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Scaling Up HIV Testing and Counselling in Asia and the Pacific

Report of a Technical Consultation
Phnom Penh, Cambodia
4-6 June 2007

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Contents

Acronyms

ANC	Antenatal care
ART	Antiretroviral therapy
ICTC	Integrated Counselling and Testing Centres
IDU	Injecting drug user
MARP	Most-at-risk populations
MSM	Men who have sex with men
PITC	Provider initiated testing and counselling
PLHIV	People living with HIV
PMTCT	Prevention of mother-to-child transmission
PPTCT	Prevention of parent-to-child transmission
STI	Sexually transmitted infection
SW	Sex worker
TB	Tuberculosis
VCCT	Voluntary confidential counselling and testing
VCT	Voluntary counselling and testing

Executive Summary

In response to concerns over low coverage of HIV testing and counselling in the Asia Pacific region, a "Joint WHO/UNICEF/UNAIDS technical consultation on scaling up HIV testing and counselling in the Asia Pacific" was held in Phnom Penh, Cambodia from 4 to 6 June 2007. The aim of the meeting was to discuss how to scale up HIV testing and counselling services, discuss core public health approaches, ethical principles and human rights values to guide the expansion of HIV testing and counselling, and identify and agree on key actions for follow-up at the regional and country level for policy and programme implementation.

The percentage of the adult population who have received HIV testing in the region is estimated to be around 0.1%.[1] Increasing the coverage of testing and counselling services can enhance access to AIDS treatment, improve treatment outcomes and expand HIV prevention, including prevention of mother-to-child transmission. However, any scale-up of testing must be done in strict adherence to the principles of voluntary participation, confidentiality, counselling, informed consent, and access to services for those in need.

Participants recognized and agreed that there is an urgent need to scale up access to HIV counselling and testing in countries of the region as a means of enhancing access to comprehensive HIV prevention, care and treatment. Existing models of voluntary counselling and testing (client-initiated HIV testing and counselling) need to be strengthened, scaled up and complemented by approaches that can best fit the local epidemiological and social context and build on the potential of health services to offer HIV counselling and testing (provider-initiated HIV testing and counselling). A set of key conclusions and recommendations was agreed on by the consultation participants.

From 4 to 6 June 2007, 73 participants from 13 countries met in Phnom Penh, Cambodia, to discuss critical actions required to scale up access to HIV testing and counselling towards universal access in Asia and the Pacific. Participants represented civil society, affected communities, governments, international development partners, academic institutions, the World Health Organization (WHO), the United Nations Children's Fund (UNICEF), the Joint United Nations Programme on HIV/AIDS (UNAIDS) and other United Nation agencies.

[1] Stover, J.,and M. Fahnestock. 2006. Coverage of Selected Services for HIV/AIDS Prevention, Care, and Treatment in Low- and Middle-Income Countries in 2005. Washington, DC: Constella Futures, POLICY Project

1. Introduction

In spite of HIV treatment becoming more widely available, few people living with HIV are aware of their status due to limited availability and coverage of HIV testing and counselling services. Multiple factors have impeded efforts to increase coverage of HIV testing and counselling services. Implementing HIV testing and counselling strategies, in particular among high-risk and vulnerable populations, in an ethical manner that respects their human rights, remains a challenge.

With the overall goal of increasing availability and coverage of HIV testing and counselling services, WHO and UNAIDS have published two policy statements on HIV testing and counselling in 2004 and 2006, and are in the process of introducing guidance for the provider-initiated testing and counselling approach to complement the existing client-initiated, voluntary, confidential, counselling and testing services.

Client-initiated HIV testing and counselling, also known as Voluntary Counselling and Testing (VCT), involves individuals actively seeking HIV testing and counselling at a facility that offers these services. VCT usually emphasizes individual risk assessment and management by counsellors, addressing issues such as the desirability and implications of taking an HIV test and the development of individual risk reduction strategies. VCT is conducted in a wide variety of settings including health facilities, stand-alone facilities outside health institutions, through mobile services, in community-based settings and even in people's homes.

Provider-initiated HIV testing and counselling (PITC) refers to HIV testing and counselling which is recommended by health care providers to persons attending health care facilities as a standard component of medical care. The major purpose of such testing and counselling is to enable specific clinical decisions to be made and/or specific medical services to be offered that would not be possible without knowledge of the person's HIV status. PITC is neither mandatory nor compulsory.

2. Meeting participants and objectives

From 4 to 6 June 2007, 73 participants met in Phnom Penh, Cambodia, to discuss critical actions required to scale up access to HIV testing and counselling towards Universal Access in Asia and the Pacific. Participants reviewed HIV testing and counselling policies and practices in different settings and contexts in Asia and the Pacific. Participants included technical experts from 12 countries, representatives from civil society and self-support organizations, development partners and institutions, government representatives, the South Asia Association for Regional Cooperation, the Secretariat of the Pacific Community, the World Health Organization, the United Nations Children's Fund, the Joint United Nations Programme on HIV/AIDS, the United Nations Population Fund, the United Nations Office for Drug and Crime, the International Labour Organization and the International Office for Migration.

The aim of the meeting was to discuss ways to scale up HIV counselling and testing services. Four main objectives were set, including:

(1) To review HIV testing and counselling policies and practices in different settings and contexts in Asia and the Pacific;

(2) To discuss the role of provider-initiated testing and counselling (PITC) in complementing existing voluntary counselling and testing services (VCT);

(3) To emphasize the need for HIV testing and counselling to be grounded in public health methods, ethical principles and human rights values;

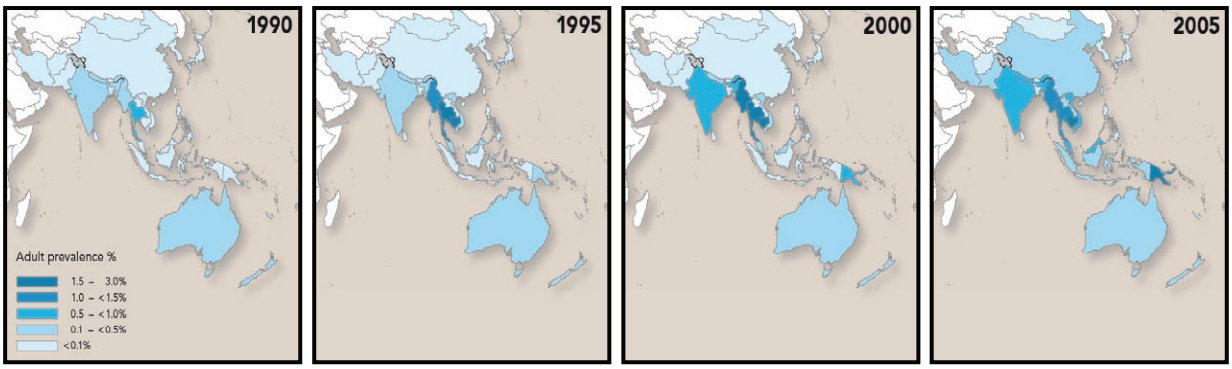
(4) To identify and agree on key actions for follow-up at the regional and country level for policy and programme implementation.

