

NATIONAL AIDS PROGRAMME MANAGEMENT

**MODULE 6
IMPLEMENTATION OF HIV PREVENTION,
CARE AND TREATMENT STRATEGIES**

**SUBMODULE 3
HIV COUNSELLING AND TESTING**



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National AIDS Programme Management

A Training Course

Submodule 6.3: HIV counselling and testing



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HIV counselling and testing

LEARNING OBJECTIVES

After completing this submodule, participants will be able:

1. To assess current HIV counselling and testing services and their linkages to prevention, care and treatment services.
2. To describe the range of service models for providing HIV counselling and testing.
3. To explain the key components for scaling up of HIV counselling and testing services.
4. To describe the process for strengthening the capacity of mainstream health services to integrate HIV counselling and testing.

INTRODUCTION

Since the development of the HIV antibody test in 1985, HIV testing has been an essential part of the response to HIV. It has been used to diagnose individuals, to track the progress of the epidemic and to secure blood supplies. The combination of HIV counselling and testing has been used as an intervention to enable individuals to know their HIV status and to channel them into care, support and treatment services. It has also provided people with an opportunity to assess their risk, to gain information about HIV transmission and to determine ways to avoid HIV transmission in the future.

As an intervention, HIV counselling and testing aims to encompass both prevention and care outcomes. It is intended to be both a pathway to care for people who test HIV-positive and a focus for HIV prevention, irrespective of whether people test HIV-positive or -negative.

The wider availability of effective HIV treatment and interventions to prevent mother-to-child transmission (MTCT) increases the importance of counselling and testing as a central strategy in the response. Despite this fact, the majority of people with HIV in the world are still unaware of their status. The wider availability of HIV treatment provides a strong case for scaling up HIV counselling and testing interventions.

Submodule 6.3 • HIV counselling and testing

This submodule focuses on HIV counselling and testing as a key intervention for the scaling up of HIV prevention, care and treatment. It outlines the components of an HIV counselling and testing programme and provides strategies for the greater integration of HIV counselling and testing into health services, including a strong emphasis in some cases on provider-initiated counselling and testing. It sets out simple recording and reporting strategies and describes the principles that can guide quality assurance of the counselling and testing programme. The use of HIV testing in HIV surveillance is covered in Module 9 on Strategic Information.

OBJECTIVE 1: To assess current HIV counselling and testing services and their linkages to prevention, care and treatment services

Most people with HIV in the world do not know their status. HIV counselling and testing should be accessible to the people who need it, and should be linked directly to prevention, care and treatment. Even in areas where counselling and testing has been considerably expanded, many of those presenting for HIV counselling and testing are lost to follow up, usually because stand-alone counselling and testing services have not provided them with a clear bridge to ongoing prevention, care and treatment.

EXERCISE A

(Country group work followed by intercountry group discussion)

In country groups, answer the following questions about your country: (You can answer the questions below or prepare a map/diagram that summarizes current access to counselling and testing services.)

1. How do people currently access HIV counselling and testing – what kinds of models are available? Describe

2. What is the geographical coverage of counselling and testing services?

3. Which populations or groups have a high need for HIV counselling and testing services, but do not currently access them?

4. What strategies would you propose for increasing access to HIV counselling and testing services for these groups?

5. What generally happens to a person who tests HIV-negative in one of your current counselling and testing services? (Try to present a range of pathways and estimate the proportion of people who follow each pathway.)

6. What generally happens to a person who tests HIV-positive in one of your current counselling and testing services? (Try to present a range of pathways and estimate the proportion of people who follow each pathway.)

Inform your facilitator when you are ready for intercountry group discussions.

OBJECTIVE 2: To describe the range of service models for providing HIV counselling and testing

The nature of the services developed for HIV counselling and testing should be shaped by a clear understanding of the aims and objectives of HIV counselling and testing and what are the expected outcomes of the programme intervention. HIV testing is a diagnostic modality that determines whether a person has been exposed to HIV or not. However, HIV counselling and testing serves several other important functions. It assists HIV-negative people to learn about HIV transmission and to take steps to avoid HIV infection. It guides HIV-positive individuals to prevent further HIV transmission and to inform people in their network who may have been at risk. Most importantly, it helps them to access the treatment, care and support services they need.

