

Voluntary Counselling and Testing

A gateway to linking HIV and sexual and reproductive health



Voluntary Counselling and Testing: a gateway to linking HIV and sexual and reproductive health

Introduction

The World Health Organization (WHO) estimates that as few as 10 per cent of people living with HIV in low and middle income countries know their HIV status. Knowing one's HIV status is very important: it enhances one's ability to reduce the risk of acquiring or transmitting HIV, to access HIV-specific care, treatment and support, and to make informed decisions about other aspects of one's life.

Making HIV testing and counselling more widely available is essential in broader efforts to respond more effectively to HIV and AIDS, and to respond to the inherent links with other sexual and reproductive health issues. The involvement of more non-governmental and community based organizations in the delivery of HIV counselling and testing services is critical to increasing access to these services. Sexual and reproductive health service providers therefore have a unique and important role to play in this regard. The possibilities for

integrating Voluntary Counselling and Testing (VCT) services into the work of sexual and reproductive health providers are vast.

This publication identifies approaches and issues that we hope will be of interest to other organizations that want to play their part in increasing access to Voluntary Counselling and Testing. It draws on the experiences of three sexual and reproductive health organizations in Africa and Asia, all funded by the Japan Trust Fund. While the settings and client profiles of each organization differ from each other, the human rights based approach towards testing and counselling emerges clearly from these case studies.

This publication includes an overview of the different types of HIV testing. It includes our understanding of recent policy and programmatic developments in the field, including calls to accelerate the expansion of HIV testing by redesigning

accepted international norms of testing. It highlights some of the different and, at times, conflicting views on the essential elements of HIV testing, and on the means by which universal access to HIV testing should be achieved.

Many of the issues under discussion were identified in 2006 during a survey of just under 100 IPPF Member Associations that already provide HIV testing services (either directly or through referrals). This survey was done with a view to identifying existing policy and practice and ways in which their work could be improved.

The principles of HIV testing have been laid out in the *Code of Good Practice for NGOs Responding to HIV/AIDS*. This publication also includes a tool designed to help organizations to begin to apply these principles to the development and delivery of Voluntary Counselling and Testing, by allowing them to measure their readiness to provide access to high quality VCT services.

Foreword

from the Ministry of Foreign Affairs of Japan

It is my great pleasure to congratulate the International Planned Parenthood Federation (IPPF) on this publication. The Government of Japan has actively supported the developing countries to tackle population issues in the view of reproductive health. Our direct support has been extended to United Nations Agencies and/or NGOs such as IPPF. In addition, Japan has also adopted a holistic approach including primary health care regarding mother and child health, education, and women's empowerment. This approach has contributed indirectly to addressing population issues and controlling HIV/AIDS.

Reproductive health is closely related to all the MDGs, including Reduce Child Mortality (Goal 4), Improve Maternal Health (Goal 5) and Combat HIV/AIDS, malaria and other diseases (Goal 6). The Government of Japan believes that, through the global efforts for

achieving MDGs, all people should gain access to reproductive health care service. The Government of Japan has announced the 'Health and Development Initiative' in June 2005 and actively contributed to the achievement of MDGs.

Furthermore, the Government of Japan promotes diplomacy with an emphasis on the perspective of 'Human Security' which is one of the key pillars of Japan's foreign policy. Human security aims to protect people from critical and pervasive threats to human lives, livelihood and dignity, and thus to enhance human fulfilment. For these objectives, human security tries to integrate and strengthen initiatives that emphasize human-centered perspectives. Therefore the Government of Japan highly appreciates activities of the Japan Trust Fund for HIV/AIDS (JTF).

JTF was established by IPPF in 2000 to

control HIV/AIDS. The projects of JTF have been implemented in Africa and Asia and born fruits through enhancing collaboration with Member Associations of IPPF at grassroots level. JTF has supported projects including the Voluntary Counselling and Testing (VCT) component, an important method for HIV/AIDS prevention and care support, which has brought about significant benefits.

This publication is based on the activities of IPPF and the Member Associations. I hope that this booklet will contribute to supporting the Member Associations and will be read by those interested in population and reproductive health issues.

Takeshi OSUGA

Director, Global Issues Cooperation Division, International Cooperation Bureau, Ministry of Foreign Affairs of Japan

from the International Planned Parenthood Federation

Knowledge is a vital weapon in the fight against HIV and AIDS. Knowledge about HIV means knowing how it is transmitted, that transmission can be prevented, that the virus can be treated and that people living with and affected by HIV and AIDS have human rights. This knowledge is essential in effectively responding to the challenge of this epidemic.

IPPF recognizes the right of people to know their HIV status, and how important it is for people to understand the practical benefits for individuals and communities of that knowledge. We know that the integration of Voluntary Counselling and Testing (VCT) into sexual and reproductive health programmes can make a significant and lasting difference to increasing the availability and quality of Voluntary Counselling and Testing.

Almost 100 of IPPF's Member Associations are now providing their clients with Voluntary Counselling and Testing, or are referring them for VCT. However, scaling up and improving the quality of the VCT services provided by our Member Associations remains a long-standing

priority for IPPF. With funding from the Government of Japan through the Japan Trust Fund, 14 Member Associations have received support to establish or to scale up VCT services. The three case studies of Member Associations in Uganda, Nepal and Cambodia that have been included in this publication reflect how they have benefited from this support. The partnership between IPPF and the Government of Japan is both highly innovative and immensely valuable. Documenting the work that we have been able to do together becomes an important means of sharing our experiences and lessons.

There is consensus among AIDS activists, policy makers and programmers in favour of universal access to affordable, high-quality HIV testing. However, there are differing views on the essential elements of testing and on the means by which universal access should be achieved. The introduction to HIV testing in Section 1 of this publication provides an overview of some of those issues. It also explores implications, for both public health and human rights, of changes to

conventional testing practices.

IPPF is on the steering committee and it is one of the signatories to the Code of Good Practice for NGOs Responding to HIV/AIDS. The tool at the end of this publication provides new guidance on the promotion and provision of Voluntary Counselling and Testing. This has arisen out of the experiences of non-governmental organizations active in the field.

We hope that this publication will provide our Member Associations, our local project partners and our colleagues in the sexual and reproductive health and HIV fields, with information and insights that will enhance their existing Voluntary Counselling and Testing services.

I would like to extend IPPF's appreciation to the Government of Japan, without which the work detailed in this publication would not have been possible.

Dr Gill Greer

Director-General, International Planned Parenthood Federation

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Abbreviations and acronyms

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral therapy
BCC	Behaviour Change Communication
CBD	Community Based Distributors
FPAN	Family Planning Association of Nepal
FPAU	Family Planning Association of Uganda
HIV	Human Immunodeficiency Virus
IDU	Injecting drug users
IDI	Infectious Disease Initiative
JTF	Japan Trust Fund
MHC	Men's Health Cambodia
MSM	Men who have sex with men
NACWOLA	National Community of Women Living with HIV/AIDS
ODA	Official Development Assistance
PIT	Provider-initiated testing
RHAC	Reproductive Health Association of Cambodia
TASO	The AIDS Support Organization
UN	United Nations
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

Section 1

An introduction to HIV testing

HIV in context

Despite increased community interest and political will directed at tackling HIV, the epidemic continues to outpace our responses. In 2006 the epidemic increased on almost every front.

The UNAIDS Epidemic Update¹ shows that in 2006 more people were newly diagnosed than in any previous year. There were a staggering 4.3 million new infections worldwide. In South Africa alone, 1400 new people – half of them young people aged between 15 and 24 – are infected with HIV every day. Between 2004 and 2006 there was a 50 per cent increase in the number of new infections in Eastern Europe and Central Asia. At the same time there has been a resurgence of the epidemic in countries that had earlier made headway, for instance Uganda, and in nearly all wealthy countries too. Despite good progress in increasing access to treatment, there were also more deaths on every continent from AIDS than ever before.

At the United Nations High Level Meeting on AIDS in 2006,² the commitment to ensure universal access was affirmed by the international community. However, if this commitment is to be realized, then the roll out of treatment services must be increased rapidly as the number of people needing treatment continues to grow.

The increase in access to antiretroviral treatment in low and middle income countries presents a critical opportunity to simultaneously expand access to HIV prevention. Without effective HIV

prevention, there will be an ever-increasing number of people who will require HIV treatment.

HIV testing and counselling: central to increasing prevention and treatment

Among the interventions that play a pivotal role both in treatment and in prevention, HIV testing and counselling are paramount. However the current reach of HIV testing services remains unacceptably poor: in low and middle income countries a mere 10 per cent of those who need Voluntary Counselling and Testing, because they may have been exposed to HIV infection, have access to it.³ Even in settings in which Voluntary Counselling and Testing is routinely offered, such as programmes for prevention of mother-to-child transmission, the number of people who make use of these services is still low in many countries.

Yet despite the low uptake of HIV testing and counselling, the benefits of increasing knowledge of HIV status are significant. These benefits can be seen at the individual, community and population levels and include the following:

- For the individual – it has enhanced the individual's ability to reduce the risk of acquiring or transmitting HIV, enhanced access to HIV care, treatment and support, as well as protection from infection of unborn infants.
- For the community – a wider knowledge of HIV status and its links to

interventions can lead to a reduction in denial, stigma and discrimination, and to collective responsibility and action

- At the population level – knowledge of HIV epidemiological trends can influence the policy environment, normalize HIV and AIDS and reduce stigma and discrimination

Scaling up HIV testing and counselling services is a critical step for scaling up a range of interventions in HIV prevention, care, treatment and support.

Further benefits derived from HIV testing and counselling are detailed in Figure 1 below.⁴

The commitment by the international community at the High Level Meeting on AIDS at UN headquarters in 2006 was made to ensure universal access to HIV prevention, treatment and care. It requires millions of people to be counselled and tested for HIV in order to identify those who can benefit from immediate access to these services.

To date, the increased availability of treatment for HIV has not generated dramatic increases in demand for HIV counselling and testing. As a result, a number of policy makers and service providers have argued that the time has come to implement HIV counselling and testing more widely. This should be done using existing healthcare settings, and by moving beyond the model of provision that relies entirely upon concerned individuals seeking out help for themselves. This will permit broader access to HIV counselling for all.

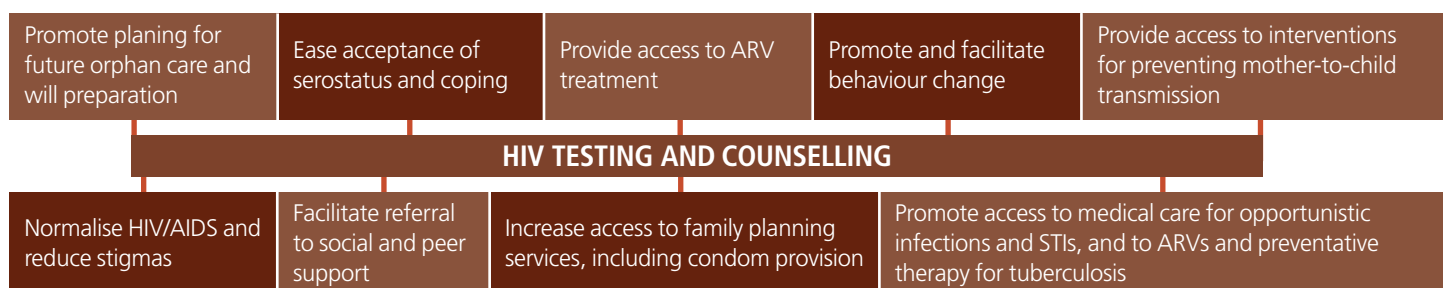


Figure 1: Further benefits derived from HIV testing and counselling



Advances in prevention of HIV infection and medical care for HIV have, rightly, fuelled a new urgency to ensure access to HIV testing.

