African Development Bank

THE DEVELOPMENT OF HARMONIZED MINIMUM STANDARDS FOR GUIDANCE ON HIV TESTING AND COUNSELLING AND PREVENTION OF MOTHER-TO-CHILD TRANSMISSION OF HIV IN THE SADC REGION

HTC COUNTRY REPORT

ZAMBIA

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ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante Natal Care
ARVs	Anti Retroviral Drugs
CHAZ	Church Hospitals Association of Zambia
CHESSORE	Centre for Health, Science & Social Research
CIDRZ	Centre for Infectious Disease Research in Zambia
CT	Counselling & Testing services
DHMT	District Health Management Team
HTC	HIV Counselling & Testing services
HIV	Human Immune-deficiency Virus
HRH	Human Resources for Health
JHIPIEGO	Jhpiego (pronounced "ja-pie-go"), is an international non-profit health organization affiliated with Johns Hopkins University
Kara Counselling	An NGO providing information and counselling on HIV and AIDS
MCH	Mother and Child Health
MoH	Ministry of Health
NAC	(Zambia) National AIDS Council
NGO	Non-Government Organization
NPO	National Professional Officer (WHO job title)
NZP+	Network of Zambian People Living with HIV
PFP	Project Focal Person
PLHIV	People Living with HIV
PMTCT	Prevention of Mother To Child Transmission
SADC	Southern Africa Development Community
SAHARA	Social Aspects of HIV/AIDS Research Alliance
TWG	Technical Working Group
UNAIDS	United Nations Joint Programme on AIDS
UNICEF	United Nations International Children's Emergency Fund
UTH	University Teaching Hospital
WHO	The World Health Organization
ZEHRP	Zambia-Emory (University) HIV Research Project
ZNAN	Zambia National AIDS Network
ZPCT	Zambia Prevention, Care & Treatment (partnership)

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1. INTRODUCTION

1.1 HIV/AIDS and HTC in Zambia

Voluntary Counselling and Testing Services were established on a larger scale in Zambia in 1999. The programme was initiated in 21 pilot sites evenly distributed in each of the nine provinces of Zambia and the major funding in this pilot phase was provided by the Norwegian Government through NORAD. The Government of the Republic of Zambia provided the required human resources through the establishment of the Zambia Voluntary Counselling and Testing Service, which is housed in the Virology Laboratory at the University Teaching Hospital.

A consolidation and expansion phase was undertaken with lessons and experiences learnt from the pilot. By January 2006, 485 HTC centres were established in all the 72 districts of Zambia.

Zambia has a generalized heterosexual HIV-1 epidemic with a stabilizing seroprevalence trend. Estimates of HIV prevalence in 2007 for people aged 15 to 49 are 15.2% (UNICEF) and 14.3% (ZHDS). Estimates from sentinel surveillance data for 15-24 year olds are 6.5% (ZDHS, 2007) and 12.5% (SADC, 2008[1]). Ninety-three percent of the population has access to antenatal care (UNICEF, 2008).

As antiretroviral treatment programs and palliative care services are being scaled up in Zambia, the demand for counselling and testing is growing exponentially. The current HTC guidelines[2] advocate universal access to HIV counselling and testing, which is to be achieved through the use of various counselling and testing models, involving both health workers and non-health workers in different settings.

1.2 Aim and Objectives of the Consultancy

The main aim of this consultancy is to develop regional harmonized minimum standards for HTC policies, protocols and guidelines in the SADC region.

To achieve this, project team of the Social Aspects of HIV/AIDS Research Alliance (SAHARA) – see Appendix 1 -- is reviewing and analysing policies, protocols and guidelines for HTC in each SADC member state (MS), in collaboration with the HTC project focal person in the MS.

The specific objectives are to:

- identify and assess policies, procedures and frameworks on HTC, and come up with best practices in implementation of HTC policies;
- conduct field visits to engage in policy dialogue with policy makers and other stakeholders (including discussions of implementation strategies and challenges, opportunities and lessons learnt, gather views of the service users/providers);
- review gender issues and consider how men and women are involved in HTC; and
- review and analyse proposed minimum standards for HTC policies.