For individuals, HIV counselling and testing offers the following opportunities:

Promotes and facilitates behaviour change	Eases acceptance of serostatus and coping	Provides a pathway to ART, OI prophylaxis and treatment, and early medical care	Provides a focus for health-seeking behaviours and lifestyle changes to promote health and well-being	Provides access to interventions for preventing mother-to-child transmission (MTCT)
HIV counselling and testing				
Normalizes HIV and AIDS and reduces stigma	Facilitates referral to social and peer support	Increases access to family planning services, including condom provision	Promotes planning for the future – care of children, preparation of a will	

Source: Adapted from Scaling up HIV testing and counselling services: a toolkit for programme managers. Geneva, WHO, 2005.

It is important to reflect on these desired outcomes when planning counselling and testing services. The primary purpose of HIV counselling and testing services is not to count and record the number of people diagnosed with HIV. It is to provide prevention, care and treatment services to people in need.

POLICY

The practice of HIV counselling and testing needs to be guided by a national policy. While a diagnosis of HIV can lead to improvement in health by providing a person with access to care, support and treatment, it can also result in considerable stigma and discrimination. The manner in which people are diagnosed with HIV therefore needs to be regulated by a policy to ensure that people are not exploited or inadvertently harmed.

Having a national policy in place also preserves the public health benefits of the HIV counselling and testing programme. It provides people with the confidence to present themselves for HIV testing. This is particularly important for people from marginalized groups, who fear the stigma and discrimination that might result from a diagnosis of HIV infection.

A national HIV counselling and testing policy usually contains a set of principles.

- That all HIV testing will be voluntary (that the individual's consent to be tested will always be sought – except for testing donated blood in rare circumstances that are set out in the policy).
- That HIV testing will be accompanied by the provision of counselling and information.
- That people diagnosed with HIV will be referred to a range of care, support and treatment services.
- That test results will be confidential (with any information about disclosure indicated clearly in the policy and with penalties for people who breach confidentiality).
- That the quality of HIV testing will be maintained by a system of quality assurance.
- That people who are diagnosed with HIV will not be discriminated against.

The policy should clearly state that testing of individuals as a part of counselling and testing needs to be kept separate from the testing that is done as a part of surveillance or blood safety or research.

WHO/UNAIDS have recently released a policy clarification statement on HIV counselling and testing (August 2006) that reinforces the basic fundamentals.

- Not enough people know their HIV status.
- Access to HIV prevention, care, support and treatment services is being hindered by the low uptake of HIV counselling and testing services.
- The reach of counselling and testing services needs to be rapidly expanded.
- Provider-initiated counselling and testing models are appropriate in some settings and can assist in uptake.
- Provider-initiated HIV testing should be voluntary, confidential, carried out with consent and accompanied by counselling.
- These requirements are often referred to as the 3 C's.

The 3 C's

- Confidentiality
- Consent
- Counselling

WHO and UNAIDS continue to strongly endorse the expansion of counselling and testing as a key HIV prevention and care strategy.

Provider-initiated counselling and testing is the norm in South-East Asia. Very few people in Asian countries are self-referred.

COUNSELLING AND TESTING MODELS

HIV counselling and testing is provided in various settings using a range of different models.

Voluntary counselling and testing (VCT) – is usually *initiated by a client*, and takes place in a stand-alone VCT centre, or in a service administered by a health service or nongovernmental organization (NGO) as part of a broader range of services.

Provider-initiated counselling and testing – refers to a range of models under which a health provider recommends HIV testing to clients. This might be a strategy used in sexually transmitted infection (STI) clinics, TB clinics or antenatal clinics in areas where the HIV prevalence is high. Testing is still voluntary and confidential, and should be accompanied by information and counselling.

Clients are informed that HIV testing is available and they make a decision to test or not to test. There are different approaches to provider-initiated counselling and testing. Some rely on the client to actively opt for HIV testing. There are other models which inform clients that everyone who attends the service will undergo HIV testing as part of routine laboratory tests unless they specifically refuse.

HIV testing is also carried out as a tool for differential diagnosis in cases where a person presents with an illness that may be related to HIV infection or associated with AIDS. This is sometimes called “diagnostic HIV testing” and requires to be accompanied by consent, counselling and arrangements to protect confidentiality.