Human rights: unabridged and inalienable

Human rights concerns remain central to the current debate about how best to increase the availability of HIV testing. Protecting the rights of people living with and affected by HIV is critical to the success of efforts to make HIV testing more widely available.

Ever since it was possible to test for HIV, concern for human rights has been a central feature of testing policy and practice. The discussion involves promoting the rights of individuals to know their HIV status, and at the same time protecting their rights to consent to the test and to have their results treated with confidentiality. The concern for human rights in this regard also includes consideration for finding the most effective ways to provide people protection from HIV-related stigma, discrimination and abuse.

The evolution of HIV testing approaches and technology

Since the HIV antibody test was first made available in the mid 80s, HIV testing has been a policy challenge for health authorities. A number of questions then arose about how the test should be provided and regulated.

Before treatment for HIV and opportunistic infections became available, it was very difficult to encourage people to test for the virus. Without treatment, even people who might consider themselves at risk of having HIV had little reason to seek HIV testing, and considerable reason to fear discrimination if they were to test positive.

The advent of treatment in the mid 90s made knowing one's HIV status more beneficial. However, even in Northern nations rich in resources, the limited impact of available treatments and well-founded fear of discrimination were still impediments to seeking an HIV test.

It was therefore recognized that HIV testing should be promoted and conducted in ways that took into account the reality of widespread stigma and discrimination against people with HIV in general, and specifically against particular groups who were disproportionately affected by the virus. These included men who have sex with men, sex workers, and people who inject drugs, all of whom were already socially marginalized and stigmatized, in many cases criminalized, and therefore fearful of seeking services.

It was understood that respecting and protecting people's rights would be central to implementing HIV testing successfully as part of the overall effort to prevent the spread of HIV and treat those living with the virus. As a result, a broad consensus emerged among public health authorities, leaders in the gay community, health care professionals, human rights advocates, and policy-makers. This consensus came to be known as the three Cs.⁵

Understanding Voluntary Counselling and Testing (VCT)

The primary model for HIV testing in most countries subsequently evolved to become Voluntary Counselling and Testing (VCT), initiated by clients.

Voluntary Counselling and Testing is the process by which an individual undergoes

Testing times:

Legal and ethical questions relating to HIV testing have included the following:

- What are the ethically appropriate uses of HIV testing, and how should testing be regulated?
- How should people be counselled about the significance of the test?
- Should the results of HIV tests be kept confidential?
- Should a person's test results be used by law, and how should they be used?
- Are there circumstances in which testing should not be voluntary?
- How can the law help people realize the benefits of HIV testing?
- How can the law protect people against the possible negative consequences of testing HIV-positive, such as discrimination?
- How can communities be mobilized to test and to respond positively to the challenges of HIV?

The three C's of testing

- People should be tested only with their informed, voluntary and specific **consent**
- **Counselling** should be provided both before and after HIV testing
- HIV testing should occur only when **confidentiality** of results can be guaranteed

confidential counselling to enable them to make an informed choice about learning their HIV status. It also enables the individual to take appropriate action once his or her status is revealed. Voluntary Counselling and Testing enables confidential HIV testing, as the voluntary nature of VCT is explicit and understood. VCT services must be client-centered and have effective links to post-test services and support. Client-centered VCT services respond to the needs of clients and make clients feel accepted and valued.

Previously, vulnerable populations that were seen as being at higher risk of HIV infection were unlikely to be willing to cooperate with public health officials without the assurance that they would not be subject to coercion or to the negative consequences of disclosure. This made it harder to reach them through HIV education and prevention programmes and ultimately worsening the impact of the disease.

The focus on a voluntary approach to HIV prevention measures represented a departure from more traditional public health strategies such as compulsory testing and contact tracing, in favour of voluntary behaviour change. This also favoured testing only with informed consent (as opposed to coercion), with protection of confidentiality (or even anonymity in some cases), and voluntary partner notification.

Shifts in HIV testing policy and practice

In 1996, the International AIDS Conference in Vancouver highlighted scientific breakthroughs in the effectiveness of treatment for HIV-related disease. By early 1998 it was known that even a short and affordable course of antiretroviral medicines could greatly reduce the risk of HIV being transmitted during pregnancy or childbirth from mother to fetus or newborn. Since then numerous other clinical benefits of people

The nature and purpose of counselling

Counselling in Voluntary Counselling and Testing consists of pre-test, post-test and follow-up counselling. During pre-test counselling the counsellor gives an individual (or a couple or group) the opportunity to explore and analyse their situation and to consider being tested for HIV. Each individual makes an informed decision of whether or not to take the HIV test after they have been given information and supported to reach an understanding of what is involved.

The client-centered nature of counselling enables trust between the counsellor and the client so that there is an opportunity for in-depth discussion of HIV/AIDS, including how to prevent it. Counselling helps people identify the implications of a negative or positive result, and helps them think through practical strategies for coping with the test result. Post-test counselling supports people in understanding their test result and its implications, whether the result is positive or negative. Counselling also helps clients explore whom they might share the test result with, and how to approach sharing their test result. Follow-up counselling is relevant for all clients whether they test positive or negative, and supports clients in coping with issues raised as a result of learning their HIV status.

knowing their HIV status early in the course of their disease have been well documented. Early diagnosis allows individuals to make important treatment decisions, and also allows for important decisions regarding other sexual and reproductive health issues. Increasingly, the need to address the fertility desires of people living with HIV has become an important issue.⁶ Advances in prevention of HIV infection and medical care for HIV have, rightly, fuelled a new urgency to ensure access to HIV testing.

This has resulted in increasingly frequent and forceful calls to accelerate the expansion of HIV testing by redesigning the internationally accepted norms of HIV testing. This redesigning includes modifying its voluntary nature and abridging the counselling provided. According to the Voluntary Testing and Counselling model, the person to be tested initiates the testing. A number of influential policy makers and programmers have called for greater reliance on testing initiated by health care providers rather than by the person to be tested.

What's in a name?

New terms have been introduced into the policy discussion:

Routine testing: this means everyone in a given setting is tested without necessarily relying on individual consent.

Opt-out testing: the default option in a given situation is to test everyone unless a person clearly and specifically refuses the test.

Routine offer: some experts promote what they call a 'routine offer' of an HIV test with the possibility of opting out. The use of the word 'offer' suggests a choice. However, that choice may not be real if the offer is so routine that it doesn't come with the chance to learn more about HIV, or if clients are influenced in such a way as they cannot refuse the 'offer'.

Opt-in testing: this means that clients must affirmatively agree to the test being performed after pre-test information has been received.

Client-initiated HIV testing to learn HIV status provided through Voluntary Counselling and Testing remains critical to the effectiveness of HIV prevention.

All of these approaches differ from the Voluntary Counselling and Testing model that has, until recently, been the dominant approach. The policy shift toward health care providers making HIV testing of clients more routine raises serious ethical and human rights questions.

But they are not intractable ones. There is little doubt of the need to improve access to good quality HIV counselling and testing in the developing world. This need is particularly great among populations that face additional barriers to health service access, those that have an increased risk of infection or that are particularly vulnerable to HIV.

A routine offer to test by health care providers

Client-initiated HIV testing to learn HIV status provided through Voluntary Counselling and Testing, remains critical to the effectiveness of HIV prevention. However, IPPF accepts that a routine offer of HIV testing by health care providers can make an important contribution to increasing the uptake of HIV testing. At the same time it provides clients, and the communities in which they live, with the attendant benefits. However, it is imperative that this 'offer' is only provided when a number of conditions are in place. Most important among these is the ability to ensure that clients are not coerced, and that they have access to any needed treatment and will not face averted discrimination.

The UNAIDS/WHO *Guidance on Provider-Initiated HIV Testing and Counselling in Health Facilities* recommends an 'opt-out approach' to HIV testing where an HIV test is recommended:

- to all clients, irrespective of epidemic setting, whose clinical presentation might result from underlying HIV infection
- as a standard part of medical care for

all clients attending health facilities in generalized HIV epidemics

- more selectively in concentrated and low-level epidemics – individuals must specifically decline the HIV test if they do not want it to be performed⁷

The 2004 UNAIDS/WHO Policy Statement on HIV testing⁸ highlights the importance of post-test counselling both for the purposes of prevention and ongoing support. The policy states that:

"Explicit mechanisms are necessary in provider-initiated HIV testing to promote **referral to post-test counselling services** emphasizing prevention, for all those being tested, and to **medical and psychosocial support**, for those testing positive."⁹

The basic conditions of **confidentiality, consent and counselling** apply, but the standard pre-test counselling used in Voluntary Counselling and Testing services is adapted to simply ensure informed consent, without a full education and counselling session.

According to the UNAIDS/WHO Policy, the minimum amount of information that clients require in order to be able to provide **informed consent** is on the following topics:

- the clinical benefit and the prevention benefits of testing
- the right to refuse
- the follow-up services that will be offered
- (in the event of a positive test result) the importance of anticipating the need to inform anyone at ongoing risk who would otherwise not suspect they were being exposed to HIV infection

Whether for purposes of diagnosis, the offering of antiretroviral prophylaxis for the prevention of mother-to-child transmission or encouragement to learn HIV status,

provider-initiated testing under this model crucially retains the patient's right to refuse testing, although the offer is made systematically to all clients of the service.¹⁰

