UNAIDS policy
on HIV testing and counselling

UNAIDS Policy Statement
HIV Counselling and Testing

Report of a Workshop for the Asian Region

9 - 13 December 1996: Bangkok, Thailand

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Joint United Nations Programme on HIV/AIDS
This statement summarizes UNAIDS' position on HIV testing and on counselling issues related to HIV testing. It is addressed to national authorities and is meant to facilitate the development or strengthening of national policies on the subject.

Voluntary HIV testing accompanied by counselling has a vital role to play within a comprehensive range of measures for HIV/AIDS prevention and support, and should be encouraged. The potential benefits of testing and counselling for the individual include improved health status through good nutritional advice and earlier access to care and treatment/prevention for HIV-related illness; emotional support; better ability to cope with HIV-related anxiety; awareness of safer options for reproduction and infant feeding; and motivation to initiate or maintain safer sexual and drug-related behaviors. Other benefits include safer blood donation.

UNAIDS therefore encourages countries to establish national policies along the following lines.

1 Make good-quality, voluntary and confidential HIV testing and counselling available and accessible. Reliable HIV testing should be provided in a non-stigmatizing environment, and the services should include pre-test counselling (where possible and if desired), informed consent, and post-test counselling.

In designing these services, countries should give special consideration to increasing women's voluntary access to them. Women should be offered information on reproductive and infant feeding options and on the use of anti-retroviral treatment to reduce the risk of mother-to-child (vertical) HIV transmission. Regardless of the presence of risk factors or the potential for effective intervention to prevent transmission, women should not be coerced into testing, or tested without consent. Instead, they should be given all relevant information and allowed to make their own decisions about HIV testing, reproduction and infant feeding.

HIV testing and counselling for couples is effective, and their voluntary participation should be encouraged. Special consideration should also be given to offering voluntary HIV testing and counselling to people thought to engage in high-risk sexual or drug-related behaviour.

2 Ensure informed consent and confidentiality in clinical care, research, the donation of blood, blood products or organs, and other situations where an individual's identity will be linked to his or her HIV test results. In situations of linked HIV testing, the individual should be informed of the potential benefits and risks of an HIV test: the principles of voluntary testing including informed consent and confidentiality should be respected; and post-test counselling should be provided.

3 Strengthen quality assurance and safeguards on potential abuse before licensing commercial HIV home collection and home self-tests. HIV home collection tests (in which specimens are collected at home and sent off for analysis) and home self-tests offer the advantages of enhanced access and anonymity. However, these tests may have serious negative consequences, especially if they are not connected
With confirmatory testing, and with counselling and care services, or if they are applied coercively to spouses, sex partners, and people seeking employment; entitlements or services. Licenses for commercial "home" tests should be continuously reviewed and test uses monitored.

4 Encourage community involvement in sentinel surveillance and epidemiological surveys. HIV testing conducted for these purposes is usually anonymous and unlinked. and may not require individual consent. However, the findings of such surveys are of great community concern. and so communities need to have a sense of "ownership" of the process. Community consent should be secured before surveys are conducted, and the community should be involved in the survey and have access to the results.

5 Discourage mandatory testing. HIV testing without informed consent and confidentiality is a violation of human rights. Moreover, there is no evidence that mandatory testing achieves public health goals. UNAIDS therefore discourages this practice. HIV testing in which the individual's identity is linked to the test result must not be done without the individual's informed consent. In addition, he or she should receive post-test counselling, and have the assurance that all results— including the fact that a test was performed—will be kept confidential.
Executive Summary

The HIV Counselling and Testing (C&T) Workshop for the Asian Region was held at the ASEAN Institute for Health and Development, Mahidol University, Bangkok, Thailand from 9-13 December 1997. This meeting was attended by thirteen C&T experts, including representatives from India, Sri Lanka, the Philippines, Indonesia, China, Myanmar, Thailand, Australia (a UNDP representative) and UNAIDS, Geneva (Appendix A). During the five day workshop, the draft report of the Myanmar Counselling Feasibility Study (1994-96) was analysed to identify important lessons learned from initiating C&T services into existing health services (Appendix B), the draft UNAIDS C&T Stock-Taking report was reviewed and strategic programmatic themes were identified (Appendix C), the draft UNAIDS Policy on HIV Counselling and Testing (Appendix D) was reviewed and modified, a five-year Strategy for Developing HIV Counselling and Testing Services in the Asian Region (Page 10 of this report) was developed, and finally an informal network of HIV C&T experts from the region was formed.

Participants in the meeting felt that the workshop had been extremely productive and worthwhile. They appreciated UNAIDS efforts to organise the meeting and to seek the opinions in experts from their region on technical documents while they were still in draft form. The work carried out by the Myanmar team in conducting the study, finalising it on time and presenting a good report was highly commended. The lessons learned were relevant for many of the participating countries and the methodology of documenting the delivery of counselling services was appreciated as a key tool in service development. The C&T strategy for the region was developed by the group, as a document to be used by national partners. UNAIDS and bilateral donors to highlight the importance of counselling and to develop appropriate programs. Participants were hopeful that the informal network developed during this workshop will assist them in sharing information, identifying appropriate consultants, reviewing each others projects and papers and accessing technical support.