3. HIV/AIDS in the Asia Pacific Region

Several countries in the Asia Pacific Region face concentrated HIV epidemics, with HIV prevalence over 5% among most-at-risk populations, e.g. injecting drug users (IDU), sex workers (SW), men-who-have-sex-with-men (MSM). Three countries in Asia currently have generalized epidemics with prevalence rates over 1% among the adult population: Cambodia (1.6%)*, Myanmar (1.3%) and Thailand (1.4%). There is also one country in the Pacific – Papua New Guinea – with a generalized (1.8%) and still growing epidemic.

In the UNAIDS 2006 Report, it was estimated that 8.6 million adults and children in Asia and the Pacific were living with HIV (this figure will be less based on India's new estimates of 2.5 million—about half of previous estimates)** and that the region accounted for one million new cases and over half a million deaths from AIDS-related illness.

Figure 1. HIV prevalence in adults in Asia, 1990—2005[2]



The major characteristics of the epidemic and the responses in Asia and the Pacific are:

- Driven by risk behaviours among most-at-risk populations. Most HIV epidemics in the region have been fuelled by IDU, SW, clients of SW and/or MSM and the partners of these high-risk and often marginalized groups.

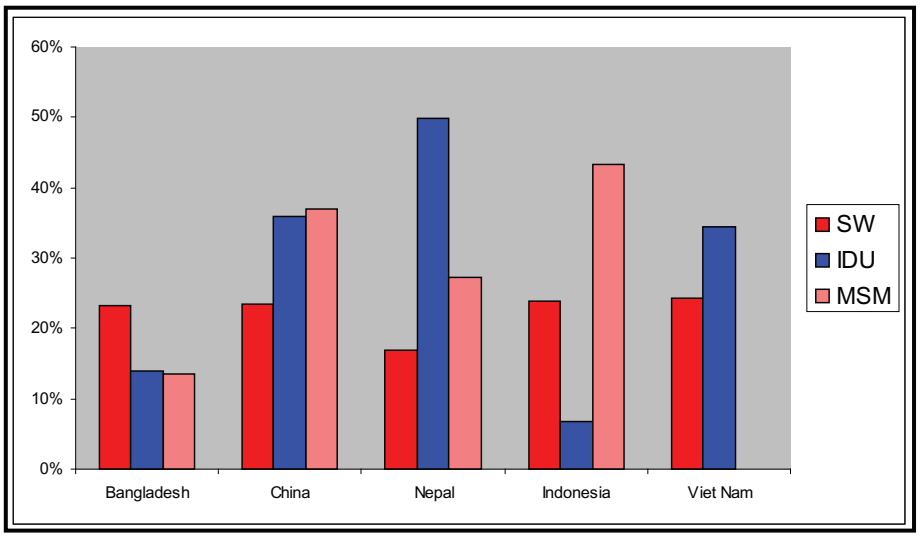
- Low level of HIV awareness. Low level of awareness and understanding of HIV, its transmission, its consequences and treatment is common in the region, particularly among most at risk populations and young people.

[2] *UNAIDS (2006) Report on the Global AIDS Epidemic*

* This report cites data published in the UNAIDS (2006) Report on the Global AIDS Epidemic to maintain consistency. Cambodia's 2006 HIV estimate is currently 0.9% based on the recent national consensus meeting held in June 2007

** New estimate from India National AIDS Control Organisation (NACO) with the endorsement of WHO and UNAIDS released in 2007

Figure 2. Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission [3]



- Wide spread stigma and discrimination. Lack of understanding about HIV often leads to stigma and discrimination, which is one of the greatest obstacles to a successful response in many Asian countries. For instance, high levels of HIV-related stigma and discrimination deter many individuals from accessing the services they need. Surveys in India, Indonesia, the Philippines and Thailand indicate that more than one in four people with HIV have experienced HIV discrimination in health-care settings. More than one third have had confidentiality about their HIV status breached, and 15% have been refused medical treatment once health care staff learnt they were HIV-positive.[4]

- Limited service coverage. An estimated 1 500 000 people are in need of antiretroviral therapy (ART) in the East, South and South-East Asia regions, yet only 280 000 or 19% currently receive treatment.

In most South East Asian countries, coverage of prevention of mother-to-child transmission (PMTCT) is largely inadequate, except for Thailand which has coverage of more than 90%.[5] In other Asian countries, this intervention has very low coverage (see Figure 3, 2005 data). Further, coverage of services for most-at-risk populations is low across the region: among IDU only 8% access harm reduction and other HIV prevention services; 26% of SW have contact with outreach programmes and only 8% of MSM are reached by HIV prevention programmes.[6]

[3] *UNGASS Country Report 2005*

[4] AIDS-related discrimination in Asia, S.Paxton AIDS Care, May 2005, survey conducted in India, Indonesia, Philippines and Thailand