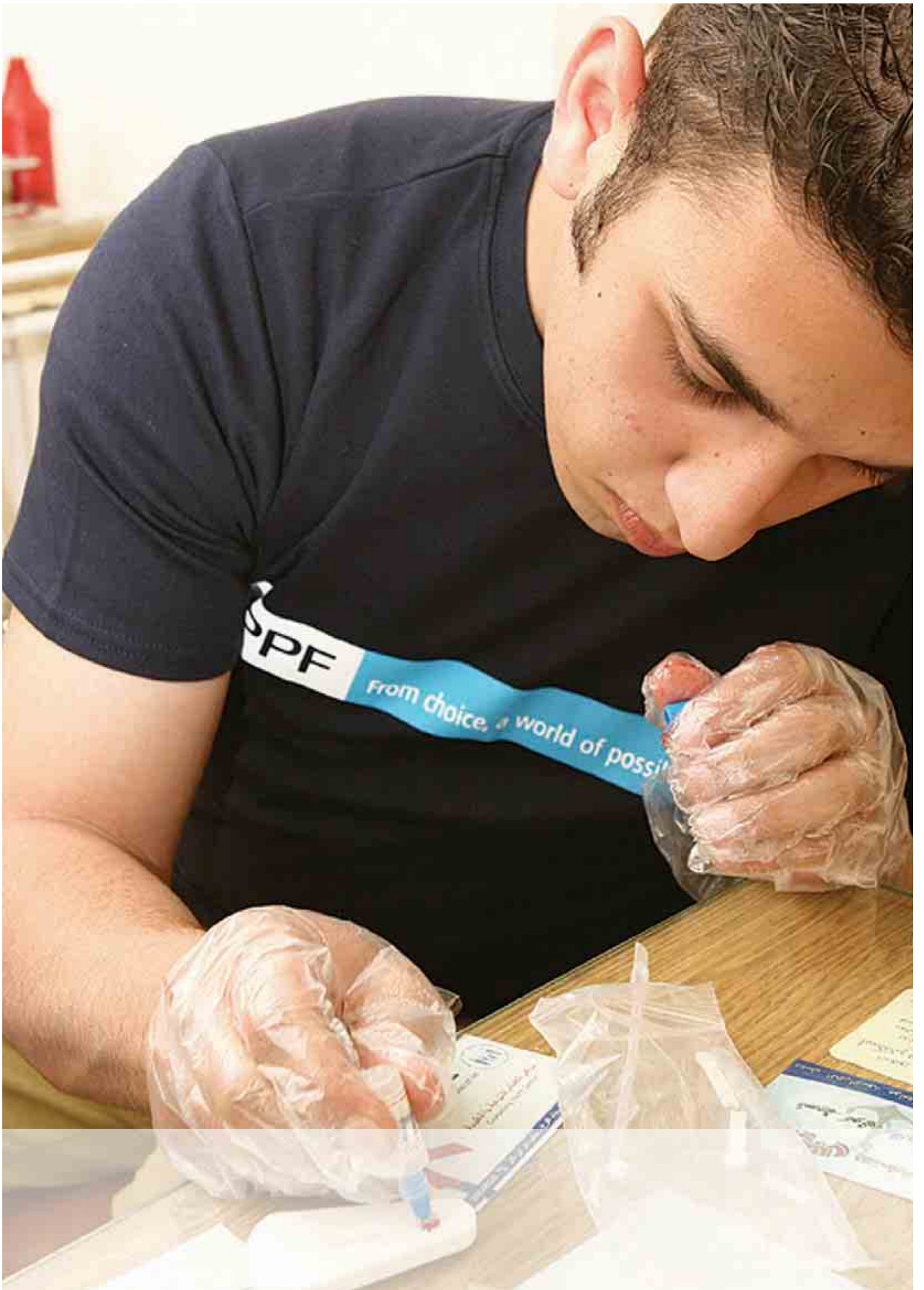
Provider-initiated testing represents a move towards the normalization of HIV testing among clients of health services who might have been exposed to the virus. These clients would include individuals seeking treatment for another sexually transmitted infection, and/or for whom knowledge of their HIV status, including the opportunity to receive treatment, would be advantageous. A pregnant woman is a good example of this kind of client.

Provider-initiated testing, along with pre-test counselling and a process that allows the client to either provide or refuse informed consent, offers the opportunity to increase the uptake of testing. At the same time the principle of the three Cs are applied in order to safeguard human rights.

Opt-out testing deprives clients of the opportunity to provide informed consent

The routine offer can be distinguished from provider-initiated opt-out testing. Opt-out testing involves testing clients for HIV unless they explicitly state that they do not wish to be tested. Although under provider-initiated testing the offer of a test will be routine in certain settings, informed consent remains a vital component of the process prior to testing. Opt-out testing assumes that the test will occur unless the client withholds consent. This radically alters the onus of responsibility for both information provision and for consent.

In order to ensure that the choice to have or not to have a HIV test is a meaningful one, it must be accompanied by the chance to learn more about HIV in the ways detailed above. If clients are influenced in such a way that they cannot refuse the 'offer', then the preconditions for informed consent will not have been met.



In their enthusiasm to increase the availability and uptake of HIV testing, health care providers must ensure that making a routine offer to test does not inadvertently become an opt-out test. This can be done by ensuring rigorous policies around the provision of pre-test counselling and a clear understanding among all staff that the test cannot be administered without the informed consent of their client.

Finally, routine offers to test for HIV should only be offered to individuals for whom the test is likely to be beneficial. As before, these would be, for example, individuals seeking treatment for another sexually transmitted infection, and/or for whom knowledge of their HIV status, including the opportunity to receive treatment, would be advantageous. Pregnant women and/or people with TB are good examples of these kinds of individuals.

An epidemic of stigma and discrimination

The obvious benefits of the increasing availability of treatment for HIV have been a critical feature of arguments to scale up HIV testing. Most advocates of changes to Voluntary Counselling and Testing concede that the availability of HIV treatment is a precondition of policy or practical changes to conventional HIV testing.

However, in some communities, even where treatment has been made easily available, community members do not necessarily seek HIV testing, at least not in large numbers. This forms part of the frustration for clinicians and public health officials. There is clearly more at issue than simply the availability of treatment.

It appears that HIV-related stigma and discrimination are persistent disincentives to test for HIV, and they include serious human rights violations such as violence, harassment and imprisonment. HIV-related stigma and discrimination and the human

What is HIV-related stigma?

HIV-related stigma reinforces deeply held prejudices against groups already marginalized and stigmatized. These groups include gay men and other men who have sex with men, injecting drug users and sex workers. HIV has also heightened the taboos associated with sex in general, and the association of HIV with Africa has reinforced racial prejudice.

HIV-related stigma occurs for a range of reasons, including the following:

- the fact that AIDS is a life-threatening disease
- because AIDS is associated with physical illnesses such as wasting
- HIV is infectious, and there remains ignorance and a lack of understanding about HIV transmission
- the association of HIV with behaviours which some consider deviant or morally reprehensible
- the view that people living with HIV are responsible for their infections
- HIV is associated with groups already stigmatized and discriminated against, including sexual minorities and racial groups

What is HIV-related discrimination?

HIV-related discrimination can be defined as any act, measure or omission that results in someone being treated less favourably because they have, or are believed to have, HIV.

HIV-related discrimination can have a wide reach, extending to people associated with people living with HIV, whether personally, or through family or professional association.

HIV-related discrimination can interact with pre-existing sources of stigma and discrimination. This means that HIV discrimination often impacts on people who are imputed to be HIV-positive because of who they are, or are perceived to be, such as gay men or people who have had a history of using drugs.

Adapted from Common at its Core: HIV-Related Stigma Across Contexts, International Centre for Research on Women, Washington DC, 2005

rights violations that often follow infection do not stop just because treatment is available. As a result, efforts to overcome stigma and discrimination, and to protect the rights of people living with HIV, must be considered essential components of programmes to increase HIV testing.

Developing a shared understanding of stigmatization and discrimination, and how this fuels vulnerability to HIV and HIV-related human rights violations, is the first vital step in developing such programmes.

Understanding risk and vulnerability

The terms 'risk' and 'vulnerability' are often used to help people understand the individual and social factors that influence our capacity to prevent HIV. These terms can also help us to understand some of the factors which might influence a person's willingness to test for HIV, including how society might perceive and treat them, particularly once they are diagnosed as positive.

HIV risk can be defined as the probability of an individual becoming infected by HIV. This infection can occur either through their own actions, knowingly or not, or via another person's actions. For example, injecting drugs using contaminated needles or having unprotected sex with multiple partners increases a person's risk of HIV infection.

Vulnerability to HIV reflects an individual's or a community's inability to control the risk of HIV infection.

Poverty, gender inequality and harassment from state officials, including the police, are all factors that can increase people's vulnerability to HIV infection.

Many populations are vulnerable to HIV. Women and girls, young people, people living in poverty, migrant labourers, people in conflict and post-conflict situations, refugees and internally displaced people all experience situations where they have less control over their HIV risk.

The three Cs of Voluntary Counselling and Testing – consent, counselling and confidentiality – have a clear foundation in human rights law.

The conditions that make people vulnerable to HIV infection often also make them vulnerable to human rights violations. Because of HIV-related stigma, testing positive for HIV is likely to exacerbate a person's existing vulnerability, complicating their situation and exposing them to the possibility of further abuse or discrimination.

Stigmatization of and discrimination against people living with HIV adversely affect their health and well-being and can touch all aspects of their lives. Stigmatization and discrimination are often subtle and difficult to change. It can result in violence and abuse, contribute to isolation and a lack of security, and can be painful and stressful.

There is a very clear correlation between HIV stigma associated with sex, gender inequality, the status of women, the violation of their human rights and the growing epidemic among women. Women are disproportionately infected with and affected by HIV. In Sub-Saharan Africa, 57 per cent of those living with HIV are female, and young women aged 15 to 24 are two and half times more likely to be infected than young men.¹¹ It is true that for many women stigma and discrimination fuel the epidemic and exacerbate its impact on them. Because of this many of them choose not to test for HIV in the fear of the discrimination and abuse that often follows infection.

The truth remains that a well-founded fear of discrimination and abuse is a common disincentive for many people all around the world to test.

A world without stigma and discrimination: a reality

The AIDS epidemic continues to outpace responses to it, despite increased funding, political commitment and progress in expanding access to HIV treatment and care. Increased leadership and commitment are needed, not just in funding or for

Reducing HIV-related stigma requires the following:

- openness in facing up to and addressing the epidemic
- active commitment to the greater involvement of people living with HIV in all aspects of the HIV response – locally, nationally, regionally and internationally
- persistent and public engagement on HIV in general, and as a human rights issue in particular
- policies, programmes and laws that protect, promote and fulfil the rights of people in general, and the poor and vulnerable in particular¹²

increased access to treatment, but also to assert the critical importance of overcoming HIV-related stigma and promote human rights as a prerequisite in the AIDS response. Without a fundamental commitment to stigma reduction and to human rights there is a risk of entrenching the very inequalities that are driving the epidemic and which increase the impact of HIV.

VCT and human rights

The three Cs of Voluntary Counselling and Testing – consent, counselling and confidentiality – have a clear foundation in human rights law. Informed consent protects the human right to security of the person, in other words, to have control over what happens to one's body.¹³ This also relates to the right to receive information.¹⁴ Pre-test counselling contributes to the protection of these same human rights. Post-test counselling also imparts information to which people have a right. Confidentiality of the fact that someone is seeking an HIV test, and confidentiality of test results form part of protecting and respecting the right to privacy.¹⁵

Beyond the components of the testing process itself, providers have a responsibility to ensure that HIV testing, like all other essential health services, is not offered or provided in a way that discriminates against any person or group of people.

For testing to be part of a comprehensive, effective and human rights based approach to responding to HIV and AIDS and to prevention in particular, it should provide the people tested with more than simply a result. It should provide the opportunity to understand and ask questions about HIV transmission and HIV and AIDS care. It should also offer the opportunity to get help on the difficult matter of disclosing their HIV status. HIV testing that includes neither counselling nor informed consent loses its utility as a prevention tool. HIV testing that secures individual consent, provides counselling and protects confidentiality not only has the greatest chance of protecting the individual's human rights, but also of enhancing the practical effectiveness of the testing intervention itself.

Section 2

Linking sexual and reproductive health services and VCT

Everyone has a right to a safe and pleasurable sex life, to decide if and when to have children, and to enjoy the highest standard of sexual and reproductive health, free from discrimination or coercion. Unfortunately, for many people these rights are more rhetoric than reality.