Brief Country Reports

Indonesia
(Staff of the Ministry of Health)

In 1994, a National AIDS Program was created in Indonesia by presidential decree, including specifications for voluntary counselling and testing (VCT). Unfortunately, this only resulted in one hospital and one NGO providing counselling. Implementing widespread counselling was hampered by several factors; counselling was interpreted to mean lecturing, their were moral objections to promoting counselling and safer behaviours (e.g. condoms), it was unclear who should provide counselling - professionals and/or para-professionals, and there are no laws addressing
confidentiality issues in counselling. The notification of HIV-positive blood donors has been addressed, but no conclusions have yet been reached. There have been some government programs to train medical doctors (MDs), teachers, sex workers as AIDS/STD counsellors. In addition, the Army has initiated a training program on AIDS/STDs.

India
(Professor Jacob K. John, Christian Medical College, Vellore)
Efforts to provide counselling began in 1987. By 1992, there was a national training program for counsellors. Six regional centres were established, which trained counsellors in the areas of care, counselling, and support needs. In turn, these counsellors have trained grass-roots field workers in preventative counselling and education. Testing became available in 1986. Unfortunately, many physicians feel that it is their right to test patients without proper informed consent and counselling.

Sri Lanka
(Mr. S.B. Abeyakoon, AIDS Control Project, Colombo)
Sri Lanka has only 200 reported cases of HIV, including 69 AIDS cases, although it is estimated that there are as many as 6000-8000 total cases in the country. Currently 7 out of 9 provinces in Sri Lanka have counselling and training activities. This includes telephone counselling. There is a 4-day basic training course in counselling, run by the Sri Lanka Association of Professional Social Workers, which has trained 100 Basic counsellors. There are no guidelines on counselling and no uniform procedures in hospitals. Currently, medical officers must inform HIV-positive patients of their test results before a trained counsellor can give the news to a patient. The government has only authorised one NGO to counsel within public hospitals. In private hospitals and at the National Blood Centre, no counselling is provided. There is a great need to develop out-of-hospital follow-up and community services for PWAs. Sri Lankan nationals who emigrate to other countries for work are often tested without informed consent, pre-test counselling or even the knowledge that they are being tested. Those found to be positive are then sent back to Sri Lanka with little or no understanding of their situation.

Philippines
(Dr Joan Regina L. Castro, Reach Out AIDS Education Foundation, Makati)
There are currently 821 reported cases of HIV in these 7,100 islands - with estimates of 18,000 to 25,000 total cases. In the Philippines, there are several different AIDS related programs. ASEP, the AIDS Surveillance Education Program, does HIV surveillance of male STD patients and registered sex workers in 10 cities. There are 51 AIDS service organisations, but these are found mostly in cities. Finally, there are
some integrated HIV/STD programs which are using counselling. Few NGOs provide counselling.

Currently, there is no standardisation of counselling. Minimum recommendations should address risk reduction, condom use (although politically difficult in this predominantly Catholic country), and STD reduction behaviours.

Philippine nationals who work as overseas contract workers must be tested for HIV before they leave. Currently, 750,000 individuals are "exported" each year. There is a pre-departure orientation seminar, with 54 agencies mandated to provide pre- and post-test counselling. This program has identified 129 HIV-positive individuals.

**China**
(Dr Xia Qiang, National Centre for STD Control, Nanjing)

HIV infection is found predominantly in southern China, among intravenous drug users (IDUs) and prostitutes. In October 1996, there were 5,100 reported cases of HIV and an estimated 100,000 total cases. Education about HIV is currently in the form of mass media campaigns. There are also HIV hotlines, which inform callers where to go for C&T. There is counselling available to individuals who test positive and their partners. But it is more difficult for healthy people to find counselling and testing services. They must go to a hospital and sign a form. This may arouse fears about confidentiality. Hence, those with such fears end up going to another location where they will not be known or recognised to receive C&T.

In early 1996, a workshop was held on counselling in the south of China. It was attended by 20 people, mostly MDs and psychologists who work on hotlines and in the community. It is difficult for health care providers (HCP) to incorporate counselling into their other duties. Currently, most HCP have a heavy work load and share office space, making it difficult to provide confidential counselling and support services.