There has also been much debate about what sort of counselling needs to accompany HIV testing. Traditional VCT models have encouraged the use of individual pre- and post-test counselling for all people considering or undertaking HIV testing. Some services have argued against individual pre-test counselling interviews due to the lack of sufficient human resources. They conduct group pre-test counselling by providing printed information or videos in waiting rooms and carry out post-test counselling only for people diagnosed as HIV-positive.

The important points to remember when deciding on the type of counselling to offer are:

- people need to be able to freely consent, or freely refuse, without pressure from peers or health workers;
- HIV counselling and testing can be a prevention activity – therefore, people need to gain a clear understanding about how HIV is transmitted and about how they can avoid HIV from this exposure;
- people whose behaviour places them at risk, but who are diagnosed HIV-negative, need to be counselled about avoiding HIV in the future and referred to HIV prevention services specific to their risk behaviour – sex worker outreach, drug user services, etc.;
- people diagnosed as HIV-negative need to understand the window period and the importance of returning for follow-up testing if they have recently been at risk and to practise safer behaviours in future; and
- people diagnosed as HIV-positive need support and information so that they can access ongoing prevention, care, support and treatment services.

The table on pages 14–16 summarizes the different models for delivering HIV counselling and testing services and the advantages and disadvantages associated with each model. This material is covered in more detail in the WHO Regional Office for South-East Asia training materials on HIV counselling and testing.

COUNSELLING AND TESTING PROCEDURES IN DIFFERENT SETTINGS

Different clinical settings require different approaches to HIV counselling and testing, but these should be clearly outlined by the national programme to ensure consistency and quality. A set of algorithms can be developed for each setting for people who present themselves for counselling and testing in these settings.

Different settings require the use of different testing assays – depending on the geographical location of the counselling and testing service, the purpose of the testing and the needs of the population being tested. The national programme has a role in determining which assays and procedures are appropriate for each setting. A number of different tests (biological assays) are available for HIV testing. None is 100% accurate, so they must be used in combination to give a more accurate result. The national programme is required to set guidelines for the use of different assays under diverse circumstances. AIDS Programme Managers (APMs) are provided with guidelines from the WHO Regional Office for South-East Asia for HIV diagnosis and a comprehensive guide to selecting and using simple/rapid test assays that can be used to determine national protocols.

Here is a sample algorithm for counselling and testing.