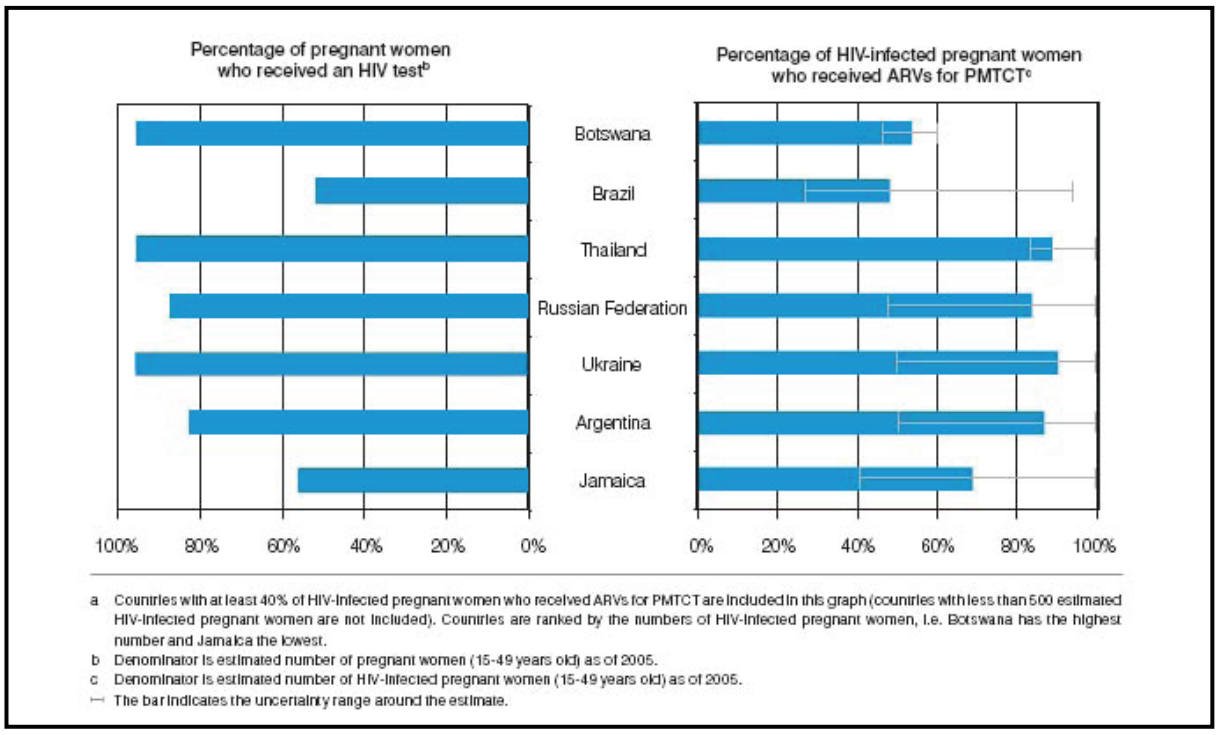
[5] Ministry of Public Health Thailand and *Towards Universal Access. Scaling up HIV/AIDS priority interventions in the health sector. Progress Report April 2007*. UNAIDS, WHO.

[6] Stover, J.,and M. Fahnestock. 2006. *Coverage of Selected Services for HIV/AIDS Prevention, Care, and Treatment in Low- and Middle-Income Countries in 2005*. Washington, DC: Constella Futures, POLICY Project.

In Asia and the Pacific, there is limited data to show coverage of HIV testing. A few surveys indicate that the proportion of adult population who have been tested and counselled is as low as 0.5% in India[7] (8.8 million tested out of 579 million adult population between 15 and 49 years of age), 0.5% in the Lao People's Democratic Republic and 0.1% in Malaysia. This leads to an estimate that overall only 0.1% of people in the region may have ever been tested and counselled.[1] However, this does not indicate what proportion of people most in need of testing are actually receiving this service.

Data are urgently needed on coverage of people in need of testing and counselling, and also on proportions of those accessing HIV testing that receive the result, appropriate counselling, and are eventually referred to specialized services for management of HIV infection.

Figure 3. Percentage of pregnant women who received an HIV test and percentage of HIV-infected pregnant women receiving ARV for PMTCT, selected countries, 2005[8]



a Countries with at least 40% of HIV-infected pregnant women who received ARVs for PMTCT are included in this graph (countries with less than 500 estimated HIV-infected pregnant women are not included). Countries are ranked by the numbers of HIV-infected pregnant women, i.e. Botswana has the highest number and Jamaica the lowest.
b Denominator is estimated number of pregnant women (15-49 years old) as of 2005.
c Denominator is estimated number of HIV-infected pregnant women (15-49 years old) as of 2005.
⊢ The bar indicates the uncertainty range around the estimate.

Increasing coverage of HIV testing and counselling in low-level and concentrated epidemics:

- HIV testing and counselling services should be targeted where they matter most, so that they are readily available in a non-discriminatory manner to those in greatest need. These would comprise people with symptoms indicative of HIV including with tuberculosis, spouses/partners of those known to be HIV-positive, infants born to HIV-positive mothers, malnourished children who do not respond to appropriate

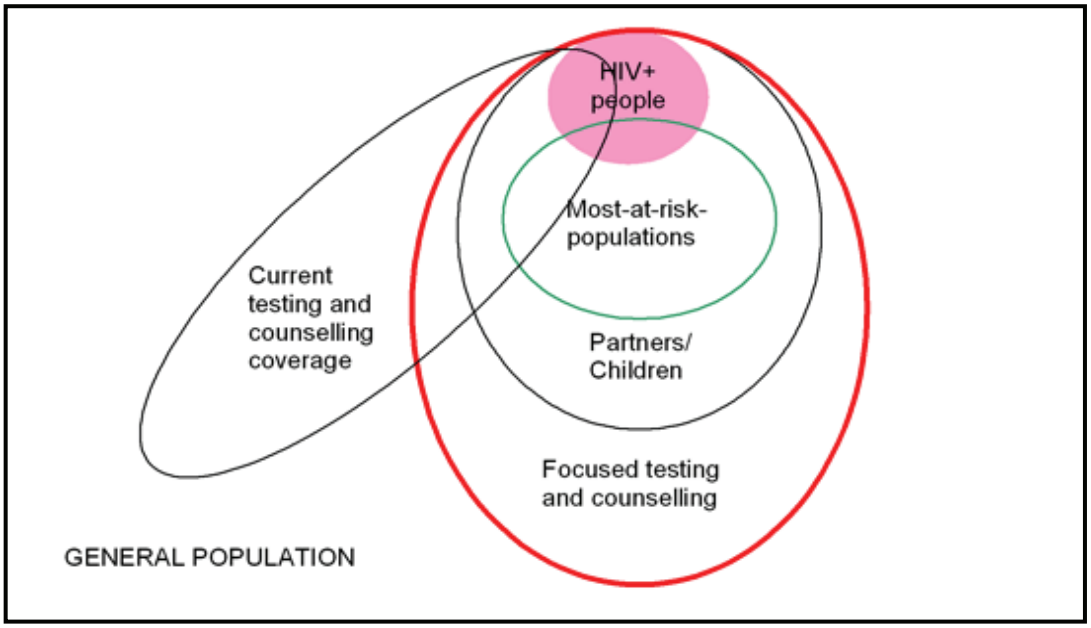
7 National AIDS Control Organization, Ministry of Health and Family Welfare India and WHO Regional Office for South-East Asia.
8 *Towards Universal Access. Scaling up HIV/AIDS priority interventions in the health sector. Progress Report April 2007*. UNAIDS, WHO.

nutritional therapy, those presenting at health services with a sexually transmitted infection, and specific populations such as sex workers and their clients, men who have sex with men, injecting drug users, prisoners and migrants. Accessible and user-friendly services will help such populations to receive necessary treatment, care and specific prevention/intervention services.