**Australia**
(Mr. Bill O'Laughlin, Australian Federation of AIDS Organisations, Victoria)

In Australia, the rate of new HIV infections has decreased, in part due to extensive education programs. Today, the population of HIV-positive persons numbers about 20,000. The success of efforts for control and prevention stem from the co-operation that began early on in the epidemic between governmental departments, NGOs, communities and People Living With HIV/AIDS (PLHAs). Prevention and counselling activities have been provided by educators, voluntary workers, counsellors and PLHAs. Efforts have been made to empower PLHAs; to set up peer support groups and to provide access to information and services. However, there is a need for continuing education and prevention measures to face the possibility of new waves of infection.
In the initial phase of the epidemic, the gay community was the most affected. Although there is a low overall prevalence in the heterosexual population, the epidemic has recently moved into the indigenous population, where there is a high rate of non-HIV STDs. In Australia, there are problems of costs for HIV-care, which are not covered by health care plans. This problem is particularly relevant with respect to the new triple combination therapies of anti-retrovirals. Costs are very high and access to treatment becomes restricted to only those with the resources to pay themselves.

The emergence of the HIV epidemic in the indigenous population has highlighted several issues with respect to prevention and care in this non-white, non-gay community. This community already suffers from inadequate health care resources with high rates of STDs and other health problems. There is little confidentiality in the provision of health care resources and the concept of one-on-one counselling is foreign to this group. This has made the western concept of counselling for prevention not well received in this group. Thus, there is an urgent need to address the socio-cultural characteristics of this group, which describe their interaction and learning style and their beliefs about health and disease. The aborigines themselves must be involved in these discussions and the plan for action, in order to facilitate an awareness of the epidemic in their community.

Thailand
(Dr Jean Barry, Xavier Hall, Bangkok and Assistant Professor Surin Ronnakiat, Thammasat University, Bangkok)

AIDS was first detected in 1984 in this country and because the first cases were among gay persons, it was thought to be a gay problem. But the infection then spread to IDUs, commercial sex workers (CSWs), and finally to the general population, first among men going to CSWs and later to their wives and the new-born children. Today, there are an estimated 1 million persons infected and the rate of full blown AIDS and AIDS related deaths is increasing rapidly. This has become a major health crisis. Massive efforts have been carried out with the result that rates of HIV infection are beginning to decrease.

At first, the government tried to keep track of all HIV positive persons. This policy led to discrimination and fear. Later, mainly through initiatives of the Thai Red Cross Society, anonymous testing and counselling become available. The government health system followed this approach with the result that counselling and testing is now available to all throughout the country. A massive effort has been made to train counsellors, from the community of health care workers, social workers and volunteers. Many programs were conducted for training community leaders and peer leaders, especially among factory workers to enable these young people to become peer counsellors.
Myanmar
(Dr Myat Thu, AIDS Counselling Team, Yangon and Mr. George Paw Tun. Ministry of Health. Yangon)

As of January 1996, there were an estimated 350,000 cases of HIV infection in Myanmar. In men seeking care for STDs the rate had risen from 2% in 1990 to 7% in 1995. In 1996, IDUs had a rate of 67%. Until 1994, HIV counselling services were not widely available in the country.
To date, there has not been the development of NGOs to facilitate HIV counselling and care in Myanmar, as has occurred in other countries. However, the National AIDS Program has identified the development of HIV/AIDS counselling services as one of its priorities.

The feasibility study presented by the Myanmar team has been the first major effort to provide counselling to individuals with a positive HIV results. on a country-wide basis. Through the study protocol, counselling services were incorporated into existing health care services. Physicians, nurses, social workers and STD investigators were trained to counsel as part of their duties. A system was created to monitor the content and quality of the counselling sessions, as well as patient satisfaction with the sessions. The target population for the study were symptomatic persons who tested positive for HIV, partners of HIV infected persons, and blood donors who have tested positive. The content and the results of the feasibility study were discussed in depth by the workshop participants.

Draft Report of the Myanmar Counselling Feasibility Study (1994-96)

This feasibility study was a two year project supported by the Government of Myanmar and UNAIDS/WHO and created a unique program which added counselling services to pre-existing health services in 28 Townships throughout Myanmar and then monitored the content and delivery of these services.

In order to implement counselling services, several initial steps were taken. These included generating co-operation and support for the intervention. conducting Basic Counselling Workshops for the health care workers who were to add counselling to their existing duties, a system to provide supportive supervision to the counsellors and an Advance Counselling training Workshop.
Once the counselling systems were in place, data were collected on the content of the counselling sessions and on patient satisfaction using pre-tested questionnaires. Overall, the counselling sessions were found to adhere to standards. Counsellors were able to provide clients with solution options to their problems and clients were able to act on these suggestions. In addition, approximately half of the counsellors were able to follow-up with their clients. Finally, 90% of clients were satisfied with the counselling services they received.
The first day of the workshop was spent reviewing the draft report of this study, which was well received by the workshop participants. Further discussions concentrated on some of the constraints inherent in implementing counselling services in the structure of a pre-existing health care system. These discussions were useful for addressing current or future situations that might arise in the countries of other workshop participants.