Sexual and reproductive health problems remain the leading cause of ill health and death for women of childbearing age worldwide.¹⁶

Impoverished women, especially those living in developing countries, suffer disproportionately from unintended pregnancies, maternal death and disability, and sexually transmitted infections including HIV. Protecting sexual and reproductive rights, and improving people's sexual health require increasing the availability of comprehensive sexual and reproductive health services for women, men and young people globally.

While recognising that there is no standard universal package of sexual and reproductive health services, emphasis has been placed on the integration of services. Integrating services such as family planning, maternal and child health, antenatal care, and prevention and management of sexually transmitted infections (STIs) and HIV, including HIV testing, provides clients with a more holistic approach to their sexual and reproductive health needs.

Organizations offering sexual and reproductive health services have a responsibility to support clients to develop the knowledge and skills to protect themselves from HIV infection. To those clients already infected with HIV, assistance should be given to get the care and any

further support that they need. Integrating and expanding voluntary HIV counselling and testing services in sexual and reproductive health settings provide opportunities for organizations to respond to this opportunity and for clients to obtain all the benefits of knowing their HIV status.

There are numerous other practical and operational benefits and opportunities of integrating Voluntary Counselling and Testing into sexual and reproductive health services.

Integration: opportunities and challenges

● Creates demand

Although much of our exploration to date has involved discussing the need to stimulate demand for HIV testing, including by altering conventional approaches to testing, the fact remains that Voluntary Counselling and Testing (VCT) services are currently not available to many people who want to know their HIV status. Integrating VCT in sexual and reproductive health settings is one way to increase the availability of these services because these settings already serve large numbers of people.

● Improves uptake

Integrating Voluntary Counselling and Testing into sexual and reproductive health services not only increases the number of people with access to testing services. It also secures the opportunity to offer VCT to clients who are being seen about another sexual or reproductive health issue, including in some instances sexually transmitted infections. Offering testing

to these individuals provides a unique opportunity for tailored counselling based on knowledge of HIV status.

● Improves synergies

Integrated sexual and reproductive health services recognize the relationship between family planning, sexually transmitted infections and HIV. In particular, sexual and reproductive health services and Voluntary Counselling and Testing have similar aims of reaching sexually active people, preventing unwanted pregnancy, HIV and STIs, and promoting safe and healthy sexuality.

● Promotes and protects human rights

Sexual and reproductive health services often have an explicit rights based approach which recognizes that sexual and reproductive health are rights and that other human rights, such as privacy, should be protected when accessing these services.

● Improves client's experience of testing services

Many people wanting to learn their HIV status do not want others to know that they are seeking HIV testing. Many people are not comfortable attending freestanding sites because of the stigma and discrimination associated with HIV testing. Voluntary Counselling and Testing services that are truly integrated into sexual and reproductive health settings are not physically segregated from other services. Clients attending the site for Voluntary Counselling and Testing could therefore appear to be attending for any of the services provided.

Organizations offering sexual and reproductive health services have a responsibility to support clients to develop the knowledge and skills to protect themselves from HIV infection.



Scaling up Voluntary Counselling and Testing to the level required to realize the goal of universal access to HIV prevention, treatment and care across the globe, will require the involvement of a range of partners doing different things.

● Provides opportunities to reach young people, men, and couples

Providing Voluntary Counselling and Testing in sexual and reproductive health settings can promote sexual and reproductive health services to those that might not otherwise access them (for example, young people and men). It can promote condom use in these groups, and increase their involvement in family planning and HIV prevention. Voluntary Counselling and Testing for couples is a promising variation. Sexual and reproductive health settings are ideally placed for supporting couples to learn their HIV status.

● Utilizes existing structures, resources and personnel

Start up costs for integrated Voluntary Counselling and Testing services are lower than those for freestanding sites, making integration an important option for scaling up VCT. The infrastructure needed to provide confidential and private Voluntary Counselling and Testing services is similar to that already provided in sexual and reproductive health settings. Integrating Voluntary Counselling and Testing may therefore require only minimal changes to the existing infrastructure.

Service providers in sexual and reproductive health settings typically have basic counselling skills. These can be further developed to deliver high quality Voluntary Counselling and Testing.

The logistics management system for sexual and reproductive health services can be used to manage Voluntary Counselling and Testing commodities. For example, sexual and reproductive health services ensure the constant supply of commodities and services, such as HIV test kits, male and female condoms.

Sexual and reproductive health service providers are familiar with providing referrals for additional services. Existing outreach activities could be developed to include HIV/AIDS prevention.

The role of Community Based Distributors (CBDs) and outreach workers could be expanded to inform communities about the benefits and challenges of knowing HIV status, and to promote Voluntary Counselling and Testing.

Experiences of integration, including the case studies detailed later in this publication, demonstrate that there are also potential challenges associated with providing Voluntary Counselling and Testing in existing sexual and reproductive health settings. Being aware of the challenges and opportunities allows those involved in service development, design and management to take these challenges into account during planning and implementation.

● Requires specialist skills

HIV counselling requires a non-judgemental approach that focuses on both sexual and reproductive health and HIV. This can be overcome through training, support and supervision of those providing counselling, and through challenging staff to examine their role in broader reproductive health issues such as preventing STIs including HIV. In addition to providing appropriate Voluntary Counselling and Testing services, this approach will improve the quality and applicability of the existing sexual and reproductive health services.

● Challenges preconceived perceptions

Providers may need to challenge their clients' perceptions that service quality has been reduced as a result of Voluntary Counselling and Testing services. Providers should help clients to see that more comprehensive sexual and reproductive health services are being provided as a result of the integration.

Equally, target groups for Voluntary Counselling and Testing services might perceive sexual and reproductive health services as being irrelevant to them. For example the perception of many sexual

and reproductive health services as primarily concerned with family planning might be a disincentive for young people, sex workers, or men who have sex with men to attend. However, experience shows that comprehensive promotion of the benefits of Voluntary Counselling and Testing may encourage these populations to access VCT services regardless of the setting, with the further benefit of reaching these groups with other sexual and reproductive health services.

Different models for delivering VCT services

There are several different ways in which Voluntary Counselling and Testing services can be delivered. As service providers identify new ways to meet emerging and unmet needs, the models for VCT provision will increase. Each of the models has its own benefits and challenges.

The case studies in this publication focus on models of Voluntary Counselling and Testing integration with existing sexual and reproductive health services, where Voluntary Counselling and Testing has been incorporated into existing service delivery. As you will see this includes the development of Voluntary Counselling and Testing from scratch in a seriously underserved area, increasing the scale and quality of VCT and special efforts to reach especially vulnerable populations.

Voluntary Counselling and Testing is part of a continuum between HIV prevention and care. Within this continuum, there are a number of components of Voluntary Counselling and Testing.

Counselling

We have looked at the importance of counselling in Voluntary Counselling and Testing. Counselling can take different forms and be offered in different ways.

The 'classic' model of Voluntary Counselling and Testing offers individual pre-test counselling, testing, and individual post-test counselling. Within this model, there are several variations regarding counselling that may be appropriate in different settings.

For example, some sites offer group information followed by shortened individual pre-test counselling as an alternative to individual pre-test counselling. This variation can extend the reach of Voluntary Counselling and Testing services and can reduce costs. Some services offer couples pre- and post-test counselling, which can be even more beneficial than individual counselling, because sharing one's HIV status with one's sexual partner is important for changing sexual behaviour for HIV prevention, and for preventing re-infection. Family counselling can help support children and other family members to understand the result and cope with the implications of the result.

Community education and mobilization

Other components are also essential for successful Voluntary Counselling and Testing. Community education and mobilization are important because they help prepare communities for Voluntary Counselling and Testing by increasing awareness of the benefits of VCT, as well as contributing to reducing stigma.

The success of Voluntary Counselling and Testing will rely on understanding and challenging myths and barriers to testing. Its success will also rely on gaining the support of the community during the development of the integrated VCT service. HIV prevention counselling involves individual counselling for risk reduction and can help identify clients that might benefit from

Voluntary Counselling and Testing. Support and care to those using VCT services must be offered. Support and care services include activities such as follow-up counselling, post-test clubs, management of opportunistic infections, interventions to prevent mother-to-child transmission of HIV, social and material support, and antiretroviral (ARV) therapy.

The principle of integration does not presume that it is necessary for every site to provide all components of VCT services, as we shall see in the following case studies. Scaling up Voluntary Counselling and Testing to the level required to realize the goal of universal access to HIV prevention, treatment and care across the globe, will require the involvement of a range of partners doing different things. This also means that if the range of VCT components is not offered directly, then mechanisms for referral to partner organizations or other providers must be well developed.

Any organization, including sexual and reproductive health providers, seeking to integrate Voluntary Counselling and Testing should consider which of these components to provide. In its consideration its own resources and capacity, the needs of the community, and existing services available within the community must be taken into account. A tool to measure an organization's readiness to provide some, or all, of these services is included at the end of this publication.

The case studies that follow look at how three organizations, each working in different contexts and with a commitment to addressing different needs, approached the task of integration. The practical experiences of integrating VCT have been varied, yet all of the lessons learned are useful food for thought for any organization thinking about providing or expanding VCT services. Each of the IPPF Member Associations profiled in the case studies was supported by funding from the Japan Trust Fund for HIV/AIDS, without which none of the projects would have been possible.

Footnotes

- 1 *AIDS Epidemic Update: special report on HIV/AIDS 2006*, Joint United Nations Programme on HIV/AIDS (UNAIDS) and World Health Organization. Geneva. Available at http://data.unaids.org/pub/EpiReport/2006/2006_EpiUpdate_en.pdf
- 2 *Political Declaration on HIV/AIDS*, United Nations General Assembly, June 2006
- 3 *The right to know: New Approaches to HIV Testing and Counselling*, World Health Organization, Geneva, 2003
- 4 Adapted from *Scaling Up HIV Testing and Counselling (TC) Services – Toolkit*, World Health Organization, International HIV/AIDS Alliance, GTZ, Geneva, 2004.
- 5 *Joint WHO and UNAIDS Policy statement on HIV testing*, WHO * UNAIDS, 2004.
- 6 *Meeting the Sexual and Reproductive Health Needs of People Living with HIV*, Guttmacher Institute & UNAIDS, 2006
- 7 *UNAIDS/WHO Guidance on Provider-Initiated HIV Testing and Counselling in Health Facilities*, Geneva, June 2007
- 8 *UNAIDS/WHO Policy Statement on HIV testing*, Geneva, June 2004
- 9 Ibid
- 10 HIV testing without consent may be justified in the rare circumstance in which a patient is unconscious, his or her parent or guardian is absent, and knowledge of HIV status is necessary for purposes of optimal treatment.
- 11 UNAIDS, UNFPA, and UNIFEM, *Women and HIV/AIDS: Confronting the Crisis*. New York and Geneva, 2004
- 12 O'Reilly, *An epidemic of stigma and discrimination*, Contact: HIV Prevention, current issues and new technologies, World Council of Churches, Geneva, 2006
- 13 International Covenant on Civil and Political Rights. United Nations General Assembly Res. 2200A, 16 December 1966, article 9(1).
- 14 Ibid. at article 19(2).
- 15 Ibid. at article 17(1).
- 16 Glasier A et al, *Sexual and reproductive health: a matter of life and death*, Lancet, October 2006.