2. METHODOLOGY

The HTC project focal person (PFP) in Zambia was tasked with three key responsibilities:

2.1: Identify policies, procedures and frameworks on HTC

2.2: Participate in the assessment of the policies, procedures and frameworks on HTC

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[1] 2008 SADC HIV and AIDS Epidemic Report

[2] Ministry of Health, Zambia. National guidelines for HIV counselling and testing. March 2006

2.3: Facilitate dialogues and stakeholder consultations on policies relating to HTC, including policy discussions on the development and implementation of policies, procedures and frameworks on HTC in the country.

A field guide, consisting of relevant tools and instructions for each of the tasks, was provided to the PFP by the SAHARA project team, and included tables for data collection and key questions to guide policy discussions with key HTC stakeholders in the country. The field guide was implemented in Botswana in collaboration with the SADC Secretariat. Lessons learnt were used to enrich fieldwork in the other MSs.

Policy discussions, facilitated by the PFP, were held with various key stakeholders in the country, including:

- government official(s) responsible for HTC policies, protocols and guidelines;
- civil society official(s) dealing with HTC policies, protocols and guidelines;
- representative(s) of international organizations involved in HTC;
- representative(s) of private or informal sector involved in HTC policies, protocols and guidelines; and
- others as appropriate.

The policy discussions were conducted on a one-to-one basis with the project focal person. Group discussions were ruled out as most officials were busy with the start of the new year's activities; while the need for clearance slowed the interview process further, threatening the meeting of deadlines. In line with the framework developed by SAHARA, a number of organizations active with HTC work programmes were identified and efforts made to undertake interviews. Interviews with government officials at national level were mandatory in order to ascertain the overall picture. Thus the NAC and MoH were purposively included. The views from two implementers on the ground were thought necessary and also sought to ascertain performance and challenges in delivering HTC programmes at the grassroots. This helped to validate theory and practices on HTC. The other targeted respondents were interviewed by convenience, determined by their willingness and availability.

3. FINDINGS

3.1 SWOT analysis of HTC in Zambia

An analysis of collected data and existing guidelines revealed the following strengths, weaknesses, opportunities and threats regarding HTC programming in Zambia (see details in Appendices 2, 3, 4 and 5).

STRENGTHS	WEAKNESSES
• Guidelines developed in collaborative fashion involving local and international stakeholders. • Guidelines checked against international standards and based on WHO (2006) guidelines. • Documents available to any stakeholders, free of charge. • Nine recognized institutions offering counsellor-training programmes. • HTC services integrated into existing services, usually public sector	• Understaffing (and under-skilled staff) in the public health system constrains programme expansion. • Inadequate infrastructure. • Disabled clients (blind, deaf) not well catered for. • Inadequate supervision of policy implementation.
OPPORTUNITIES	**THREATS**
• ZEHRP research project on couples counselling offers	• Unpredictable funding arrangements

opportunity to involve men.
- Traditional leaders in Southern Province helping get men involved.

3.2 Assessment of HTC policies in Zambia

A multidisciplinary team representing public health workers, non-governmental organisations, physicians, social workers, counsellors and laboratory experts developed guidelines for HIV counselling and testing, published in 2006. This team solicited inputs from a wide range of experts such as support groups, people living with HIV/AIDS (PLWHA), donors, the private sector, people with disabilities and many others with varied expertise. All service providers in both public and private, Zambia Defence Force Medical Services and mission hospitals and facilities are expected to use these guidelines (MoH, 2006[3]).

3.3 HTC policy gaps in Zambia

- Policy and practice does not always match, due to differences in socioeconomic and perhaps socio-cultural factors at play.
- Programmes have demonstrated the need for additional staff and staff skills but the policies to make these available are not in tune; leading to a situation where programmes are run by fewer staff and sometimes by staff with lower skills than required.
- Poor or lack of male involvement. There are currently no policies on this issue and a growing realization of the need for a policy to enable male partners' participation in PMTCT programmes. (Expansion of a pilot couples counselling venture was thought necessary).
- More effective supervision of policies and guidelines is required.
- Inadequate quality assurance.
- Poor infrastructure compromises confidentiality.
- Mentorship programmes are needed to ensure all staff are updated and motivated for optimal performance.

3.4 HTC situation analysis in Zambia

- PITC (at ANC clinics) with opt-out approach is seen to be ideal and saves time
- Individual pre-test sessions replaced with group sessions.
- Test results given out the same day, usually within 15 minutes. If positive, a reflex CD4 cell count is undertaken to determine eligibility for ARVs
- HTC uptake promoted through mass media campaigns (radio, newspapers and TV), and translation and transmission of messages in local languages.
- Couples counselling is also being advocated and expanded. In some rural areas of Zambia, chiefs and headmen support PMTCT programmes with a focus to induce men to accompany their wives to ANC and PMTCT sessions.