Algorithm for counselling and testing

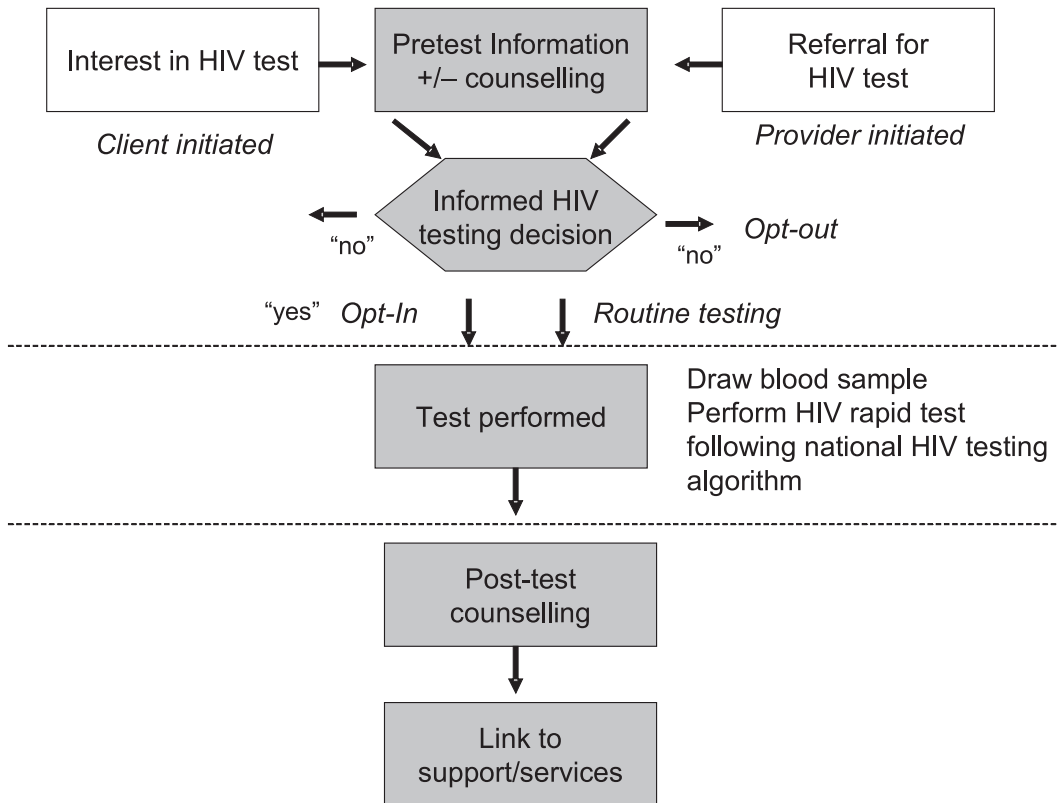


Table 1. Models for delivering HIV counselling and testing

Model	Description	Advantages	Disadvantages
Free-standing VCT service	<ul style="list-style-type: none"> • A stand-alone VCT centre or clinic • Staff specifically trained in and allocated to HIV counselling • Sometimes run by NGOs • Refers people on to prevention and care services 	<ul style="list-style-type: none"> • Anonymous service – can be more private than a general clinic • Can be located near populations at risk • Flexible opening hours • Can be staffed by people from the target population • Can host PLHA support groups 	<ul style="list-style-type: none"> • Expensive if you want to achieve geographical coverage • Can be stigmatizing as it is identified as an HIV service • Staff burnout from high caseload of PLHA
Integrated into the medical services	<ul style="list-style-type: none"> • Counselling and testing offered to people attending for other reasons – local primary care clinics • Counselling done by existing clinic staff 	<ul style="list-style-type: none"> • Lower cost than stand-alone centres • May have greater reach • Easier to scale up than stand-alone clinics • Promotes access for women who may not attend stand-alone clinics • Does not rely entirely on the client determining the need for testing and seeking stand-alone services 	<ul style="list-style-type: none"> • Result included in clinical notes – can lead to loss of privacy, stigma, discrimination • Staff may not be trained in HIV counselling • Busy clinics, little time to spend with a newly diagnosed person • Lack of knowledge of referral options
Integrated into family planning services	<ul style="list-style-type: none"> • Building HIV counselling and testing into family planning services • Combined with STI, reproductive health, MCH care • Counselling done by existing staff 	<ul style="list-style-type: none"> • Services and systems already in place • Good way to reach women 	<ul style="list-style-type: none"> • Limited access for men • Limited access for young people, unless pregnancy is an issue • Increases workload of already busy staff

Model	Description	Advantages	Disadvantages
Integrated with antenatal care	<ul style="list-style-type: none"> • Provision of HIV counselling and testing as part of antenatal care • Directly linked to PMTCT services • Counselling done by specifically trained staff and/or existing staff 	<ul style="list-style-type: none"> • Opportunity to prevent HIV transmission to the child • Can form normalized part of comprehensive care 	<ul style="list-style-type: none"> • Not as useful if pregnant women are not a population at high risk in a country's epidemic • Can result in the woman being blamed for HIV in the family – increased stigma and discrimination • Limited access for men and for couple counselling
Integrated with STI services	<ul style="list-style-type: none"> • Counselling and testing offered to people who attend STI services • Counselling done by specifically trained staff and/or existing staff 	<ul style="list-style-type: none"> • Safer sex counselling reduces transmission of STI and HIV • High detection rate – people with STIs at greater risk of HIV infection and transmission • Systems in place for partner notification, disclosure • Staff already trained in STI counselling 	<ul style="list-style-type: none"> • Limited access for asymptomatic people • Some people fear the stigma of attending STI services
Integrated with TB services	<ul style="list-style-type: none"> • Counselling and testing offered to people diagnosed with TB • Counselling done by specifically trained staff and/or existing staff 	<ul style="list-style-type: none"> • High detection rates • Better TB treatment outcome can be achieved if you know the patient has HIV-related TB • Structures already in place for good geographical coverage, follow up and adherence 	<ul style="list-style-type: none"> • Does not reach asymptomatic people • TB clinic staff might feel that offering HIV counselling and testing has a negative effect on people availing TB services

Table 1. Models for delivering HIV counselling and testing (cont.)