Section 3 Case studies

The following three case studies show how Voluntary Counselling and Testing (VCT) services have been introduced or improved by different IPPF Member Associations. Their aims and situations vary widely, but all represent best practice in certain areas, and highlight the real life challenges of turning VCT concepts and principles into practical programmes.

Cambodia, Siem Reap

Building the right response: reaching vulnerable populations with appropriate and acceptable services

The context

Cambodia is the country most affected by HIV in Asia, with a national prevalence of approximately 1.6 per cent. Over 130,000 people in Cambodia have been infected with HIV since the beginning of the epidemic and 16,000 people have died of AIDS.¹ Encouragingly, increased political commitment, stronger responses from non-governmental organizations, and a wide range of activities by the Ministry of Health are beginning to stem the tide of new infections. The estimated national prevalence of HIV among those aged 15 to 49 years declined from 2.1 per cent in 2002 to 1.9 per cent in 2003. The larger decline observed among young female sex workers compared with those older than 20 years suggested declining incidence in this group. However, despite this decline, HIV prevalence continues to be high among female sex workers: 20.8 per cent among direct sex workers and 11.7 per cent among indirect sex workers in 2003.²

In Cambodia, sexual transmission of HIV occurs most commonly through sex work and sex between men, and these populations continue to be disproportionately affected by HIV/AIDS. There is increasing recognition among both governmental and non-governmental

organizations of the importance of recognizing and working with these and other vulnerable groups to prevent HIV and mitigate its impact.

IPPF's Cambodian Member Association, the Reproductive Health Association of Cambodia (RHAC), is increasing its work with vulnerable groups. Part of its efforts have included the development of Voluntary Counselling and Testing (VCT) services for indirect sex workers, men who have sex with men and construction workers in and around Siem Reap.

Which needs did the project respond to?

Three vulnerable populations were identified:

Indirect sex workers

Siem Reap is one of Cambodia's eight provinces and home to the famous temples of Angkor Wat. The province is the centre of the country's growing tourism industry and large numbers of Cambodia's rural poor have moved there to look for work.

Young women moving to Siem Reap often find employment in the city's entertainment industry, working as beer promoters, karaoke singers and masseurs, many of whom supplement meagre

incomes through sex work. These women are known as indirect sex workers and are distinct from women working directly in brothels or on the street. According to Cambodia's 2002 sentinel surveillance, HIV prevalence among indirect sex workers in Siem Reap was 22 per cent.

Entertainment industry-based indirect sex workers have historically resisted identification as sex workers. As a result, outreach to and mobilization of indirect sex workers is relatively undeveloped, in contrast to that of brothel-based sex workers. The seasonal nature of tourism-based entertainment work means that many of these young women are highly mobile, posing additional challenges for sustained outreach. Knowledge of HIV in general, and of Voluntary Counselling and Testing in particular, was subsequently very low among indirect sex workers. The capacity of the Government's provincial HIV and sexual health services was also limited, leading to high levels of unmet need for HIV education and prevention services among this group.

Construction workers

The growth in Siem Reap's tourism industry has seen a sustained building boom throughout the city and province. This has led to large numbers of young men

Sexual transmission of HIV occurs most commonly through sex work and sex between men, and these populations continue to be disproportionately affected by HIV/AIDS.



Ignorance about the extent of male-male sex in Cambodia has, until recently, resulted in a relative lack of MSM programming.

migrating to the city looking for work in the construction industry, with up to 14,000 men currently living and working on building sites there.

There was no previous history of non-governmental organizations focusing on HIV education among construction industry workers. Although no HIV prevalence data for construction industry workers was available, their need for HIV prevention and education was readily identifiable.

Men who have sex with men

According to the latest survey by the Cambodian National Centre for HIV/AIDS Dermatology and STDs, the HIV prevalence rate among men who have sex with men is 8.7 per cent.³

In terms of HIV risk, male-to-male intercourse is significant because it can involve anal sex, which, when unprotected, carries a risk 10 times greater than unprotected vaginal intercourse does for the receptive partner. That risk, together with complex sexual networking among many men who have sex with men, significantly increases the risk of HIV transmission among this group.

According to a survey of Cambodian men who have sex with men, 58 per cent of these men reported having sex with female partners in the past year. Almost 25

per cent also reported having sex with female sex workers, with 16.6 per cent having had sex with casual female partners in the past month.

Ignorance about the extent of male-male sex in Cambodia has, until recently, resulted in a relative lack of MSM programming. This, in turn, has contributed to high levels of risk behaviour and poor knowledge of prevention methods. The focus of the government's HIV and STI clinical services on female sex workers has further widened the HIV services gap for men who have sex with men.

How have these needs been addressed?

The Reproductive Health Association of Cambodia recognized the need for efforts to significantly increase HIV and STI prevention services in general, and for VCT services for these three groups in and around Siem Reap in particular.

Fostering partnerships

Partnership development was a key feature of the Reproductive Health Association of Cambodia's efforts to meet the needs of these groups.

Existing providers – the government

clinic and the Reproductive Health Association of Cambodia – agreed to scale up Voluntary Counselling and Testing provision in Siem Reap. Scaling up involved both increasing the availability of Voluntary Counselling and Testing services and working to improve the quality and accessibility of the services for these groups.

Clear agreements were reached with the Provincial AIDS Office about how Voluntary Counselling and Testing service levels and quality were to be enhanced. This included training for service providers, how services would be modified in response to the groups' needs, and how NGOs, including the Reproductive Health Association of Cambodia, would work with the Provincial AIDS Office over time.

Partnerships with non-government organizations already working with the vulnerable groups were equally critical to the success of the project. These included Cambodian Women for Peace and Development (CWPD) who had programmes with indirect sex workers, Men's Health Cambodia (MHC) who had a programme of outreach to men who have sex with men, and the Cambodia Construction Worker's Trade Union Federation (CCWTUF) who were working with construction industry employees.



Small group discussion on how to improve referrals to RHAC clinic.



Peer educators and construction workers at their project bi-monthly meeting.



Counselling session at RHAC clinic.

Increasing knowledge and stimulating demand through peer education and outreach

Initially, knowledge of HIV in general, of Voluntary Counselling and Testing services and, consequently, of HIV status was low among all three vulnerable populations. Increasing knowledge of the importance of Voluntary Counselling and Testing and the benefits of knowing one's HIV status among all three groups was therefore essential in order to stimulate demand for the service. This was done through the selection and training of peer educators who became champions for VCT within their respective communities.

In each entertainment venue and construction site two workers were selected for peer educator training, one of whom assumed a supervisory role for the project within their workplace. Attempts were made to ensure that the person enjoyed good relations with management, to help facilitate the running of the project within the workplace.

Educators were selected if they had the time to devote to the project, were able to read and write in Khmer, enjoyed the trust of their colleagues, and intended to work for more than one year in their current workplace. In the case of men who have sex with men, Men's Health

Cambodia, helped the Reproductive Health Association of Cambodia to select peer educators from among the men with whom they were already in contact.

Two days of training were provided for peer educators. The training included both skills development in outreach techniques and knowledge of HIV and STI prevention and of VCT in particular. During 2005, training was provided to 390 peer educators. This included 246 construction industry workers, 126 from entertainment venues and 18 men who have sex with men.

Construction and entertainment industry-based peer educators were then asked to conduct between three and four group education sessions in the workplace over the course of a year. In addition to providing basic HIV information, these sessions focused on the benefits of knowing one's HIV status and on how and where to test for HIV.

Peer educators were also provided with specially produced material on both STIs and Voluntary Counselling and Testing to distribute to their colleagues and friends. This included 20,000 leaflets providing an overview of Voluntary Counselling and Testing, and 30,000 on the prevention and treatment of STIs.

In addition to work-based information

sessions, peer educators were encouraged to make themselves available on an informal, ongoing basis to their colleagues in the workplace. This approach created workplace champions who were knowledgeable about Voluntary Counselling and Testing and who could meet the need for information on the nature and availability of VCT services. This informal method was also the principal approach taken by MSM peer educators working in the community and at locations where men who have sex with men met and socialized.

After providing information, including the information material that was produced as part of the project, the educators were encouraged to refer their peers for Voluntary Counselling and Testing to the Reproductive Health Association of Cambodia or, in the case of construction workers, to the government clinic.

Building good relations with employers and community leaders

Initial meetings were organized with key stakeholders, including owners of the entertainment establishments, construction site managers and MSM community leaders. This was vital to ensuring that decision makers and gatekeepers from

(l-r) RHAC/Cambodia, RHAC/Cambodia, IPPF/Christian Schwetz/Cambodia



Outreach activity with construction workers.



Group discussion session on VCT at a karaoke parlour.



Condom demonstration at RHAC.

At each of the sessions for clinical staff, representatives of all three communities were invited to share their experiences, including experiences of accessing health services.

these communities knew about the project and supported it. These meetings also introduced both the Reproductive Health Association of Cambodia and the Provincial AIDS Office to these groups, to raise awareness of these organizations and the services and support they provided.

These meetings were held quarterly and helped maintain the interest and commitment of stakeholders. They provided an opportunity to directly seek feedback on the programme, including challenges or difficulties encountered in its implementation.

Providing better quality and more accessible VCT services

Improving access to high quality Voluntary Counselling and Testing services was critical to the success of this project. The decision to proactively market VCT services to all three vulnerable groups was a new one for the Reproductive Health Association of

Cambodia. In doing so, the Association recognized the need to ensure the services it was offering were appropriate and acceptable to all three groups.

Both the Reproductive Health Association of Cambodia and the government clinic's experience of providing reproductive health services had previously had a focus on heterosexual couples. In light of this, both service providers needed to consider how their services would have to change in response to the envisaged increase in use by indirect sex workers and men who have sex with men.

Training was provided to staff at both the Reproductive Health Association of Cambodia and government clinic and was aimed at making staff more familiar with the issues of each of the three target groups. Vulnerable populations commonly report that the highest levels of HIV-related stigma and discrimination they experience occur in health care settings, so it was

important to familiarize staff with the issues and needs of vulnerable groups and to develop a culture of inclusion and respect for human rights.

At each of the sessions for clinical staff, representatives of all three communities were invited to share their experiences, including experiences of accessing health services. Physical changes were made to the clinics to ensure greater levels of privacy and to encourage each of the target groups to feel more at ease in approaching and using the service.

A decision was made to ensure that a female counsellor was available for indirect sex workers, a male counsellor for construction industry staff, and an MSM counsellor for men who have sex with men presenting for Voluntary Counselling and Testing.

Changes were also made to clinic opening hours to ensure the service was open at the most convenient times for each of the three groups.

What has been achieved?

Service use and uptake

The numbers of vulnerable populations accessing both the Reproductive Health Association of Cambodia and government clinics for both Voluntary Counselling and Testing and STI services increased dramatically over this two-year project.

- 1,695 indirect sex workers received VCT and 2,449 received STI services at both clinics.
- 1,178 construction workers received VCT and 614 received STI services at the RHAC and Government clinics.
- 339 men who have sex with men received VCT and 162 received STI services at the RHAC and Government clinics.