- Services often do not reach those who would benefit from and need them the most (Figure 4). Specific population groups in Asia and the Pacific are at higher risk for HIV and have difficulty accessing quality health services. Strategies are needed to increase access to and uptake of HIV testing and counselling for these groups, including most-at-risk population friendly VCT and outreach services.

- Expanding the coverage of services to the general population may not be making the best use of already limited resources and may result in partial or inadequate coverage of most-at-risk populations.

Figure 4. Current coverage of testing and counselling services in Asia and the Pacific



4. Testing and Counselling in the Region

Encouraging progress in preventing HIV transmission has been made in several countries with decreasing HIV prevalence such as Cambodia, Tamil Nadu State in India, and Thailand. Most countries in Asia and the Pacific are providing client-initiated and provider-initiated HIV counselling and testing services or a mix of both approaches. Yet, less than 10% of people living with HIV are aware of their status.

Country presentations

Cambodia. Voluntary confidential counselling and testing (VCCT) first started in 1995 and expanded from 12 sites in 2003 to 162 sites in early 2007 with the scale up of ART services. A training curriculum was standardized in 2003. Provision of ART is currently widely available and VCCT is integrated within the Continuum of Care for HIV/AIDS. The demand for HIV testing was increased through a range of demand creation strategies, including through mass media, outreach activities at the village level and referral through the INTHANOU—a unique free, anonymous and confidential telephone counselling service in Cambodia. Some VCCT sites employ trained people living with HIV (PLHIV) as counsellors. Quality assurance of counselling is conducted through counsellor networks at the regional level and regular monitoring and quality control of HIV tests are performed.

PITC was approved by the Ministry of Health and started in 2006. A one day orientation workshop is conducted to encourage health providers to offer HIV testing at antenatal care (ANC) clinics, tuberculosis (TB) services, sexually transmitted infection (STI) clinics, skin care services, and paediatric wards. Patients are offered the test and with their consent they (or their blood) are referred to the nearby VCCT site for testing. Post test counselling is given by a trained counsellor. More than 200 000 people accessed VCCT in 2006. With same day test results, 97.7% of people returned for post test counselling in 2006. However, there are still challenges. The workload of health staff involved in testing and counselling is increasing and the referral of patients within the continuum of care is slow with health staff competing for incentives. Further, there is a lack of harmonization between partners.

China has had a policy document for VCT since 2004. The objective of the National Action Plan is to have two to three VCT sites available in each county by the end of 2007. VCT is free of charge and voluntary. There are four models of testing and counselling: (1) the CDC based or hospital-based independent VCT; (2) VCT services integrated into ANC and STI clinics; (3) counselling integrated into ANC and STI clinics where lab services are absent; (4) following this, patients are referred to CDC for testing and outreach VCT services for high-risk groups and prisoners.

Initially, the drop out rate for return for test results was high, likely due to the one week delay in obtaining results. The programme is currently moving to rapid testing with same day test results. In 2005, only 28% of the estimated number of PLHIV in China knew their HIV status. In 2006, 1.2 million people were tested in VCT sites. But with 3037 VCT sites in June 2006, the goal of two to three VCT sites in each county has not been achieved. There are still many counties with no VCT site, or only one, especially in some remote areas. In June 2007, the China AIDS centre introduced PITC guidance. Members of the Joint United Nation team are exploring ways to better support China

in its efforts to develop a comprehensive testing and counselling policy. There has been a pilot of PITC protocols in three cities, preformed by CDC Global AIDS Program (GAP) and in five urban and six rural sites under the China Comprehensive AIDS Response (CARES) project.

India. The National AIDS Control Programme of India initiated VCT and Prevention of parent-to-child transmission (PPTCT) programmes in 1992. Operational guidelines for VCT and PPTCT were designed in 2001 and revised in 2004. In 2006, VCT and PMTCT were merged under heading of Integrated Counselling and Testing Centres (ICTC) – HIV testing at ANC and out patient departments at hospitals. The new operational guidelines for ICTC are being introduced with several new initiatives such as PITC. The 2011 targets are to establish 4955 ICTC and conduct 12 million tests per year. As of December 2006, the Government of India had established 4219 ICTC centres in 611 districts. The cumulative number of people tested during 2002—2006 amounted to 8.8 million (Table 1). Testing increases were highest in areas where ART services are also available. The national ART programme has expanded from eight operational centres in April 2004 to 101 centres in December 2006. A total of 68 461 patients have started ART in these centres.

Table 1: Select Indicators of ICTC performance in India, 2002—2006

Year	Number ICTC	Number Pre-Tested	Number HIV Tested	Number Received Post-Test Counselling	Number tested HIV Positive	% of those tested who tested positive
2002	409	452 078	279 351	261 677	61 960	22%
2003	576	723 478	504 055	465 760	91 049	18%
2004	720	1 085 638	795 197	660 500	116 947	15%
2005	1386	2 669 754	2 127 723	1 396 837	142 380	7%
2006	3623	3 932 723	3 402 304	2 788 887	192 508	6%
TOTAL	**3623**	**8 863 671**	**7 108 630**	**5 573 661**	**604 844**	**9%**

Excluding pregnant women, 55% of HIV testing was client-initiated and 25% provider-initiated in 2006. The consent rate at ICTC has increased from 62% in 2002 to 86% in 2006. The HIV positive yield decreased from 22% in 2002 to 5.7% in 2006. TB-HIV cross referral exists in 14 states. HIV testing of TB patients has doubled from 2005 to 2006. However, HIV testing is recommended only for TB patients who do not respond to TB treatment. The TB programme is awaiting the results of a HIV prevalence survey among TB patients with plans to eventually recommend HIV testing for all TB patients.

However, the quality of counselling services has to be strengthened, especially at sub-district level and discrimination by health care providers is of particular concern in some areas. In future, India plans to expand ICTC to primary health care centres and sub-centres with use of rapid tests on whole blood by nurses, strengthening partnerships with the private sector, and promoting PITC and conducting a media campaign to increase demand for HIV testing and counselling.