Overall, it was noted that extensive co-ordination was required to train counsellors and organise counsellor's meetings. Many of the counsellors had to travel significant distances to attend meetings, so meetings held in more heavily populated areas were more frequently attended. For most of the counsellors, counselling duties were added to already full schedules at the clinic or hospital where they worked. This often made it difficult for the counsellors to spend the time that they would have liked in their counselling duties. It was suggested that some extra compensation be arranged for the counsellors to encourage them to spend the necessary time on counselling activities. There was also the issue of integrating counselling, a western concept, into the relationship between the counsellor and client. The counsellors tended to give, rather than suggest solutions for their clients. And the clients often followed, rather than chose the options given. It was suggested that further workshops on counselling skill building be organised for the counsellors: It was also recognised that for counsellors everywhere, the skills used in counselling are always evolving with time and practice. In addition, it was noted that efforts should be made to broaden counselling beyond the health services sector, by including NGOs and other community services in providing counselling services. Finally, the issue of sustainability of a counselling program was addressed. It was noted that in order for a successful program to continue, program managers, planners and policy makers must all be involved to ensure continued support. A presentation of preliminary data from this study was made at the Asian International Conference on AIDS in Chiang Mai, Thailand, September 1995 and an oral abstract was accepted at the International Conference on AIDS in Vancouver, June 1996. The full report of the study will soon be published as joint publication of the Government of Myanmar and UNAIDS.

Draft UNAIDS Counselling and Testing Stock-Taking Report

This is an extensive 75-page document which reviews the state of counselling and testing throughout the world as of mid-1996. The draft form presented at the workshop addressed the following content areas: What is being done in the name of counselling? What, in reality, is counselling used for? By whom is counselling provided? Counselling: where is it provided? Counselling: distribution and availability, VCT: distribution and availability. Availability of Telephone Hotline HIV counselling, HIV Counselling without testing, Community Counselling and HIV testing and how it relates to counselling practices.
The second day of the workshop was spent reviewing this document. Given the amount of material presented in the draft, a short overview of the document was presented. Small groups where then formed and the sections divided among them. Presentations were then made by the individual groups at a plenary session. where it was decided that the paper should be reorganized into "Strategic Programmatic Themes." The proposed themes included: (1) A VCT section divided into Cost. Efficacy. Service Development, Social Support. and Funding. (2) A section on Counselling ServiceDelivery which highlights the crucial role that NGOs play in the role of counselling (3) A section on Hotlines, including examples from Sri Lanka and the Philippines and examples to show that hotlines existed before HIV/AIDS (4) Broaden the section on Counselling without testing to include more concrete examples of these practices (5) Broaden the section on VCT to include examples of the spectrum of available forms of pre-test counselling. such as videos, leaflets, and group counselling, and (6) Broaden the examples of counselling to include illustrations of the many different levels of counselling that are currently being provided.

Draft UNAIDS Policy Statement on Counselling and Testing

Parts of the third and fourth day of the workshop were spent reviewing the current draft of this policy statement. The participants felt that the document was needed. They had several suggestions on ways in which the document could be modified to make it more useful. There were two large content areas which were addressed: the section on providing C&T to women was rewritten and an additional section on sentinel surveillance and ad hoc epidemiological surveys was added. In addition, all other sections underwent extensive revision to make them clearer and more directed, including the introductory section on counselling and testing.

It was felt that the pre-workshop section of the document which focused on the C&T needs of women concentrated too heavily on the need to reduce maternal-child transmission of HIV without addressing the many other concerns that many women have regarding the possibility of being or becoming HIV-infected. The section was rewritten to reflect the broader issues of HIV in women's lives, including the need to access confidential risk assessment. the need for VCT, information on decreasing the risk of becoming infected if they are sero-negative, birth control options, infant feeding options, information on reducing maternal-child transmission, and information on pregnancy termination where legally permissible. The need for widely available. non-coercive, voluntary counselling and testing was stressed.

A section on sentinel surveillance and ad hoc epidemiological surveys was added. Although the group recognised that these are important tools for identifying the prevalence and trends of HIV in a community, they also recognised that the results of the surveys have not always been used in ways which are beneficial the study community. For example, surveillance studies have identified communities of IDUs where 50% of the members are HIV-positive. However, within these communities there have been no provisions for VCT and other counselling and care services. The result is that the community of IDUs knows that half of them are positive, but without any support or care in this knowledge. The workshop members recommended that.
networks be involved in the planning and implementation of such surveys, as well as the discussion of the results and the plan for action. In addition, people should be enabled to act on this information, including accessing VCT and care services. The final statement was published in August 1997 and is now available at the UNAIDS information Centre in Geneva.