Results from baseline and end line surveys

also showed increases from 2.7 per cent to 15.6 per cent in the use of STI services at RHAC clinic and Government health centre. The number of people who reported using VCT services in the two health facilities (clinic RHAC and Government health centre) significantly rose from 32 per cent to 54 per cent.

Long term changes in the nature of both the Reproductive Health Association of Cambodia and the government's STI clinical services have been secured, with the expectation that the inclusivity and accessibility of their services for vulnerable groups will continue to improve.

Individual and community awareness

Individual awareness of HIV in general

and of the benefits of Voluntary Counselling and Testing in particular has increased. Nearly 450 group discussions were attended by over 7,000 indirect sex workers and construction workers.

Two MSM gatherings were organized, with over 120 participants. Targeted VCT and STI information was produced and made available to the three groups.

Sustainability

The sustainability of the project has been assured through the support of new funding from the Global Fund and key stakeholders in the participating clinics, organizations and from the affected communities committed to the project on an ongoing basis.

What challenges were identified?

In the course of this project the following challenges were identified:

☁ The drop-out rate of peer educators was higher than hoped. One third of the construction industry and indirect sex workers recruited to be peer educators withdrew from the programme.

☁ The Reproductive Health Association of Cambodia's partnership with the Cambodian Construction Workers Trade Union Federation helped RHAC begin to work with a target group with whom it did not have any experience. The partnership at an

organizational level was therefore new and the work on HIV was new for the union too. A new partnership had to be built at the same time as working to develop the knowledge and skills necessary to implement a project of this kind.

☁ Poor knowledge of beneficiary communities, particularly the numbers and needs of workers in the construction industry, meant that estimates for project outreach were not accurate.

☁ The emergence of new construction sites was not adequately factored into project planning. This meant that the project's coverage was not as high as it could have been at the end of the first year.

☁ Some barriers to clinical access were identified as outside of the scope of the project, and therefore could not be addressed. This included the fact that the cost of transport to clinical sites was a disincentive for attendance, especially by construction workers.

How are these challenges being addressed?

In response to the challenges it has identified, the Reproductive Health Association of Cambodia is:

☀ developing plans for the ongoing recruitment of peer educators throughout the project to compensate for the drop-out rate

☀ working to strengthen its relationship and collaboration with the Cambodia Construction Workers' Trade Union Federation (CCWTUF)

☀ re-estimating the number of construction workers as target beneficiaries for more reliable and accurate project statistics

☀ developing a system to provide resources as new construction sites are identified

☀ increasing the resources devoted to field supervision and monitoring, so that challenges to project implementation are identified earlier

☀ developing a system for sharing the findings of site and supervisory visits with NGO partners in order to improve follow up and to better address any issues that are identified

Issues to consider

When developing a project aimed at improving the accessibility and quality of HIV testing for vulnerable populations, service planners should try to do the following:

✓ Provide training beyond technical aspects related to service delivery

Staff need to be familiarized with and taught more about the proposed new client group in order to offer the best possible service. Target groups should be involved in staff training.

✓ **Ensure full respect of clients' rights**
IPPF's Charter of Rights includes the right to information, access to services, choice, safety, privacy, confidentiality, dignity, comfort, continuity of services, and the ability to express their opinions. This charter should also apply to vulnerable groups.

✓ Develop new (or invest further in existing) partnerships

Non-government and community-based organizations that represent or are already working with the vulnerable population are important partners.

Collaborate with them on service delivery, and meet to learn from each other's experiences.

✓ Involve representatives of the affected community

Life experience from members of the affected community can bring valuable insights for delivery of services and provision of information that is tailored to real needs. These community members need to be involved in all aspects of the project's design, implementation and monitoring.

Uganda, Iganga

Mobilizing communities: a three-pronged strategy to improve prevention, access and service

The context

As one of the first countries in sub-Saharan Africa to experience the devastating impact of HIV and AIDS and to take action to control the epidemic, Uganda is widely regarded as one of the rare success stories in a region that has been ravaged by the HIV/AIDS epidemic. While the rate of new infections continued to increase in most countries in sub-Saharan Africa, Uganda succeeded in lowering its infection rates from a high of almost 30 per cent in the early 1990s to just under 5 per cent today.⁴

However, the burden of the AIDS epidemic continues to grow. Recent data from the Uganda HIV Sero-Behavioural Survey provides serious cause for concern, as it shows that previous gains are being eroded by increases in the rate of infection.

Major barriers to HIV prevention, treatment, care and support in Uganda include: limited public investment in prevention, infrastructure and human resources; limited service coverage, especially in rural areas; and a lack of financial resources, including constraints arising from suspension of Global Fund support, and failure to obtain Round 6 funding.

Even though HIV prevalence in Uganda is much lower than it once was, it still remains very high, and AIDS continues to claim tens of thousands of lives each year. Young people living in Uganda's rural areas, or poor young people living in the country's urban areas who are not attending school

or who are involved in transient work, are particularly vulnerable to HIV and are disproportionately affected by it. The relative lack of HIV prevention education programmes targeting these young people, together with the unavailability of clinical services, makes them particularly vulnerable.

IPPF's Ugandan Member Association, the Family Planning Association of Uganda (FPAU), developed a project to meet the sexual health and HIV related needs among young people at risk and hard-to-reach young people in the rural district of Iganga.

Which needs did the project respond to?

The project responded to three identified needs: the need for improved HIV and STI prevention information and support among at risk young people; the need to support prevention outreach by improving access to clinical services, including Voluntary Counselling and Testing; and the need to improve the quality of those services and ensure their sustainability.

The unmet needs of HIV prevention information, service deficiencies, and institutional challenges to service development and maintenance were particularly acute in Iganga District in Eastern Uganda.

Iganga is Uganda's most populous district with a large transient population, including many highly mobile traders distributed along the national and regional

highways that go through the area. These traders include both men and women working in various occupations. The occupations are varied and include as bar staff, taxi drivers, car washers, food vendors, hairdressers, tailors and dressmakers. High levels of transactional sex are also found in the district.

How have these needs been addressed?

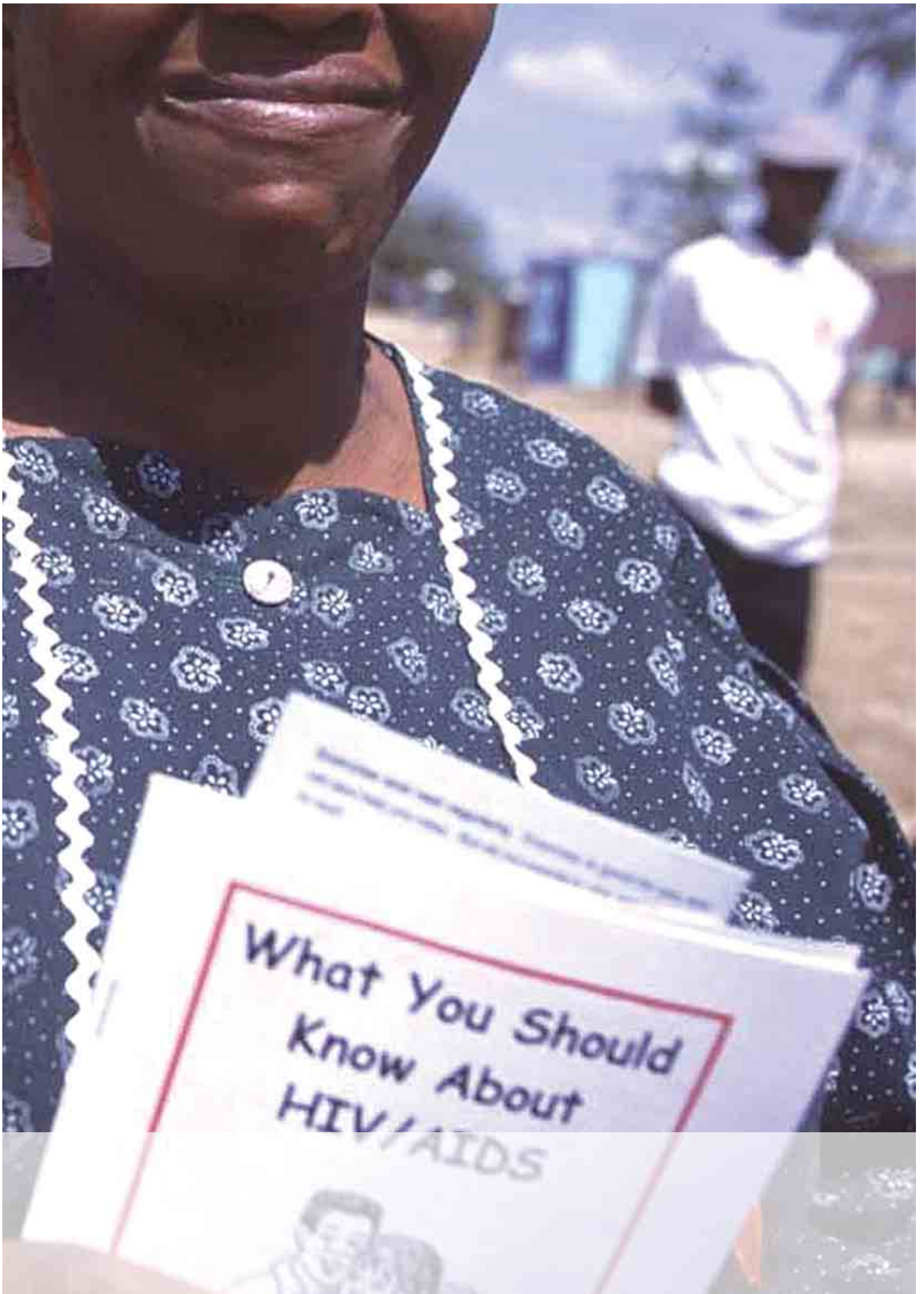
The Family Planning Association of Uganda developed a three-pronged project strategy in response to the identified needs. The strategy involved a variety of interventions grouped together in three clusters: increasing Behaviour Change Communication (BCC) among the target group using a peer education approach; clinical service development and delivery; and capacity building.

Peer education and community outreach

The peer education and outreach strategy involved multiple techniques aimed at significantly increasing HIV prevention information among the target population, with a view to improving sexual health decision-making, including knowledge of one's HIV status. It also included the recruitment and training of various mobile traders to work as peer educators.

In addition to the one-to-one education and outreach undertaken by peer educators, monthly meetings were held

Even though HIV prevalence in Uganda is much lower than it once was, it still remains very high, and AIDS continues to claim tens of thousands of lives each year.



Providing VCT services in association with faith-based organizations helped raise the visibility of testing, and reinforced its importance.

for mobile workers in and around their workplaces. These interventions supported the one-to-one sessions being undertaken by the peer educators and stimulated interest among workers who had not previously shown an interest in these sessions.

Broader community outreach was also critical to the success of the project. Workshops for over 120 community leaders were organized, providing participants with an overview of the project. This also included information about the increased availability of Voluntary Counselling and Testing and of other HIV prevention services for young people. The workshops were also used to gain the support of community-based leaders for the project.