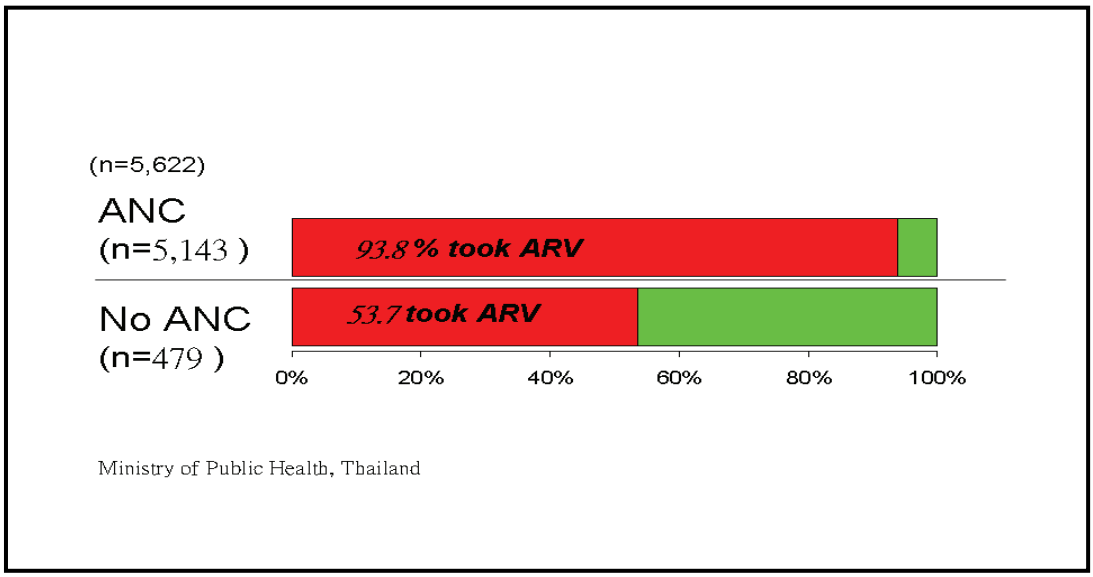
Pakistan. The National HIV testing strategy states that HIV testing should be voluntary, confidential and accompanied by pre-and post-test counselling. Testing for diagnosis uses three different tests. There are currently 16 VCT centres (both community-based and hospital-based) for the general population and VCT is integrated as part of 20 projects for most at risk populations (IDU, SW, MSM, truck drivers and prisoners). ART is available at nine sites. Challenges still exist in scaling up testing and counselling to most-at-risk populations.

Indonesia. While there has been a large expansion of testing and counselling services, there has also been under-utilization of testing and counselling services by the population. The objective of Indonesia's national programme is to have VCT services available in all districts and cities by 2010. National guidelines and training curriculum have existed since 2005. Currently, 290 VCT sites offer HIV testing and counselling. In 2006, 15 facilities started to offer HIV testing and counselling at ANC as part of PMTCT services. Testing of TB patients was initiated at the end of 2006 and guideline development is ongoing. PITC is still being discussed to avoid missed opportunities but there are concerns about poor utilization of PITC by health staff and limited human resources. For Indonesia, the challenge is to expand coverage at current VCT services.

Papua New Guinea. Testing and counselling is integrated into ANC services using an "opt out" strategy, although follow-up after testing is limited. Within reproductive health services (family planning, gynaecology), PITC is implemented. ART and support services are not widely available and early infant testing is not available, despite the fact that Papua New Guinea now faces a generalized epidemic and heavy burden of disease. Challenges for scale-up testing and counselling in Papua New Guinea include: stigma and discrimination; gender inequality and domestic violence against women; low attendance at ANC services; limited human resources and lack of staff capacity; logistical difficulties, such as geographical isolation of communities and difficult terrain; and lack of a simple testing algorithm for use at the provincial health centre level.

Thailand. HIV voluntary counselling and testing started in 1991 through anonymous clinics in government hospitals. PITC was introduced in the late nineties with the PMTCT programme and recently as part of the national TB directly observed treatment short-course (DOTS) programme. PITC includes group pre-test information giving and if requested individual pre-test counselling is accompanied by informed consent and gives the option to opt out, depending on the type of health services. The PITC was a key to the success of the national PMTCT programme. Out of a total of 672 035 deliveries in 2005, 98% attended ANC and out of those, 99.7% had an HIV test.

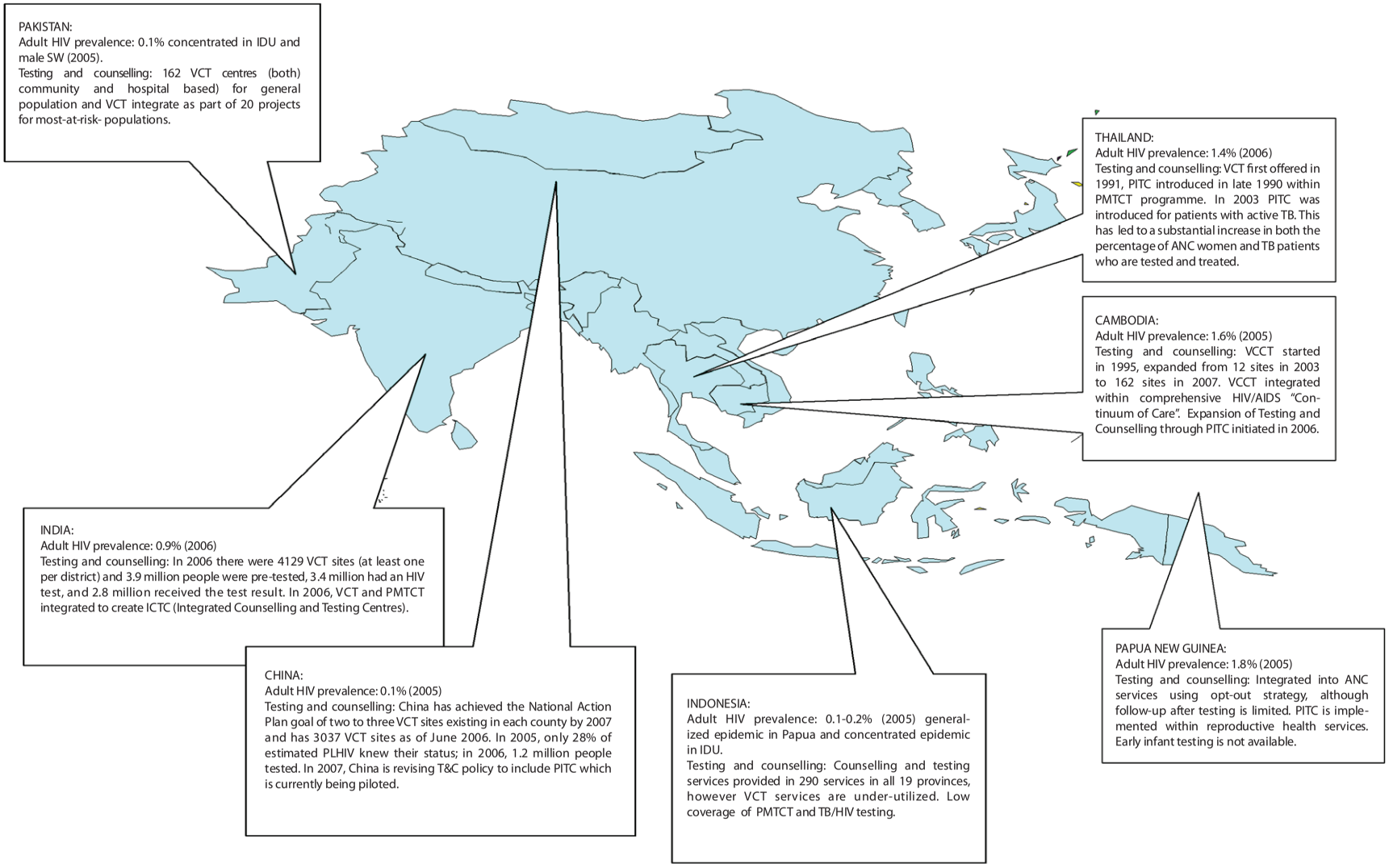
Figure 5. Zidovudine (ZDV) +/- NVP Use Among HIV+ Women Giving Birth by Antenatal Clinic (ANC) Status, Thailand, January – December 2005