3.5 HTC approaches Zambia

- **Stand alone (free standing)**

  For reasons of cost and cost-benefit, located in high population density areas and where HIV infection rates are high.
- **Integrated**

  HTC services integrated into existing services, usually public sector, such as hospitals, STI clinics, TB clinics, ANC clinics, or out patient clinics.

[3] Ministry of Health, Zambia. National Guidelines for HIV Counselling & Testing March 2006

- **Mobile/Outreach**
  There is limited experience with these models – current models offer temporary, rotating services for hard to reach groups.

3.6 HTC policy discussion: Success, Challenges, Best practice views of stakeholders

A summary report on the policy discussions is provided in Appendix 5.

Successes

- Task shifting has been successfully applied with involvement of NGOs in HTC
- PLHIV involved in motivating others to go for HTC

Challenges

- An acute staff crisis means that confidentiality and privacy may be compromised. In some sites test results were announced publicly to save on time - often in the form of saying "the following persons should remain behind for counselling while the rest of you are alright and you can go home". This approach results in passive compliance; even though the post-test counselling sessions were undertaken on a one-to-one basis.
- VCT services are mainly used by women
- Some ambiguity regarding age for consent. Legal age of majority (and therefore consent) is 18, although some health facilities accept those of 16 years, in accordance with current guidelines.

4. RECOMMENDATIONS FOR MINIMUM STANDARDS

Based on the current counselling and testing guidelines (MoH, 2006[3]) minimum standards should address the following issues.

4.1 Age of Consent in testing

- Those 16 years of age and above requesting HTC are considered able to give full, informed consent.
- Young people under 16 who are married, pregnant, parents, heads of households, engaged in behaviour that puts them at risk or are child sex workers are considered 'mature minors' who can give consent for HTC.

4.2 Standards for service provision

To offer high-quality standards HTC services at any site, HTC program planners need to address the following key issues:

- National policy issues and plans regarding HTC services;
- Establishment of design, management and partnerships at all levels;
- Site selection, development, support and maintenance processes;
- Counselling and testing protocols;
- Training needs;
- Community support and linkages with other services, including formation of post-test clubs/support groups;
- Promotion and advocacy, including the need for communication materials;
- Monitoring and evaluation, including quality assurance measures;
- Care for counsellors. (Stress management and Burn out)

4.3 Training of providers

- HTC counsellors do not necessarily require training as health workers and should be recognized as an independent cadre.
- Willing to speak about "taboo topics".
- Counsellors should be willing to get tested themselves, voluntarily, both for their own personal risk-reduction planning and to understand HTC as a consumer. However being tested should not be mandatory for selection as a counsellor.
- Employing PLWHIV may be highly beneficial for the counselling process.
- All counsellors shall undergo the required training and possess the requisite certification. The training shall take place in institutions recognized by the ZCC and counsellors should be registered with the ZCC. It is recommended that curriculum and operational procedures for training counsellors are standardized.
- Community counsellors should be able to read and write in English and be accepted by their community.

4.4 Accreditation of HTC sites

Minimum requirements: Staff, space, equipment and supplies.

	Large facility	Small health centre
Staff	o Minimum of two counsellors o Minimum one counsellor supervisor o Laboratory staff for QA for all HIV testing in the facility o CT coordinator	o Minimum of two counsellors including community counsellor o Arrangement for supervision can be made with a supervisor from another facility
Space	o Dedicated CT rooms with good ventilation and privacy	o Any room with auditory and visual privacy and good ventilation
Equipment	Each CT room to have : o 3 chairs, o one desk, o one lockable cabinet for documents, o one lockable cabinet for storage of HIV test kits and supplies, o testing table with sharps disposal bin, o hand washing facility o bench in waiting area	o 3 chairs, o one desk, o one lockable cabinet for documents, o one lockable cabinet for storage of HIV test kits and supplies, o testing table with sharps disposal bin, o hand washing facility
Supplies	o HIV test kits o Gloves and other supplies o Disinfectant o Counselling registers and monthly summation forms, other required stationary	o HIV test kits o Gloves and other supplies o Disinfectant o Counselling registers and monthly summation forms, other required stationary

4.5 Quality assurance of HTC services

Counselling QA

- All C&T sites and counselling services must ensure that the counselling provided to clients is of high quality. Strategies to maintain quality counselling should address:

- staff competency, follow-up training, supervision, monitoring sessions, counsellor reflection form, client exit survey, mystery client survey, stress management, exchange visits, and formation of a counsellor support network.