Model	Description	Advantages	Disadvantages
Private sector	<ul style="list-style-type: none"> HIV testing through private pathology services, laboratories and clinics 	<ul style="list-style-type: none"> Wide coverage Can be anonymous, more confidential 	<ul style="list-style-type: none"> Usually diagnostic only, consent rarely taken and counselling or information rarely provided May not follow guidelines on test assays and algorithms Excludes the poor and marginalized No follow up or referral networks
Mobile/community outreach	<ul style="list-style-type: none"> HIV test offered as part of a mobile service 	<ul style="list-style-type: none"> Good for marginalized groups who do not trust health services Anonymous Can refer people to other services 	<ul style="list-style-type: none"> May be difficult to provide follow up in the days after a result is given Confidentiality is of concern in these settings Resource intensive—only one person seen at a time to maintain confidentiality

Source: HIV counselling and testing training curriculum, Module 5: Models of VCT service delivery. New Delhi, WHO/SEARO, 2004.

EXERCISE B

(Country group work followed by intercountry group discussion)

The algorithm above represents a client's movement through the various parts of the counselling and testing process in a stand-alone service, and what decisions are to be made at each point by the person providing the service.

In country groups, take a different setting, for example:

- a prevention of mother-to-child transmission (PMTCT) service incorporated into an antenatal care clinic, or
- an HIV counselling and testing service incorporated into an STI clinic, or
- injecting drug users (IDUs) attending a primary care clinic.

Choose a group or setting and develop an algorithm that shows the decisions that are made by the persons and the service at each point in the HIV counselling and testing process.

Inform your facilitator when you have finished your algorithm and are ready for intercountry group discussions.

OBJECTIVE 3: To explain the key components for scaling up of HIV counselling and testing services

Scaling up HIV counselling and testing requires strategic planning, technical advice and the cooperation of a range of groups and sectors. WHO has produced a toolkit for APMs that details the scaling-up process and includes references to technical materials that provide assistance and guidance.

The components of the scaling-up process include:

1. Determining the policies that will guide counselling and testing services and advocating for national policies that support a public health approach.
2. Mobilizing the community to create a supportive environment for increased testing – increasing the demand for counselling and testing, and reducing stigma and discrimination experienced by people living with HIV/AIDS (PLHA) and people assumed to be at risk of HIV.
3. Determining which commodities will be purchased and how their continued availability will be managed.
4. Determining where HIV counselling and testing will be provided, setting standards and guidelines and monitoring compliance with these, assisting services to integrate HIV counselling and testing.
5. Having a skilled workforce to carry out HIV counselling and testing by providing training, setting appropriate staff levels, determining who will carry out counselling and testing tasks, and monitoring quality.
6. Developing systems to coordinate and manage the counselling and testing programme.
7. Determining costs and securing finances for scaling up the services.

This process can be assisted by establishing a national advisory committee comprising:

- health service planners from national ministry of health, particularly those coordinating primary care, maternal and child health (MCH) and STI services;
- people with expertise in HIV counselling and testing;
- people from national AIDS programme;
- representatives of PLHA groups;
- people from health worker training institutions;
- laboratory services managers;
- people from procurement and logistics departments; and
- NGOs providing health services to the community.

OBJECTIVE 4: To describe the process for strengthening the capacity of mainstream health services to integrate HIV counselling and testing

The scaling up of HIV counselling and testing needs to be strategic and should be based on information that identifies the gaps in access for populations that are of the highest priority in the response to AIDS for the country.

One clear way to expand access to HIV counselling and testing services is by providing it through a range of existing health services – primary care clinics, antenatal care clinics, STI clinics and so on. Adding HIV counselling and testing to the array of services that a clinic or health service provides requires careful planning. It is not a simple matter of deciding to carry out HIV tests. There are complex issues to consider. One of the first issues to consider is what will happen to people diagnosed with HIV? Who will counsel them? To what extent will their privacy and confidentiality be preserved? Who will help them to discuss their result with their partner and family? How will they find their way to ongoing HIV care, support and treatment services?