Network of Counsellors

Included as an outcome of the meeting, was the formation of an informal network of counselling and testing experts from the Asian Region. Most of the attendees at the workshop have seen progress in the creation of counselling services in their countries over the last several years, but also have very clear visions of the need for additional counselling and testing services in their communities. Throughout the week, the participants shared their experiences, which included the results and failures of services in their countries, their goals for the development of needed legislation and national government support for counselling, the need for financial support to develop counselling services, the need to develop guidelines for counselling, the need to address issues of confidentiality, and the need to "mainstream" information and education about HIV. Through this experience, the participants have created a new community of friends and colleagues whom they can contact for information and advice, can call on to review papers and projects, and can contact to identify appropriate consultants and enhance access to technical support.

Strategy on Counselling and Testing for the Asian Region

UNAIDS estimates that as of mid-1996, more than 4.7 million adults have been infected with HIV in the South East Asian region since the start of the pandemic. By the year 2000, more than 5 million adults in this region will have died of AIDS. These figures demonstrate the urgent need to equip and strengthen the health care systems in this region. As part of a comprehensive care and prevention plan, HIV/AIDS counselling services must be provided.

This strategy was developed by counselling and testing experts from the Asian Region. As such, it is a reflection of their experience and includes a very acute sense of the most important steps necessary for the implementation of widespread, accessible, supportive and voluntary counselling and testing, and other counselling and care services. Although this strategy clearly reflects the needs of this region, it is also very comprehensive and identifies important strategic and content issues which are important for any community wishing to provide these services. The workshop participants organised the strategy into the following components: Rationale, Advocacy, Training, Implementation, Sustainability and Monitoring, and Research.
Rationale

The growing epidemic in South East Asia underscores the need to openly address the presence of HIV in communities and provide education, counselling and testing in a manner which researches those at risk, without stigmatisation or discrimination. Although the need for HIV education and counselling services is great, the infrastructure and resources needed to provide these services is often lacking. At the national level, policies on C&T are often non-existent: when C&T has been addressed, documentation is often inadequate and unavailable to counsellors and PWAs. There is often a shortage of health and social workers, in particular those who have had training and developed skills in counselling. There is often a lack of financial support and commitment to create VCT sites and to support dedicated counsellors at the sites.

For those who are trained in counselling, it is often in a “western model” with little attention paid to special cultural needs. On the individual level, there is often minimal or no access to counselling services. When services are available, they are often not used out of fear, ignorance or distrust. There is often a reluctance to speak openly about HIV. This attitude is frequent in all areas and has resulted in few public health messages addressing HIV. There is little awareness of HIV in the general population, including a lack of knowledge of the activities which can put one at risk for HIV and even less awareness of the ways to reduce the risk associated with practising certain sexual and drug-use behaviours. In addition, there is little knowledge of the impact which HIV can have on individuals, families, communities and countries.

Despite these obstacles, there are many reasons to work toward increasing the availability of counselling in this region. Knowledge does not in and of itself catalyse behaviour change. More in depth and personalised approaches, such as that provided by counselling are needed. Counselling and testing has been shown to improve the lives of people infected with HIV. Most people are able to cope and live positively with their disease when they receive support, rather than discrimination and rejection.

HIV causes pain and suffering to individuals, families and communities in a way in which few other diseases do. A community's spiritual, psychosocial and economic aspirations are hampered by HIV/AIDS. Humankind is interdependent and we have an obligation to help one another. Counselling, through the creation of a supportive personal relationship is an excellent way to help others.

Advocacy

Advocacy: An Overview

In order to solicit support and to increase the availability of counselling services, including VCT, advocacy meetings will be held with policy makers, community leaders, PWAs, service managers and health professionals. Although there is significant diversity among these groups, their early involvement in the process will ensure a multi-sectoral approach. Likewise, community involvement is essential, as it will allow for the development of services to meet the particular needs of that group and will result in services which the communities will identify with. Finally, dialogue with donors should be established to ensure that their is an understanding and appreciation for how their support is being used. Advocacy is not
only used to promote and broaden C&T services: it is also an important means to educate leaders about the pain and suffering related to HIV/AIDS.

Advocacy: Objectives
1. To ensure involvement of policy makers, service providers and service users in order that there is consistency in planning and implementation of projects in accordance with the needs of the communities concerned.
2. To carry out social mobilisation aimed at causing awareness of the importance of and availability of counselling.
3. To ensure that national policies on HIV/AIDS are supportive and not punitive.
4. To develop a multi-sectoral approach which includes the private sector at policy. Planning and implementation on level of C&T services. e.g. insurance. employers. etc.
5. To work with authorities to ensure that new HIV tests are licensed only after the necessary safeguards against abuse have been put in place. A case in point is the home test kit.
6. To develop policy guidelines which clearly state the roles of different cadres in C&T. including standardised procedures and quality assurance. Counselling guidelines should be developed and agreed upon as national standards.
7. To ensure that donor priorities are in line with perceived community needs such as complementary care and social support needs. Prevention and care cannot be separated.
8. National resource allocation should be in line with community needs. Community leaders and PWAs should participate in this process.
9. To collaborate with international agencies such as the UN to advocate for more resource allocation to care and support. including clinical care and social support.