The high coverage of PITC and ART prophylaxis did result in a decrease of reported paediatric AIDS cases.

In 2003, the Office of Disease Prevention and Control Region 7 (ODPC 7), Ministry of Public Health in Ubon Ratchathani, in north-eastern Thailand, started provider-initiated voluntary HIV testing and counselling for patients with active TB disease with the purpose of providing access to HIV care and ART. All newly registered TB patients are offered voluntary HIV testing and counselling. If they test HIV-positive, clients undergo a CD4 count measurement, and are accordingly offered HIV care, including ART. Retrospective data analyses from all hospitals showed that the proportion of newly registered TB patients who underwent HIV testing increased from 33% in 2003 to 84% in 2007. Out of 468 TB/HIV patients diagnosed during the period October 2006 to March 2007, 74% (346) had a CD4 count and of those, 78% had a CD4 count of less than 250 cells/mm^3 and were in need of ART. The success of this activity led Thailand's Ministry of Public Health to adopt a national TB/HIV action plan in late 2005. Under the plan, more than 90% of TB patients receive HIV-testing, over 75% of HIV-infected persons would be screened for TB, and all TB patients with HIV would have access to ART. The plan now covers every province in Thailand.

Figure 6. Selected reports from the region on testing and counselling



Consequences of low coverage

Knowledge of HIV status is essential for:

- Expanding access to HIV/AIDS treatment, care, and support
- Improving HIV/AIDS treatment outcomes
- Enhancing HIV prevention, including PMTCT.

The number of people receiving ART continues to increase globally. However, many PLHIV remain untreated. Increasing coverage of testing and counselling could increase the number of people treated, but only if those who are HIV positive, rather than low risk individuals come forward for testing, and there is adequate availability and linkage between testing and counselling and treatment and care services.

Without timely testing and counselling, HIV infection may not be detected at early stages of HIV disease and treatment outcomes will be poor. Studies show that earlier enrolment in pre-ART and eventually on ART is associated with decreased mortality and overall a more favourable prognostic outlook.

There remains a substantial gap in the number of women attending ANC services who are tested for HIV, and this low coverage carries dramatic implications with regards to preventable paediatric HIV infections. It also represents many missed opportunities for counselling them and their partners on HIV prevention, especially male sexual behaviours and HIV risk during pregnancy.

Some countries face substantial human and financial constraints, weak health infrastructures (in particular at the community level), inadequate use of HIV testing technologies (e.g. rapid testing), limited knowledge of HIV in the community and among health care workers, and stigma and discrimination. Commonly, laws and policies inhibit the implementation of interventions targeting people most-at-risk such as SW and their clients, IDU and MSM. Various countries have different experiences with HIV testing and counselling in closed settings such as rehabilitation centres, prisons, camps and juvenile institutions. These include mandatory HIV testing on entry, release, or during the period of detention with voluntary counselling and testing exceptional and often not accompanied by access to appropriate prevention or care-related services.

5. Highlights and key messages

Countries in Asia and the Pacific have had varying success with scale-up of testing and counselling services, and employ different practices and policies. However, it is recognized that there is an urgent need to scale up access to and uptake of testing and counselling services in the region. This is a necessity for the achievement of universal access targets by 2010. However, the scale-up of testing and counselling must be done with careful consideration of the possible consequences on affected populations.

There is consensus that the principles of voluntary participation, counselling, confidentiality, informed consent and access to services are fundamental to effective testing and counselling but there is concern that in some settings, these principals are not being followed.

The experience of some of the most-at-risk-populations in the region show that in general, there appears to be little understanding of the guiding principles and patients' rights. There are clear examples of hospitals testing patients without their consent. Compulsory testing is practised in a number of settings, for instance, among IDU and migrant workers. Similarly, the requirement of confidentiality is not strictly observed in the region. The understanding of consent and the legal requirements for informed consent vary in different countries.

It is recognized that people may seek HIV testing only if they can see its benefits. In the region, discrimination against people infected with HIV and limited availability and accessibility of treatment services discourage people from seeking HIV testing and counselling.

It is clear that any scale-up of testing and counselling needs to be linked to improved provision of other services such as high quality treatment and treatment monitoring, positive prevention, care and support for people living with HIV.

The rapid disease progression of infants makes early diagnosis very important. Across the region there are significant challenges surrounding the consent of adolescents and young people to HIV testing and other services, and limited experience and tools for guiding disclosure of HIV status, both of parents to children and the child's individual sero-status.

Given the nature of the epidemic in the region, that is, several countries with concentrated high-risk groups, not all interventions will take place in health settings. Furthermore, marginalized most-at-risk populations may not readily access health services and may be better reached through community-based interventions and services. Careful consideration needs to be given to creating linkage between non-health and health settings, and improving the quality of service in all settings.

