides opportunity to scale up HTC especially to remote areas where there is no health network.
Namibia	*Training on PITC and VCT will be offered as a package to heath workers (doctors and nurses) from 2008; *PITC will be incorporated in other health worker training to maximize opportunities for training health workers as a separate module; *VCT programme will review current VCT to HTC guidelines.

Country	Opportunities for scaling up HTC
Seychelles	*Focal health workers trained in HIV and AIDS: 6 regional health coordinators implement and coordinate HIV and AIDS activities.
South Africa	*More people will know their HIV status leading to behaviour change, better management of the disease, reduction of mother-to-child transmission of HIV, and access to ART when need arises.
Swaziland	*Integrating PITC in clinical services as part of the standard package of care; *Financial and technical support from development partners and global health initiatives; *Availability of ARVs and rapid expansion of the ARV programme; *Political commitment and leadership for HTC *Consideration of using finger prick technique for rapid HIV testing; *Provision of HTC for special groups such as CSW, prisoners, people with disabilities; *Community involvement in scaling up HTC services.
Tanzania	*There is political will; *Partners are ready to support HTC.
Uganda	*Many people (up to 70% of Ugandans) want to be tested; *ART care and HIV basic care now more available than ever before; *Infrastructure available in health facilities; *Trainable personnel: health workers just need short duration tailored training curriculum; *Great opportunity for learning on the job: available infrastructure for practicum; *Political support from leaders; *Lots of support from development partners and global health initiatives.
Zambia	*Broadening base of HIV testing cadres.
Zimbabwe	* Availability of enabling policy to offer HTC services and a sound network of health facilities; *Strong leadership and political commitment *Availability of OI, ART and PMTCT services; *Availability of good health infrastructure; *Availability of early infant diagnosis.

Annex-6 Technical assistance needs

Country	Technical assistance needs from WHO
Botswana	*Development of HTC national guidelines; *Development of child Counseling guidelines; *Development of training and participants' manuals for the above guidelines.
Comoros	*Adapt WHO generic training modules to local context *Continue training personnel; *Organize the referral systems of PLWH towards case management.
Eritrea	*Development and printing of different tools: guidelines and manuals; *Human and institutional capacity-building.
Ethiopia	*More advocacy to influence policy-makers regarding blood sample collection technique so that there is a move away from venipuncture; *Support to implement the new HCT guidelines; *Strengthening referral and linkage of patients between various interventions in chronic care and treatment services; *Increasing the coverage of HCT training among health workers and lay/community providers.
Kenya	*Review of documents especially guidelines, training tools and communication materials; *Policy advocacy e.g. HTC for children; *Guidance on quality issues for rapid test kits; *Evaluation of HTC programme from time to time; *Strategic plan.
Lesotho	*Review of current guidelines to include PITC and child Counseling; *Development of job aids for Counseling; *Establishment of evaluation research on QA for community-based HTC; *Evaluation of HTC training and review of training tools.
Madagascar	*Technical, financial and material resources for decentralized levels of the health system.
Malawi	*TOT in PITC *Monitoring quality of HTC training.
Mauritius	*Development of training manuals for PITC and VCT for health personnel *Carrying out HIV surveillance surveys.
Mozambique	*Clear norms and guidelines, training tools, planning and forecasting tools, IEC materials and quality assurance (QA) tools for VCT referred to as “Community HTC”.
Namibia	*Assist in development of PITC protocols and guidelines; *Assist in development of HTC child Counseling training modules.

Country	Technical assistance needs from WHO
Seychelles	*Comprehensive monitoring and evaluation software for various HIV and AIDS programmes; *Specialized training of service providers e.g. doctors, nurses, programme managers, laboratory technicians; *Experienced person to implement decentralization services; *Financial assistance or support with regards to material resources such as rapid test kits, reagents; *Equipped mobile van to facilitate outreach activities.
South Africa	*Training of health facility staff; *Training of staff regarding QA; *Ongoing technical support.
Swaziland	*Development of SOPs for PITC in different clinical settings; *Review of HTC guidelines *Development of HTC policy *Evaluation of HTC trainings; *Training of staff regarding QA ongoing technical support; *Review of stress management strategies for HCW.
Tanzania	*Develop paediatric HTC guidelines.
Uganda	*Provide full-time TA for at least 1 officer to strengthen coordination; *TA for research in best practices for scaling up HCT; *TA for child Counseling and testing (several legal and ethical considerations); *Research on good practices for scaling up HTC; *Child Counseling and testing.
Zambia	*Capacity-building in finger prick: TOTs; *Reviewing guidelines and policy on use of lay counsellors in testing (current law allows only health providers to do so); *Finalization of child Counseling guidelines.
Zimbabwe	*Finalization of child Counseling training manuals; *Training of health workers in child Counseling.

World Health Organization

Regional Office for Africa