Advocacy: Expected Outcomes
1. Inclusion of C&T issues in national policies on HIV/AIDS. Although many countries have developed national policies on HIV/AIDS, many of these do not adequately address the need for counselling and testing. This is often because those who devise the policies and laws are not aware of the importance for quality counselling services and the positive impact that these services can have on the lives of people living with HIV/AIDS or at risk for HIV/AIDS. Decision makers and policy writers must be educated about the importance of counselling and testing in the context of HIV/AIDS services.
2. Appointment of a counselling co-ordination unit at the national AIDS program level. Once counselling and testing is included in national policies on HIV/AIDS, it must have an advocate at the National level to ensure that resources and policies continue to be focused toward counselling and testing issues. Thus, a counselling co-ordination unit must be created within the National AIDS Program of each country.
3. Demonstration of high level political support for C&T including support of managers, administrators, health care workers and facilities for C&T. This unit can then work to ensure that political support for UT services is provided. This will help ensure that adequate personnel, such as managers, administrators, and health care workers, are allocated to C&T services. It will also ensure that facilities for C&T are created - either as stand-alone sites or integrated into current health care facilities.

4. Community involvement in the provision of C&T services. Communities must be involved to help set the needs for C&T services at a local level. Working groups must be formed which include community leaders, service providers, health care workers and PWAs to assess and discuss the needs for C&T services.

5. Allocation of financial and human resource to C&T based on agreed upon activities in a timely manner. Community working groups must then work with national and local sources to procure funding and other resource support to provide the necessary C&T services. The involved parties should determine a timeline for activities and resources allocated in a timely manner to ensure that these goals are met.

Training

Training: An Overview

In addition to legislative, policy, and financial support for counselling and testing, there are also large human resource needs to ensure that quality counselling can be provided. Counsellors must be recruited and trained, which requires both basic and advanced training sessions, as well as “refresher courses” to ensure that skills are maintained and built upon. Measures will be put in place to ensure that these providers remain motivated. Counsellors come from a variety of backgrounds, including community workers and community leaders, health workers, counsellors, clinicians, care providers, health educators, social workers, community based volunteers, religious workers, PWAs, and school teachers. Measures must be taken to ensure that representatives from all of these groups are trained to provide counselling. The selection of the category to be trained will depend on various factors, such as the required services (counselling, awareness education etc.) and the availability of the different cadres.

Training: Objectives

1. To develop training plans that are centered around the actual locations where the most urgent need is. For example at IDU sites, CSW sites, PWA care sites and other community sites based on existing studies on high risk groups.
2. To plan and conduct training of trainers' (TOT) workshops in order to ensure even distribution of skills, knowledge, understanding, and positive attitudes.
3. To impart training and supervisory skills among trainers, service managers, etc.
4. To develop a counselling training curriculum in addition to manuals and guidelines.
5. Enhancing the skills of counsellors so as to function as educators, community change agents, peer educators, group and family counsellors.

6. Establish and provide training for different cadres of counsellors at three levels to enable two-way referrals of clients. For example, a community worker could be the counselling provider at the primary level, trained counsellors would then be considered to be at a secondary referral level while professional counsellors such as psychologists would be at the tertiary level. These levels of counsellors will be designed to meet the differing counselling needs of society to respond to the epidemic which range from AIDS awareness to on-going emotional support.

7. To put in place a mechanism to motivate counsellors and provide support.

Training: Expected Outcomes

1. Publication of training manuals, and curricula as well as guidelines for counsellors for various levels of counselling. The need for these materials is great. There is also concern that these materials reflect the specific cultural needs of the community they are going to serve. For example, in India the manuals used early in the epidemic for training sessions “could have come from New York”. Consequently, the training sessions differed significantly from the format suggested by the manuals. Clearly, the approach for training and setting standards for counselling must reflect the needs and cultural factors inherent in the community they are to serve.

2. Adequate number of trainers and counsellors who meet the set standards. Special mechanisms must be put into place which monitor the epidemic and allocate resources to providing adequate numbers of counsellors for the projected number of clients who will need these services. This approach requires pre-planning such that trained counsellors are available as demand grows, rather than being quickly (and often inadequately) trained to meet acute needs.

3. An operational system of support and supervision for trained counsellors. In order to maintain a cadre of counsellors who are providing quality counselling, a system of support and supervision must be implemented. This can include self-evaluation of sessions by the counsellors themselves, site-visits by supervisors, counsellor information and support groups, and regular training and refresher courses.