Leaflets, posters and stickers were written in English and Uganda's local language, Luganda, and a series of innovative methods were used to deliver Voluntary Counselling and Testing information and messages. A one-hour interactive radio programme on local FM radio stations was aired on a weekly basis throughout the duration of the project. The programme was further complimented by a radio announcement aired three times per day, three days per week on the same stations, detailing the importance of

knowing one's HIV status and indicating where a HIV test could be obtained. Peer educators were also recruited into drama groups and subsequently performed in communities, including at mobile clinical sites whilst outreach clinical services were being provided.

Innovative clinical service development and delivery

The Family Planning Association of Uganda began to increase service accessibility by providing Voluntary Counselling Testing services in new, non-clinical settings. This included the creation of two clinics at community outreach centres and at various churches in the district. Providing VCT services in association with faith-based organizations helped raise the visibility of testing, and reinforced its importance.

HIV testing was also incorporated into the Family Planning Association of Uganda's static Iganga clinic. This extended the services on offer to clients presenting at the clinic for STIs and other sexual health concerns.

Collaborative relationships were built with other service providers, including the AIDS Support Organization (TASO) and AIDS Information Centre, and the National Community of Women Living with HIV/AIDS in Uganda (NACWOLA). This was

done to improve the referral of clients to support and other services.

Capacity building

The third arm of the project strategy involved working to build the longer-term institutional capacity of the Family Planning Association of Uganda and its other partners to continue to provide Voluntary Counselling and Testing services. Activities included the provision of training, purchasing capital equipment and making improvements to clinic infrastructure.

The Family Planning Association of Uganda recognized that in order to provide Voluntary Counselling and Testing services to this target group, it would need to improve the quality and appropriateness of its services. Some of these improvements were delivered by staff training, which included providing clinic staff in Iganga with the information and skills necessary to conduct VCT. Laboratory staff were also trained by the Uganda Virus Research Institute.

The project also required new equipment, supplies and infrastructure. Provision of Voluntary Counselling and Testing often requires modifications to existing buildings in order to properly and appropriately deliver the new service. Building work was subsequently



Introducing VCT services to the local communities.



Community outreach in Iganga.



FPAU youth peer educators.

undertaken at FPAU's Iganga clinic to ensure that the facility met established quality-of-care standards, including those that related to privacy, comfort and confidentiality, and where laboratory and clinical waste material are disposed of in a proper and safe manner.

What has been achieved?

Increased knowledge and awareness among the target group

The Family Planning Association of Uganda's evaluation of the first round of the project found significant improvements in key areas relating to HIV and sexual health knowledge among respondents who had been exposed to the project or accessed its services. For instance, after the project respondents had greater knowledge of common symptoms of STIs and knew about the sexual transmission of HIV.

Critically, more respondents had also heard about Voluntary Counselling and Testing. More knew FPAU clinics and outreach services provided Voluntary Counselling and Testing, and more would feel comfortable taking a HIV/AIDS test at a FPAU facility or outreach service.

Successful experience of innovative clinical service delivery

One of the project's key achievements is that the Family Planning Association of Uganda and the organizations with whom it partnered, including government agencies, now have direct experience of a highly successful and innovative method of clinical service delivery in the form of mobile units and church-based outreach.

This experience has increased the willingness of FPAU and its partners to consider new ways to deliver services.

(l-r) IPPF/Mahua Sen/Uganda, IPPF/Mahua Sen/Uganda, FPAU/Uganda



Drama performance during outreach activity.



The youth sport team at a local school.



FPAU community outreach for girls in school.

What challenges were identified?

In the course of this project the following challenges were identified:

☁ Demands outstripped supplies
The project was so successful in stimulating demand for VCT services that demand sometimes outstripped the capacity of the services to provide tests.

☁ Poor access to post-test treatment and care for positive people
In spite of the project's achievements there is no systematic arrangement to ensure continuity of care for those testing HIV positive. Although antiretroviral therapy (ART) is available in Uganda and has benefited more than

75,000 people to date,⁹ it is not accessible to poor rural communities. Antiretroviral drugs can only be given after CD4 cell count tests, and significant barriers exist for clients needing to access these tests. Lack of follow-up services, including care and treatment, is increasingly becoming a disincentive to take up an offer of Voluntary Counselling and Testing.

☁ Stigmatization and discrimination
HIV-related stigma and discrimination remain significant in Uganda and

seriously affect people who test positive for HIV in numerous ways. Members of the target population for this project have reported that when they have disclosed their HIV status they have been fired. Women continue to report that when they have disclosed their HIV status to their husbands that they were thrown out of their own homes and disowned. In the absence of more robust protections, numerous human rights violations continue to follow infection with HIV in this country.

How are these challenges being addressed?

☀ The Family Planning Association of Uganda has sought funding to increase staff and other resources to help meet the need for VCT services in the next stage of the project.

☀ The next stage of the project seeks to build on the work done by FPAU through peer education, mobile Voluntary Counselling and Testing service development and capacity building, and aims to secure follow up care and treatment for people testing positive.

☀ The Family Planning Association of Uganda plans to ensure access to CD4 tests and ART services for a specific number of young people from the target population in Iganga who test positive.

☀ Behaviour Change Communication initiatives in the next round of the project will incorporate anti-stigmatization messaging, and peer education activities will actively address issues of discrimination.

☀ In recognition of the importance of post-test peer support, especially for people living with HIV, the Family Planning Association of Uganda is also establishing post-test clubs. The aim of the clubs will be to support self-determined community organizing in response to HIV among newly positive young people in Iganga. As part of the second phase of the project the FPAU has also identified the need to tackle poverty and vulnerability to increased poverty among people living with HIV, and will support income generating activities.



FPAU peer educators at Iganga clinic.



Participants of the bicycle race during the International Youth Day Celebration.



The winner of the bicycle race receiving his prize.

Issues to consider

When developing a project aimed at taking Voluntary Counselling and Testing services out into the community, planners should consider the following:

✓ Identifying locations and partnerships that could increase access to VCT

The development and delivery of Voluntary Counselling and Testing services outside traditional clinical settings was critical to the success of this project. Organizations looking to scale up VCT in the community should consider where services could be located and delivered, and decide which organizations are best to partner with.

Partnerships with community organizations, such as faith based organizations, could be developed to help bridge the gap between the target population's needs and the broader community's capacity and commitment to scaling up service delivery.

✓ Providing post-test support and services

Voluntary Counselling and Testing on its own is not an effective

intervention. Knowledge of HIV status should be matched with post-test support services and HIV-related treatment and care for people who test positive.

Organizations looking to make Voluntary Counselling and Testing available in the community must develop systematic processes and programmes to ensure that the post-test needs of people living with HIV are met, including by ensuring access to HIV treatment.

✓ Developing a strategy that ensures community based VCT helps reduce stigmatization and discrimination

Taking HIV-related services out into the community can help reduce HIV/AIDS related stigma and discrimination. Organizations looking to provide Voluntary Counselling and Testing in the community should develop a strategy that improves community understanding of HIV and reduces associated stigma and discrimination. The strategy should identify and implement anti-stigma initiatives as part of broader community preparedness work.

Nepal

Lalitpur, Chitwan, Morang, Kaski, Rupandehi, Makwanpur and Dang districts

Injecting new ways of working: creating community awareness through integrated VCT services in rural Nepal

The context

Nepal, like other countries in the region, has a concentrated HIV/AIDS epidemic. Recent HIV prevalence figures indicate that whilst the general prevalence rate is 0.52 per cent,⁶ significantly higher rates have been recorded in vulnerable populations.

40 per cent of injecting drug users in urban centres in Nepal were recorded as being HIV positive in 1999.⁷ In 2001, 15.7 per cent of female sex workers in the Khatmandu Valley were found to be HIV positive,⁸ and in 2005 it was estimated that in the capital city of Nepal, 3.9 per cent of men who have sex with men (MSM) were HIV positive.⁹

Whilst injecting drug use is the primary mode of transmission, female sex work and the migration of men out of Nepal to seek work opportunities are two other significant factors driving the HIV epidemic in Nepal.

The Maoist insurgency, and the resultant conflict and displacement of communities, coupled with economic hardship, are increasing vulnerability to HIV and exacerbating its impact. In displaced communities it is estimated that between 42% and 60% of the population live below the poverty line.¹⁰

There is growing evidence that conflict-related displacement, migration and the breakdown of social structures and family systems have increased HIV infections among migrant labourers (estimated at 1.5 million) and their female partners. Greater

numbers of women are now pressured to augment family income through occasional sex work because of irregular financial support from migrant husbands.

Current health infrastructure and systems are clearly inadequate to address HIV prevention and treatment services. There is extremely low service coverage for most-at-risk populations due largely to lack of service integration and referral systems. Service delivery to conflict affected and geographically inaccessible rural areas is also seriously constrained.

In direct response to these challenges, the Family Planning Association of Nepal (FPAN) implemented a programme of HIV service development that included the integration of Voluntary Counselling and Testing within its existing sexual and reproductive health services.

To which needs did the project respond?

Outside the Nepalese capital of Kathmandu, access to HIV services is extremely poor. The concentration of the HIV epidemic among injecting drug users, sex workers and men who have sex with men, and the stigma associated with all of these groups, has made HIV service delivery difficult at the local level.

Despite extremely high rates of HIV among injecting drug users, very few HIV specific services have been developed to target them. Where they do exist, such as at Nepal's needle exchange programme (the

first of its kind in the developing world), limited coverage means that their impact on HIV transmission has also been limited.

Due to their highly marginalized status in society, female sex workers in Nepal have limited access to information about reproductive health and safe sex practices. Cultural, social, and economic constraints bar female sex workers from negotiating condom use with their clients, and/or from obtaining legal protection and medical services.

Although accurate data on sex between men are not available, a recent report suggests that MSM activity in Nepal is not different from MSM activities in the rest of the South Asia region. Current HIV prevalence among urban based men who have sex with men is 4 per cent, and knowledge of safer sex and condom use is low in this community.

The Family Planning Association of Nepal (FPAN) identified the potential to fill at least some of the HIV services gap for these groups by developing Voluntary Counselling and Testing services in its own clinics outside Kathmandu.

How have these needs been addressed?

The Family Planning Association of Nepal's HIV Programme started in early 2000. It initially focused on awareness raising and the diagnosis and treatment of STIs as part of its routine sexual and reproductive health services. The decision to offer

FPAN's HIV programme initially focused on awareness raising of HIV and AIDS and the diagnosis and treatment of STIs as part of its routine sexual and reproductive health services.



Voluntary Counselling and Testing services therefore represented a significant change in the extent of the Family Planning Association of Nepal's HIV focused work.

A decision was made to provide VCT services at seven FPAN clinics, in the districts of Lalitpur, Chitwan, Morang, Kaski, Rupandehi, Makwanpur and Dang. The decision to launch VCT clinical services at these sites was made on the basis of estimates of target population numbers, together with an assessment of the gaps in existing service provision. The seven sites all represented areas of high demand and low service.

This project was the Family Planning Association of Nepal's first major HIV specific service delivery. The principal focus of the project was on developing the organization's institutional capacity to provide Voluntary Counselling and Testing services.

Training

Most FPAN staff had little or no experience of seeing clients for HIV related issues. The

orientation and training of FPAN staff was a key component of the Association's efforts to scale up HIV services through its seven sites.