6. Summary of working group sessions

On day two of the consultation, participants split into three working groups to discuss key issues, concerns and challenges for HIV testing and counselling in different settings. The groups identified ways to improve the quality and coverage of HIV testing and counselling which are inline with recommended international standards and practices, with the aim to improve access to prevention, treatment and care services.

Group 1: testing and counselling in health settings

Group 1 recognised that a mix of VCT and PITC approaches are used across the region, although uptake and quality of VCT is low in most countries. They also highlighted that PITC implementation in some programmes, such as ANC and TB services, has resulted in higher uptake of HIV testing. However, availability and linkages to HIV/AIDS treatment, care and support are critical and many of the most-at-risk-populations are currently being coerced into testing.

Group 1 recommended:

- further research to identify and understand the reasons for low uptake of testing and counselling and ongoing sensitization and training of health care providers;
- national consultations with all stakeholders to revise guidelines, policies and strategic planning related to testing and counselling and further clarification of the roles of providers in both VCT and PITC in health settings;
- an assessment of the type of services or programmes where PITC could be implemented;
- mobilization of resources for the scale-up of testing and counselling;
- for health settings where the needs of most-at-risk populations are addressed, VCT should be expanded and be the preferred option if the patient has no signs or symptoms of HIV;
- further definition of a minimum services package (ART, plus CD4 counts, ongoing care and support, PMTCT and cotrimoxazole) and linkages between testing and counselling services and treatment and care.

The way forward involves high-level advocacy, mass promotion of HIV testing and counselling, a strong monitoring and supervision system and ongoing quality assurance. Group 1 also called for legal protection of HIV infected people and an abolishment of anti-sodomy laws in the region. Further, group 1 called for legislation which allows for harm reduction services to be scaled up.

Group 2: testing and counselling in outreach and community settings

Group 2 recognized that many effective responses for engaging with marginalized populations have been developed but the nexus with government services has seldom been well managed. Tension exists between community organization's ability to engage with populations and the responsibility of governments to ensure quality of testing and counselling.

Group 2 highlighted the importance of active partnership between governments, communities and other stakeholders to optimize services. Also important is "ownership" of services by community organizations in order to ensure their credibility within communities and to empower them to engage as active partners.

Group 2 recommended:

- that governments play a greater role in the development and adaptation of standards (in laboratory testing procedures, tests, quality assurance and control, counselling, training and supervision), and accreditation mechanisms and thus endorse community organizations who are already performing high quality work;
- governments should monitor the maintenance of these standards and gather local evidence through which the quality of services is judged;
- sensitization of health care workers through engagement with community members;
- consideration of HIV testing must be made in the context of the person's other health and social needs;
- create linkages between health and community services by:
    - placing peers in government organizations;
    - designate "link workers" to connect community and mainstream services;
    - placing government health care services within community settings.

Group 3: testing and counselling in regulated settings

Members of group 3 chose to focus on only two types of "regulated setting": drug dependence treatment and rehabilitation centres and pre-or post-migration check-up settings.

Drug dependence treatment and rehabilitation centres:

The group voiced concern that pre-test counselling in drug treatment and rehabilitation centres is difficult since the person is detained, and most often, has no access to HIV prevention tools (condoms, sterile needle/syringes) within the centre. Further, few centres have the capacity to offer HIV treatment and monitoring and therefore linkage to treatment, care and support services do post-test is usually not possible. All members of the group were concerned about confidentiality, consent, links to other services, separation and stigma, and lack of staff capacity to offer testing and counselling.

Group 3 recommend that any policy development should be made after consideration of:

- laws in place and ways they affect the detainees;
- type of treatment/rehabilitation centre—-i.e. operated by police, military or another organization;
- current HIV testing protocol;
- availability of prevention measures;
- linkages of testing to other HIV treatment, care and support services.

Pre-or post-migration check-up settings:
The group made the following recommendations:

- pre-departure
  (a) do not promote testing to this relatively low risk group. Instead provide HIV/AIDS knowledge, education and prevention but no mandatory testing;
  (b) ensure confidentiality;
  (c) if the patient is HIV positive, design protocols to link patient to AIDS treatment, care and support services in their home country.
- in host country
  (a) develop guidelines for informed consent and confidentiality;
  (b) develop a repatriation protocol.
- on return to home country
  (a) protocol to link to HIV/AIDS services;
  (b) no mandatory testing.
- strengthen access to HIV counselling and testing for returning and returnee migrant workers in a broader framework of treatment and care;
- advocate for regional intergovernmental bodies to encourage governments to change policies of mandatory testing and disclosure of status.

7. Conclusions and recommendations

Mandatory and other coercive forms of HIV testing do not serve a legitimate public health goal and jeopardize access to health services, reduce health-seeking behaviours and increases stigma and discrimination.

Participants recognized and agreed there is an urgent need to scale up access to HIV counselling and testing in countries of the region as a means of enhancing access to comprehensive HIV prevention care and treatment. Existing models of voluntary counselling and testing need to be strengthened, scaled up and complemented by approaches that build on the potential of health services to offer HIV counselling and testing. Such an approach to HIV testing, initiated by health providers, should be accompanied by counselling, confidentiality and be conditional upon the person's informed consent (the "3 Cs"). Guidance published by WHO and UNAIDS[9] in May 2007 provides a useful framework which now needs to be considered by all countries.

In order to scale up voluntary HIV counselling and testing and achieve universal access to prevention treatment and care services, participants recommended:

1. Countries need to review national HIV testing policies, and approaches and practices to embrace existing guidance on VCT, and consider the new PITC guidance.

2. National consideration needs to be a participatory and transparent process.

3. HIV counselling and testing, irrespective of settings, must be accompanied and linked to a nationally agreed minimum package of defined services and linked to HIV prevention, including harm reduction services, treatment and care, including ART.

4. Additional attention is required to clearly define terms used locally, and to reinforce the voluntary nature of HIV testing and the requirements of consent, counselling and confidentiality ("3 Cs").

5. Countries need to optimize the use of newer HIV testing technologies, including rapid tests, to allow same day access to results, and virological testing for infants.

6. Countries will need to define, revise and apply standards, guidelines and training tools for HIV testing and counselling, including internal and external quality assurance schemes to support quality service delivery.

7. Countries need to review and amend laws and policies which criminalize practices like sex work, drug use, and sex between men, with a view to facilitating access to HIV counselling and testing, prevention, treatment care and support (including ART and harm reduction).