Implementation

Implementation: An Overview

Different types of services related to C&T will be developed according to the needs of the communities as determined by the prevalence of HIV, the level of awareness of HIV in the community, and the most prevalent transmission risks within the community. There are many HIV/AIDS and related services that should be available in all communities. These include basic HIV education, including a focus on risk factors for transmission and information on the prevalence of HIV in the community and what it means to be HIV positive for the individual, family and community. Voluntary counselling and testing services should be available, with
adequate pre- and post-test counselling. Counselling should be confidential and include information on both HIV and STD transmission, risk reduction and harm minimisation. Counselling services should be appropriate for children. Finally, counselling services should provide psychosocial care to PWAs and their families. These services will be developed in a phased manner, with priorities set by each community.

As services are provided, there are many needs which must be taken into consideration and met. These include care and support, concern and mercy for sufferers, a reduction in stigmatisation and discrimination experienced by those living with HIV/AIDS, preparing families and communities to accept PWAs, providing for the availability and referral to C&T when desired, enabling PWAs to live positively with HIV/AIDS, and the creation in the community of an awareness of risk.

As services are developed, they should target concerned individuals, the worried well, PWAs, those at risk whether they are perceived to be at risk or not, and women of child-bearing age. Services should be provided in a co-ordinated fashion through NGOs, government and private hospitals, health units, blood banks and community settings.

Implementation: Objectives
1. To develop a list of responsibilities and job descriptions for different cadres, such as counsellors, community workers, trainers, peer educators, community change agents, and health professionals.
2. To establish a supervisory and supportive mechanism for all counsellors.
3. Integrate counselling into other health and social services, as well as community services.
4. To implement plans for service development that take into consideration the projected magnitude and impact of the epidemic in men, women and children.
5. To plan for allocation of personnel, resources, and reassignment of duties and responsibilities as driven by the needs of the epidemic.
6. To encourage and support communities to develop C&T projects.
7. To develop innovative initiatives aimed at reaching the hard-to-reach and to enhance access to counselling.

Implementation: Expected Outcomes
1. All those undergoing linked HIV testing have received pre and post-test counselling. There are currently many settings where linked testing occurs without adequate pre-test counselling, including an understanding that blood is being taken for HIV and what a positive test result could mean. These include clinical settings, such as hospitals and clinics, research settings, such as clinical trials, and blood and organ donor sites. In addition, results of HIV-positive tests are often given without adequate support and counselling in these settings. All HIV tests must be accompanied by adequate and appropriate pre- and post-test counselling and counselling and care services.
2. All members of at risk groups who seek special services such as STD care and drug testing if they treatment services must receive HIV counselling and desire. Many at-risk individuals are currently unaware that they may be infected with
HIV or are at risk of becoming HIV-infected. By providing C&T services or referrals to these services at sites that treat high risk individuals for other health problems. those most at risk will gain an appreciation that they are at risk. as well as have the opportunity to learn their HIV-serostatus. if they so desire.

3. Mechanisms to cause awareness of risk in the general population are in place. Much of the general population does not understand what HIV is. how it is spread or what to do to avoid infection. There are many ways that the awareness of HIV in communities can be increased. These include mass media campaigns. school education programs. and pamphlets and flyers provided in relevant settings. such as pre-natal clinics. vaccination sites. and community centres.

4. All women seeking services at specific sites such as ANC/FP clinics STD clinics and CSW treatment facilities should receive counselling and testing. including premarital counselling. if desired. These services should be offered and be voluntary; women should never be coerced into testing or tested without their knowledge. Knowledge of one's sero-status should only be in the best interests of the individual - and that decision can only be made by the woman herself.

5. Demands for counselling at community based sites are met. Many individuals infected with HIV. at risk for HIV or concerned about HIV infection are more comfortable discussing their concerns at community based sites. rather than medical centres. In fact. many of these people will avoid dealing with their concerns and fears if their only option for information is from a medical setting. Thus. it is imperative that community sites be developed which meet the needs of these individuals.

6. Counselling should be provided at the workplace for hotel and factory workers transport workers construction workers logging and mining. industry workers. migrant workers in the Gulf and other places fishermen and trishaw drivers. to name a few. Many specific occupations are associated with a higher risk for HIV than is found in the general population. This is often a result of complex social. Economic and cultural factors which are difficult to change. However. individuals in these professions can decrease the risk of spreading HIV or becoming HIV infected if they are equipped with knowledge that will allow them to make risk reductions decisions concerning their sexual and drug use behaviours. Many of the individuals working in these occupations have little access to formal medical care and education. making counselling targeted at the workplace an important intervention.

7. Ongoing counselling. provided to all PWAs and their families. The availability of counselling. beyond the pre- and post-test counselling associated with the HIV test. is important for PWAs and their families. After being given an HIV-positive diagnosis. PWAs and their families often need support and guidance in learning how to cope with HIV and to live positively with their disease.