Quality assurance for HIV testing

All components of QA, i.e., pre-analytical, analytical and the post analytical phases, must be adhered strictly. Issues to be addressed include:

- adherence to laboratory protocol;
- quality control of samples;
- internal quality control (part of test kit);
- external quality control (known positive and negative reference specimens);
- quality control of testing kits and supplies.

4.6 Monitoring and evaluation of HTC policies

4.7 Comprehensive HTC approaches

4.8 Referrals

In consultation with the client, make appropriate referrals to additional services as needed.

- These may include medical, social, legal, economical, spiritual and psychological support.
- For clients who are HIV positive, post-test support services should include referral to ART, PMTCT, treatment services for TB, STI and other OIs.

APPENDICES

APPENDIX 1: SAHARA PROJECT TEAM

NAME	TITLE
Dr. Vincent Agu	Team Leader
Prof. Karl Peltzer	PMTCT Expert
Prof. John Seager	Monitoring and Evaluation Expert
Prof. Geoffrey Setswe	HTC Expert
Dr. Njeri Wabiri	Project Director
Ms. Mercy Banyini	Researcher

APPENDIX 2: ASSESSMENT OF HTC POLICIES, PROTOCOLS AND GUIDELINES

	Yes, No, N/A and Additional comments
Is HTC policy available?	Y
Has HTC policy been approved? Indicate year	Y, 2007 (updated 2008)
Are there HTC guidelines? (indicate the year of the operational guidelines)	Y, 2008
When were the guidelines published?	Y, 2006
Please list the stakeholders involved in the consultation process for developing HTC policy?	Public health workers, NGOs, physicians, social workers, counsellors, laboratory experts, support groups, PLWHA, donors, private sector, people with disabilities and others
Are policies/guidelines easily available?	Y
Is there an HTC implementation plan?	
Which CT methods/approaches are used?	Stand alone, integrated, mobile/outreach
Which types of staff do the counselling?	Trained counsellors
Other relevant documents	Ministry of Health, Zambia. National Guidelines for HIV Counselling & Testing March 2006 Zambian HIV Guide http://www.zambiahivguide.org/guidelines/zambia_hiv_national_guidelines/introduction.html

APPENDIX 3: SUMMARY OF HTC IMPLEMENTATION CHALLENGES IN ZAMBIA

Implementation Challenges	Yes, No, N/A Additional comments
Inadequate financial resources, which are often narrowly earmarked by donors	Y
Inadequate human resources; problems with lay counsellors	Y
Poor partner and sectoral coordination and donor support resulting in verticalisation of programmes and poor implementation of national policies	Policy & Implementation is now highly inclusive, harmonized and better coordinated
Stigma and discrimination	It exists, but is more of a problem for the well-to-do in society
Inadequate support for infant feeding which remains a complex issue, requiring further research	Y
Unequal emphasis on the needs of women, their children, partners and families, and insufficient follow up within a continuum of care and assurance of adequate care, treatment and diagnosis of exposed infants	Y
Insufficient integration of HTC services and insufficient linkages with other health and social services;	Y
The need to decentralize implementation and service delivery, and focus on developing and strengthening of community structures and systems to include HTC;	Y
Programme monitoring, recording and reporting	Y
Quality assurance and impact assessment;	Y
Inadequate efforts to ensure male engagement in HTC;	Y
Impact of gender inequality and of gender-based violence	This is considered as a major bottleneck for effective performance
Lack of capacity to cost plans	This is an ongoing challenge in the decentralization efforts
Slow scale-up of provider-initiated testing and counselling services, where appropriate, and the limited creation of demand for these services.	
Other: Please include other challenges not covered above	

APPENDIX 4: HTC IMPLEMENTATION NEEDS IN ZAMBIA

Implementation Needs	Yes, No, N/A Additional comments
Need to speed up development of HTC policies and guidelines	Guidelines revised in 2008
Need to improve M & E (HTC indicators, registers)	Y
Need to improve C & T (quality)	Y
Appropriate use of lay counsellors in the health care setting	Y