Training included a 10-day study tour for 14 FPAN managerial and technical staff, visiting VCT centres in Lucknow run by the Family Planning Association of India. Staff nurses and paramedics received VCT counselling training and ongoing professional support, in addition to follow up training. Training was also provided to laboratory technicians.

An orientation programme for branch managers, volunteers and staff members was also conducted. This provided a general overview of the project and was designed to help elicit organizational support for the project.

Infrastructure development

A range of infrastructure related programming issues needed to be addressed in order to meet the project's service targets. These included accessing

rapid HIV test kits, monitoring the quality of the HIV testing, purchasing the necessary equipment for the refurbishment of the clinic laboratories to enable them to implement Voluntary Counselling and Testing, establishing organizational protocols related to Voluntary Counselling and Testing, setting up data capturing mechanisms, and implementing agreed monitoring and evaluation tools.

Increasing community awareness of VCT

A series of activities were aimed at increasing community awareness of HIV/AIDS, and of the benefits of Voluntary Counselling and Testing in particular.

Most of the community based VCT awareness-raising activities were incorporated into the Family Planning Association of Nepal's existing outreach activities.

VCT awareness sessions were organized to provide various groups with information about HIV and the availability of VCT at FPAN clinics. Sessions for community leaders, transport workers and school students were organized in the project district branches during the programme year.

In addition to community-based meetings, other methods of communication were used. Information on Voluntary Counselling and Testing was produced in the form of a pamphlet, which was supplemented, in at least one region, by a more specific one on the services offered at a particular clinic. Street drama was used to raise general awareness, and condom blowing competitions were held in a number of districts. A five-part TV serial focusing on Voluntary Counselling and Testing and HIV was also produced and aired on national television as part of the project.



Youth volunteers perform street drama raising awareness about HIV and AIDS and stigma and discrimination.

What challenges were identified?

In the course of this project the following challenges were identified:

Focusing on target populations

Because much of the Family Planning Clinic of Nepal's HIV and VCT specific awareness raising activities were incorporated into existing outreach methods, most of the awareness raising failed to target vulnerable and marginalized groups.

The high rates of HIV infection amongst sex workers, injecting drug users, men who have sex with men, and mobile labourers, coupled with the services gap for these groups, showed an urgent need for the development of VCT services, but this wasn't adequately reflected in the nature and type of outreach activities undertaken.

Awareness-raising on Voluntary Counselling and Testing among the general population is important and ought to continue, but the lack of specific targeted

outreach activities reflected the challenges for an organization relatively new to HIV and to working with marginalized groups.

Post-test support and services

The emphasis of FPAN's VCT counsellors was on providing clients with one pre- and one post-test counselling session. Limited planning was conducted on what care and support services FPAN clinics could provide to clients beyond the HIV post-test counselling session.

The Family Planning Association of Nepal learned from providers of Voluntary Counselling and Testing outside Nepal that offer additional counselling sessions, facilitate support groups for people newly diagnosed with HIV, provide treatment of opportunistic infections and access to


ARVs, and link their VCT services with their STI treatment services.


The fact that support services for HIV positive people are largely non-existent at the local level further highlighted the need for FPAN to facilitate and support accessible post-test support services locally.


Stigmatization and discrimination

The significance and impact of stigmatization and discrimination on attitudes to HIV at risk groups, and VCT in particular, was not sufficiently understood at the outset of the project. HIV-related stigma and discrimination contributes to HIV vulnerability and inequalities in the provision of HIV services, and is a principal barrier to the uptake of HIV testing – it must therefore be a key feature of VCT programming.

How are these challenges being addressed?

 In response to the challenges identified, the Family Planning Association of Nepal is developing a more comprehensive strategy for working directly with vulnerable populations. This strategy includes developing partnerships with community-based organizations representing or already working with groups such as sex workers, men who have sex with men and injecting drug users.

 Plans have also been developed to improve post-test support and referral of people living with HIV to other services following post-test counselling. Consideration is also being given to what other services the Family Planning Association of Nepal itself can provide to people living with HIV.

 A stigma and discrimination strategy has been developed by the Family Planning Association of Nepal and will be implemented as part of the next stage of the project. The strategy involves internal and external activities aimed at increasing awareness of HIV with a specific anti-stigma orientation.



FPAN Itahari VCT clinic.



FPAN member of staff outside clinic displaying price list for laboratory services.



FPAN clinic services price list.

Issues to consider

When developing a project aimed at establishing VCT services for the first time, including by integrating them in to existing sexual and reproductive health services, planners should:

✓ **Identify how existing services relate to the HIV needs of clients, and what new services must be developed to meet those needs**

It is critical that organizations planning to provide Voluntary Counselling and Testing identify clearly how their existing sexual and reproductive health programming can be used to respond effectively to the HIV related needs of their clients. This understanding should be developed across the entire staff pool.

A clear sense of how existing services need to be changed or reconfigured to meet the specific demands of HIV prevention, treatment and care is also required. When this has been developed it should form the basis of an action plan for service redevelopment.

✓ **Provide HIV-specific training and support to staff**

Organizations looking to provide any HIV-related service, including Voluntary Counselling and Testing on the back of their existing sexual and reproductive

health programming, should identify the training and support that staff will need in order to take on this new area of work.

✓ **Develop clear protocols with other service providers**

Sexual and reproductive health organizations looking to increase their availability of Voluntary Counselling and Testing services need to work with other service providers to ensure a continuum of care for their clients affected by HIV.

Developing a clear understanding of how your organization as a sexual and reproductive health service provider will work with existing HIV service providers is very important. These existing service providers include laboratories, medical centres and hospitals and community-based organizations, such as organizations of people living with and affected by HIV.

✓ **Develop awareness and trust among communities most affected by HIV**

Developing awareness of the service you want to offer among communities most affected by HIV will be essential to ensure service utilization. The sustainability of those relationships and the confidence of the community in your service will only be secure if that relationship is built on trust.

Working to build partnerships with organizations representing vulnerable or highly affected communities, and ensuring that they are part of the service's development and ongoing quality assurance, is essential.

✓ **Provide support and services to clients who test positive**

Organizations that provide Voluntary Counselling and Testing services have a responsibility for the follow up care and support of clients who test positive. This includes providing post-test counselling and access to further psycho-social and medical assistance, including access to HIV treatment.

Although sexual and reproductive health providers may decide not to offer all these services themselves, it is important to ensure that these services are available, accessible and affordable, and have clear referral pathways so clients can access these services easily.

In addition to these issues which are specific to scaling up in a particular context, the self-assessment tool included in this document, aimed at NGOs considering providing Voluntary Counselling and Testing, identifies and describes a range of standards which can help organizations measure their readiness to provide VCT.

Footnotes

- 1 UNAIDS/WHO Global HIV/AIDS Database, *Cambodia Epidemiological Fact Sheet*, December 2006
- 2 *Ibid*
- 3 *STI Sentinel Survey 2005*, Cambodian National Centre for HIV/AIDS. Available at: <http://www.nchads.org/publication.php>
- 4 UNAIDS, 2004 Report on the Global AIDS Epidemic, July 2004.
- 5 UNAIDS/WHO Global HIV/AIDS Database, *Uganda Epidemiological Fact Sheet*, December 2006
- 6 Ministry of Health, HMG Nepal, March 2004, cited on the USAID website's health profile of Nepal. [www.usaid.gov]
- 7 Karki (2000), cited in: National Centre for AIDS and STD Control, Ministry of Health, HMG Nepal. (March 2004). *National Estimates of Adult HIV/AIDS Infections, Nepal 2003*. Page 9.
- 8 National Centre for AIDS and STD Control, Ministry of Health, HMG Nepal. (March 2004). *National Estimates of Adult HIV/AIDS Infections, Nepal 2003*. Page 5.
- 9 UNAIDS. (May 2006). *2006 Report on the global AIDS epidemic*. Annex 2, Page 516. [www.unaids.org]
- 10 Richoi Associates. (December 2000). *Situational Analysis of HIV/AIDS in Nepal*. Page 1.

About IPPF

The International Planned Parenthood Federation (IPPF) is a non-governmental organization. It currently represents a network of 150 national associations that are dedicated to improving the sexual and reproductive health and rights of people in 179 countries worldwide.

The goal of IPPF's work in HIV and AIDS is to reduce the global incidence of HIV and to protect the rights of people infected and affected by HIV and AIDS.

We are working to:

- reduce the social, religious, cultural, legal, political and economic barriers that make people vulnerable to HIV
- increase access to interventions for the prevention of STIs and HIV and AIDS through integrated, gender-sensitive sexual and reproductive health programmes
- increase access to care, support and treatment for people infected and support for those affected by HIV and AIDS
- strengthen the programmatic and policy linkages between sexual and reproductive health and HIV and AIDS

The number of IPPF's Member Associations providing HIV-related services continues to grow. Critically this includes efforts to increase access to Voluntary Counselling and Testing (VCT), as well as to improve its quality.

About the Japan Trust Fund for HIV/AIDS

The Japan Trust Fund for HIV/AIDS (JTF) was established in 2000 to support and realize the goals of Japan's Okinawa Infectious Disease Initiative (IDI). The aim of the Fund is to assist IPPF Member Associations, working individually or as a group, to strengthen their institutional capacity and managerial skills, enabling them to carry out effective and innovative HIV/AIDS prevention programmes.

In 2006 JTF adopted a new framework for action that is in keeping with the goals of IPPF's Strategic Framework. The aims of the IPPF Japan Trust Fund are:

- to reduce the global incidence of HIV and AIDS and promote the full protection of the rights of people infected and affected by HIV and AIDS
- to increase public awareness about partnership between IPPF and Japan under JTF in order to respond to human security challenges, including HIV and AIDS

The expected results of the new IPPF-JTF initiative include:

- strengthened links between IPPF Member Association projects and Japan's Official Development Assistance (ODA) programmes to respond to HIV/AIDS in selected countries
- increased ability of IPPF Member Associations to respond to the challenges of the HIV epidemic and post-conflict and post-natural disaster situations in selected countries
- increased public awareness about partnership between Japan and IPPF and enhanced overall profile of Japan's ODA to respond to human security issues including HIV/AIDS
- increased impact and enhanced accountability of JTF projects in most affected countries in Africa and Asia
- more comprehensive responses to HIV/AIDS offered by IPPF Member Associations under JTF initiatives

Since the establishment of the JTF in 2000 and up until 2006, 38 Member Associations in Africa and Asia have received support from the fund to implement a total of 99 projects. Of these, 14 projects have helped Member Associations to establish or increase Voluntary Counselling and Testing services.

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Cover photo: IPPF/Chloe Hall/Gambia

IPPF is a global service provider and a leading advocate of sexual and reproductive health and rights for all. We are a worldwide movement of national organizations working with and for communities and individuals.

IPPF works towards a world where women, men and young people everywhere have control over their own bodies, and therefore their destinies. A world where they are free to choose parenthood or not; free to decide how many children they will have and when; free to pursue healthy sexual lives without fear of unwanted pregnancies and sexually transmitted infections, including HIV. A world where gender or sexuality are no longer a source of inequality or stigma. We will not retreat from doing everything we can to safeguard these important choices and rights for current and future generations.

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