Health services planning to integrate HIV counselling and testing into their services should consider the above questions, develop policies and procedures, and satisfy themselves that their staff has the necessary skills and knowledge to provide this service before they start HIV counselling and testing. Services also need to decide how samples will be tested, how supplies will be procured and managed and how quality of results will be maintained.

Steps to follow for strengthening the provision of HIV counselling and testing through the existing health services

Step 1: Identify

Which services would be suitable and where for the incorporation of HIV counselling and testing?

Key questions

- Who is at risk, their HIV status and their access to existing HIV counselling and testing services?
- What services do these people or populations currently use?

- What skills and resources already exist in these health services that could be brought to use in HIV counselling and testing?

The obvious places to consider are STI clinics, maternal and child health clinics, primary health-care centres and services that already target specific populations, such as NGOs delivering services to sex workers, IDUs and men who have sex with men (MSM). It is important to start with the services that currently serve the people you most want to access.

Step 2: Decide

How will HIV counselling and testing be integrated into the service?

Key questions

- Will HIV testing be offered during the consultation with the doctor?
- How will pre-test counselling be given?
- How will the person's consent be obtained?
- Where will the samples be tested?
- What testing assays and algorithm will be used?
- Will the client be charged?
- Who will be responsible for giving the result?
- Where will counselling take place – are there private spaces available?
- Who will provide post-test counselling?
- What about partner notification?
- How will confidentiality be preserved?
- How can it be ensured that the client has been linked to the necessary services?

Services need to develop a set of policies and procedures, based on the national HIV counselling and testing policy, which clearly explains to the staff and clients how HIV counselling and testing will be carried out.

Step 3: Decide whose capacity needs to be strengthened

Once the personnel who will be involved in the HIV counselling and testing have been identified, what are their capacity development needs?

Key questions

- Who will carry out HIV counselling?
- What are their current skills?
- What are their training needs?

- Which other staff members require training – clerical staff, records staff, laboratory staff?
- Who will conduct the training – NGO, health worker, training institution?

Look back at the gaps that you identified in Exercise A in this submodule and think about how answering the above questions might help fill those access gaps.

EXERCISE C

(Country group work followed by intercountry group discussion)

Country group brainstorming exercise: On a sheet of flip chart paper, come up with a set of strategies for a significant expansion in access to HIV counselling and testing in your country which particularly addresses the gaps in access that you identified in Exercise A.

Inform your facilitator when you are ready for intercountry group discussions.

RESOURCES

1. http://www.who.int/hiv/toronto2006/WHO-UNAIDSstatement_TC_081406_dh.pdf.
2. <http://www.searo.who.int/EN/Section10/Section18/Section1562.htm>.
3. *Guidelines for HIV diagnosis and monitoring of antiretroviral therapy*. New Delhi, WHO/SEARO, December 2005 (http://www.searo.who.int/LinkFiles/Publications_HLM-382Rev1.pdf).
4. *HIV simple/rapid assays: operational characteristics: Phase 1*. Geneva, WHO, 2004 (http://www.searo.who.int/LinkFiles_Prevention_and_Control_Operational_HIV_testinghivrep14.pdf).
5. *Scaling up HIV counselling and testing services – a toolkit for programme managers*. Geneva, WHO, 2005. (<http://www.who.int/hiv/pub/vct/toolkit/en/index.html>).
6. *Handout 4, WHO/SEARO HIV counselling and testing training: the role of VCT in HIV prevention and care* (http://www.searo.who.int/LinkFiles/Training_Materials_voluntary-module1-5.pdf).
7. *Scaling up HIV counselling and testing services: a toolkit for programme managers*. Geneva, WHO/UNAIDS, 2005 (http://www.who.int/hiv/pub/vct/counsellingtesting_toolkit.pdf).
8. *Guidance on provider-initiated HIV testing and counselling in health facilities*. WHO/UNAIDS, Draft, November 2006.
9. *Increasing Access to HIV testing and counselling*, WHO. 2002.
10. *The Right to Know – new approaches to HIV testing and counselling*. WHO, 2003.
11. *HIV testing and counselling – the gateway to treatment, care and support*. WHO, 2003.
12. WHO & UNAIDS Secretariat Statement on HIV testing and counselling, August 2006.
13. *HIV counselling and testing training curriculum, Module 5: Models of VCT service delivery*. New Delhi, WHO/SEARO, 2004.



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