8. Group counselling provided to all high schools and colleges and other youth groups. Youth are particularly vulnerable to HIV infection during the years in which they become involved in sexual relationships. This is due to several factors. including an ignorance of sex and sexually transmitted diseases. as well as a sense that they are immortal and immune from a fatal illness. Group counselling is an effective and efficient way to educate youth about HIV and risks for HIV infection in a setting that is comfortable and geared to their interests and concerns.
Sustainability and Monitoring

Sustainability and Monitoring: An Overview
In order to ensure that quality and accessible C&T services are available in a sustainable fashion, several measures must be implemented. The first is situation analysis, which will include an assessment of the numbers of HIV/AIDS patients, the number of trained providers, the locations where counselling is currently being provided and areas where it is needed, but not provided and rapid assessments to monitor levels of risk behavior. In addition, a network of agencies whose mandate includes HIV testing and care must be formed to ensure stronger and efficient provision of services. Finally, a framework for monitoring and evaluating services must be put in place by collaborating agencies within communities.

Sustainability and Monitoring: Objectives
1. To conduct a situation analysis including the numbers of HIV/AIDS patients, numbers of trained providers, the locations where counselling is needed, and rapid risk behaviour assessment.
2. To establish a network of collaborating agencies such as testing laboratories, clinical care facilities, AIDS Service Organisations (ASOs), hospices, PWA networks, STD clinics, blood banks, IDU treatment facilities, CSW networks, FP services, meditation centres and other religious facilities.
3. To establish a monitoring and evaluation framework which includes the availability of service delivery, number of active counsellors, statistics of work done, and number of sites.
4. Periodic upgrading of counselling skills.
5. Monitoring the efficiency and impact of counselling.

Sustainability and Monitoring: Expected Outcomes.
1. Short and long term targets of program implementation have been set and are being measured. These standards should be developed at the community level, with the involvement of community leaders, those involved in HIV services and PWAs. They should incorporate, when ever possible, more general standards devised at the national level.
2. Regular report of activities produced and circulated in a timely manner. An agreed upon timetable for these activities should be produced. Support for the personnel needed to report on the activities and disseminate the information should be provided.
3. Established and functional network for support of care-givers and counsellors. Both HIV/AIDS counsellors and care-givers have a high rate of "burn-out." In order to lessen this stress, networks and support groups of these individuals should be established. The long term sustainability of a counselling and care program is dependent on the presence of individuals who can support and care for PWAs and their families.
Research - Directions for the future

To date, most of the research focusing on HIV/AIDS related counselling and testing has been conducted outside of Asia in the America's, Europe, and Africa. Although this work provides a foundation of knowledge on the content, style and efficacy of counselling, it cannot address many of the needs and cultural factors specific to the Asian Region.

The primary area requiring further research is that of culture and counselling. Asian cultures do not typically identify with the western concept of “one-on-one” counselling. Thus, it is important to identify ways in which counselling can be offered and carried out that are acceptable to those who could benefit most from the services. This includes an evaluation of what it is that works in innovative projects that are meeting the psychosocial and cultural needs of a population. Insights can also be gained from studying the coping behaviors of PWAs, families and communities as they struggle to live positively with HIV/AIDS. In addition, studies monitoring the impact that counselling services have on individuals, their families and communities can also be used to identify creative ways to integrate effective counselling services in the community. Studies evaluating the efficacy of different modifications to pre-test counselling, such as videos, leaflets, group counselling, and short lectures may also provide cultural insights and further effectiveness of counselling. Finally, the impact of specific interventions such as group counselling, peer counselling and spiritual counselling should be evaluated.

Research targeting specific risk groups must also be initiated. Social behavioural studies documenting risk taking and coping behaviours of IDUs, CSWs and their clients are needed. Efficacy of risk reduction and harm minimisation strategies must be documented and their long-term sustainability studied.

Finally there are two technology-based areas in counselling which warrant special attention: home test kits and telephone counselling. Both are becoming more available and prevalent in Asia and little is known about their psychosocial effect on individuals and their impact on HIV/AIDS.

Conclusions

The HIV C&T Workshop for the Asian Region provided a unique opportunity for counselling and testing experts from the region to come together and share their experiences and insights. Through the process of reviewing; discussing, debating and revising the draft forms of the UNAIDS Policy on HIV Counselling and Testing, the UNAIDS C&T Stock Taking report, and the draft report of the Myanmar Counselling Feasibility Study (1994-96), the experts were able to highlight current HIV C&T practices in their communities, identify both the successes and failures of their current C&T services, present possible solutions to some of the identified needs, and create strategies for increasing services in the future. The participants then organised their ideas into a comprehensive strategy that addressed the advocacy, training, implementation, sustainability and monitoring and research issues necessary for the creation of widespread, accessible, supportive and voluntary counselling and testing, and other counselling and care services in their communities. Finally, an informal
network of counsellors from the region was created, which will serve as a source of information and advice. reviewers for papers and projects. consultants. and as a way to enhance access to technical support. Through this workshop. experts from the region were able to synthesise and share their experiences. while UNAIDS and her co-sponsors were able to form collaborative links with those at the country level and identify and support current and future projects that meet both her objectives. as well as address the most urgent priorities in communities.
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