Improve integration of HTC into AIDS treatment and care activities	Y
Effective communication on HTC	Y
Improve community support for HTC	Y
Strengthen quality assurance for HTC services	Y
Best practice/models in HTC	Y
Other: Please include any other needs not captured in the table	

APPENDIX 5: SUMMARY OF DIFFERENT POLICY DISCUSSIONS

Policy managers and implementers at the grassroots were conscious of the need to involve disabled clients, and acknowledged that their needs were not being fully met in current programmes. In support of this view, they pointed to the following information gaps that arose: (a) information was not available in Braille for blind clients; and (b) there were no sign language interpreters for the deaf. These shortcomings made the experience of the disabled at the HTC rather uncomfortable and without the required level of privacy and feeling of confidentiality. The deaf were also generally 'excluded' from schooling programmes (and thus unable to be reached with HTC and PMTCT messages) because there were no sign language interpreters in most public schools.

There is an on-going focus on creating youth-friendly health services in Zambia to take care of the needs of teenage and adolescent clients. However, there was a need to make the services more effective and responsive to needs of the youth.

For organizations representing people living with HIV and AIDS, the need to expand services in response to increased demand for HTC and PMTCT was good. However, there was a general sense of disquiet in the way the opt-out approach for PMTCT was being implemented. The challenge to this lay in the acute shortage of HRH for ART and PMTCT programmes. This acute staff crisis meant that confidentiality and privacy were compromised as clients did not fully reach the point to make a decision whether or not to enrol in HTC and PMTCT programmes with commitment when they took the initial step to take part. This scenario led to increased default rate in subsequent follow-up programmes as clients dropped out. The test results after opting in were announced publicly to save on time, often in the form of saying "the following persons should remain behind for counselling while the rest of you are alright and you can go home". This approach trapped the HIV+ clients into passive compliance; even though the post-test counselling sessions were undertaken on a one-to-one basis.

Another important strategy has resulted in task-shifting and involvement of lay counsellors in PMTCT and HTC programmes. This move has led to lifting the burden off health workers who can now perform more specialized tasks that cannot just be shifted away. In practice, this has led to NGOs working from health facilities and with the collaboration of health workers and the public health system, figure 1.

Figure 1: Task shifting and involvement of NGOs in PMTCT and HTC programmes (A mural painting at Kamwala UHC informing clients of services provided and times

Characteristics of HTC service Users

Like other SADC countries, Zambia has a policy on HIV Testing and Counselling (HTC) services offered to clients. The HTC programmes adhere to set global standards following the 3 C's (Consent, Confidentiality and Context). Of the available approaches to HTC, the VCT approach is perhaps the most widely known at the moment, though the provider initiated testing is also gaining ground (with the opt-out model for PMTCT being most prominent).

With respect to the VCT approach, access and utilization patterns tend to be in favour of female clients. Respondents cited several reasons for this observed pattern in utilization and access to VCT services. Women were said to have the advantage in that "they were always around health centres for child and family problems and thus used health facilities more than men." Women are more inclined to share their problems with others more than men do. Men were said to keep problems to themselves much of the time. Women prefer to talk over things with others (and especially with peers) while men tend to talk very little when confronted with an issue. After all, as one respondent put it, "counselling is about talking and women fitted into this better than men." Another possible reason was that men tended to spend less time thinking about health than their female counterparts. Men tended to be preoccupied with "action to earn bread for their families." Other respondents noted that far more men were still in the denial phase compared with their women folk.

Access for young people was described as a 'tricky issue' in Zambia. It is tricky in than the legal age of marriage consent and voting was 18 years; while the age for being registered as an independent individual was 16 years (to get a national ID). Sixteen years is also the age when one is considered to be an adult (even in terms of health statistics) and yet at this age one could not give consent for an HIV test. In practice, the decision to offer services to such young people depends on the attitudes of staff and local practices on the subject. At some facilities such young people can be free to give consent, while at others this was not the case. This is an area of active current debate.

HIV Counselling & Testing (CT) Services

The quality of post-test counselling services were described as good, in that clients counselled usually came back to seek additional help and support. The tests are carried out on a one-to-one basis with good confidentiality. The sessions were estimated to last between 5 and 30 minutes. During these post-test counselling sessions, issues of positive living and treatment literacy are covered adequately for HIV positive patients. Such sessions provide information on what treatments are available and where. They also discuss

the possible side effects of the drugs and the various possible actions the client can resort to. Positive clients are referred to the next level of care for assessment of suitability to be put on ARVs. They may thus be referred to HIV/TB clinics, or to the doctor in charge. Clients are also referred to post-test counselling clubs in their community for support and fellowshipping. Through the post-test counselling clubs, clients can be availed with information on further follow-up sessions. Arrangements between post-test clubs and ART clinics are 'standard' so to speak, offering what were described as friendly services.

Youths and youths groups are the targeted beneficiaries for services provided. Though no special efforts were cited for involving youths, respondents emphasized that youths were involved like any other volunteers in their work. The youth volunteers had the advantage of having good peer influence on their age mates; which usually proved useful. As the largest block of clientele, youths could not be ignored.

Cryptic coding inserted on ANC and Under-5 cards was used by the health system to ensure second and other follow up of children and mothers that were HIV positive. With these codes, it means that a health worker at any clinic in Zambia would continue with follow up care along standard guidelines.

HIV Counselling Staff

PLHIV were involved in service delivery in different ways at different ART sites. For a start, they were very much involved in counselling services at ART clinics. They were also involved in a range of community based programmes, such as nutrition and infant feeding clinics. During these sessions, PLHIV provided valuable motivation to new clients to comply and continue with the treatment they had been put on. As such, the counselling sessions provided by PLHIV were credited with high morale and low drop-out rates.

In community programmes, PLHIV gave moving testimonies that usually convince others to volunteer for HTC. Other PLHIV were involved with undertaking actual laboratory testing sessions

Discussion interview guide

Please tell me about the Country's HTC programme, what has been it's a great achievements or strengths, and where you think it could be improved?"

What are the gaps in HTC policies? Give examples.

What are the HTC implementation challenges?

Describe the characteristics of HTC service users?

Which groups of people does the CT service mainly target? What is the age and gender of the clients who used your counselling and testing services during the past year?

What are the differences between males, females and young people (under age adolescents) in terms of access and utilization of HTC?

What is the legal right to access HTC under the age of 18 years?

HIV Counselling & Testing (CT) Services

Is HIV testing done on site? If YES, is rapid HIV testing available with clients being given their HIV test result on the day of testing? If NO, how long do clients have to wait for a HIV test result? ______ days

What can you say about the quality of (post) test counselling sessions? How long are (post) test counselling sessions on average?

How is treatment literacy covered for positive clients? Are there any mechanisms for (second) follow-up counselling session?

Elaborate on referral and follow-up services?

Multi disciplinary liaison between different counselling, care and support networks e.g.

Medical referral/ follow up

Social Support

Are you familiar with the CT methods/approaches used in the country?

Do you use traditional one-one-one HTC, or is CT is part of a prevention of mother-to-child transmission (PMTCT) programme, Provider-initiated CT, Group counselling (pre-test), Couples counselling, Family counselling, Partner counselling (partners of HIV-positive people), Home-based CT or any other method of CT?

Which types of staff do the counselling?

Is it Health workers, Professional counsellors (registered with the country's professional health authority) or Lay counselors.

Are PLHIV involved in service delivery?

Do you know of HTC policies in this country?

How closely do the HTC policies, protocols and guidelines match practice?

Where are HIV Counselling & Testing (CT) services provided in this country?

Is it nationally (all provinces), provincially (services spread throughout one or more provinces in the country), district (services spread throughout a health district or a municipality) or local (services spread over an area smaller than a health district or municipality)?

Service Load

How many HIV counselling sessions were conducted (across all service delivery points combined) in the past year?

How many HIV tests were done (across all CT service delivery points combined) in the past year?

Hours of Operation of HIV Counselling & Testing (CT) Services

How many days per week are counselling and testing services available at service delivery points in this country?

What are the service delivery points for providing HIV Counselling & Testing (CT) in this country?

Is it HTC clinics, hospitals, community health centres, clinics, (stand-alone) counselling and testing facilities or other fixed HTC service points? What is the approximate number of service delivery points in urban/rural areas?

What are the strategies to promote HTC uptake in the country?

In your view what issues should proposed minimum standards for HTC in SADC critically consider under each of the following themes?

a. Age of Consent in testing

b. Standards for service provision

c. Training of providers

d. Accreditation of HTC sites

e. Quality assurance of HTC services

f. Counselling QA
   i. Rapid HIV Testing

h. Monitoring and evaluation of HTC policies

i. Comprehensive HTC approaches

j. Referrals