[9] *Guidance on provider-initiated HIV testing and counselling in health facilities*. Geneva, May 2007. WHO, UNAIDS

8. Countries need to review laws, policy and practice to prohibit mandatory testing of persons in closed settings (such as rehabilitation centres, prisons, detention centres and immigration lock-ups) to facilitate access to voluntary HIV testing and counselling, prevention, are and treatment and support (including ART and harm reduction).

9. Countries should ensure increased access to HIV testing and counselling, HIV prevention, treatment and care, including ART for infants, children and adolescents.

10. Countries should prioritize where and how testing services should be scaled up based on national and sub-national epidemiological patterns and at risk populations (including the need for HIV counselling and testing in STI, TB and ANC services). This should be reflected in agreed benchmarks and targets.

11. In order to scale up quality, accessible, equitable and acceptable HIV testing and counselling services, countries will need to revise existing costed plans and mobilize additional resources.

12. Scaling up community response requires broad-based advocacy, greater collaborative interactions between community and health facilities, and specific steps to support and facilitate referrals.

13. Codes of conduct and mechanisms for receiving, examining and responding to complaints are needed for HIV services, including HIV testing and counselling in health facilities, closed settings and in the context of labour and migration.

14. Countries need to review and revise national policies and laws to prohibit mandatory HIV testing for migrant workers and ensure access to HIV prevention, treatment, care and support, and referral services in both home and host countries, and advocate for this through regional and intergovernmental mechanisms.

15. Simplified national monitoring mechanisms should be put in place and adapted to reflect progress towards achieving set targets.

16. A working group should be established at the regional level (comprising civil society, people living with HIV/AIDS, global and regional partners, and technical experts) to support the process of scaling up voluntary HIV counselling and testing to secure access to care and prevention at the national level and to monitor progress against these recommendations.

17. Technical support should be extended to countries by global and regional partners to implement the above recommendations.

Programme of Activities

Day 1: Monday, 4 June 2007		
08.00 – 08.30	Registration	
08.30 – 09.15	Welcome • Opening statements o WHO o UNICEF o UNAIDS o Ministry of Health, Cambodia	Master of ceremony Dato' Dr Tee Ah Sian Mr Ian MacLeod Mr Prasada Rao H.E. Dr Mam Bun Heng
09.15 – 10.00	Introduction of participants Selection of Chair persons Objectives and expected outcomes Administrative announcements	Master of ceremony Dr Massimo Ghidinelli UNAIDS
10.00 – 10.15	COFFEE-TEA BREAK	
10.15 – 10.40	Global situation on HIV testing and counselling: perspectives towards Universal Access	Dr Kevin DeCock
10.40 – 11.00	The role of HIV testing and counselling in Universal Access in Asia and Pacific countries	JVR Prasada Rao
11.00 – 11.15	Questions and Answers	
OBJECTIVE 1: To review HIV testing and counselling policies and practices in different settings and contexts in Asia and the Pacific		
11.15 – 12.15	Presentations (15' each)	
	• Scaling up VCT and PITC in Cambodia	Dr Mean Chhi Vun
	• HIV testing and counselling experiences in China	Dr Ma Wei
	• National programme for HIV testing and Counselling in India: Successful implementation and lessons learnt	Dr Suresh Mohammed
	Questions and Answers (15')	
12.15 – 13.30	LUNCH	

13.30 – 14.30	• HIV voluntary counselling and testing services in Indonesia: Challenges and opportunities	Dr Dyah Erti Mustikawati
	• HIV testing and counselling in the context of PMTCT expansion in Papua New Guinea • Voluntary counselling and testing in Pakistan	Dr Grace Kariwiga Dr Nadeem Ikram
14.30 – 14.45	Highlights on VCT services in Asia and the Pacific	Dr Kathleen Casey
14.45 – 15.00	Questions and Answers	Chairperson
15:00 – 15:15	COFFEE-TEA BREAK	
15.15 – 15.30	The community feedback on the current HIV testing and counselling policy and practice in Asia and the Pacific	Mr William O'Loughlin
15.30 – 15.45	Study on mandatory HIV testing for employment of migrant workers in 8 countries of Asia-Pacific Region	Ms Ema Naito/ Dr Maria Nenette Motus
15.45 – 16.00	Questions and Answers	
16.00 – 16.15	Review of HIV testing and counselling laws and policies in East Asia and Pacific	Atty Manuel Goyena
16.15 – 16.30	Legal aspects of HIV testing and counselling in South Asian Countries	Mr Anand Grover
16.30 – 16.45	Questions and Answers	Chairperson
16.45	Conclusions of Day 1 and wrap up	Chairperson
18.30	Reception – Mekong II Room	

Day 2: Tuesday, 5 June 2007		
OBJECTIVE 2:	**To discuss the role of provider initiated testing and counselling (PITC) in complementing existing voluntary counselling and testing services**	
08.30 – 08.45	Testing and counselling for children and adolescents	Dr Suomi Sakai
08.45 – 09.15	Introduction of Global guidance on PITC and fundamental principles	Dr Jos Perriens
09.15 – 09.30	Questions and Answers	
09.30 – 09.45	Expanding TB/HIV joint activities: the role of provider-initiated HIV testing and counselling for access to HIV care and treatment	Dr Somsak Akksilp
09.45 – 10.00	PITC in STI settings	Dr Sophaganine Ali
10.00 – 10.15	The role of provider-initiated testing and counselling for scaling up national prevention-of-mother-to-child transmission programme	Dr Siripon Kanshana
10.15 – 10.30	Questions and Answers	Chairperson
10.30 – 10.45	COFFEE-TEA BREAK	
OBJECTIVE 3:	**To emphasize the need for HIV testing and counselling to be grounded in public health methods, ethical principles and human rights values**	
10.45 – 11.00	HIV testing and counselling as a public health strategy and human rights approach	Prof. Daniel Tarantola
11.00 – 11.40	Presentations on experience of HIV testing and counselling by representatives of vulnerable groups: • Injection drug users • Sex workers • Men who have sex with men • People living with HIV	 Mr Bijaya Pandey Ms Mony Pen Dr Dede Oetomo Mr Shiba Phurailatpam
11.40 – 12.00	Discussion	Chairperson
12.00 – 13.00	LUNCH	

13.00 – 16.00	Introduction of group-work (Break out into 3 groups to identify key issues, concerns and challenges for scaling up HIV testing and counselling)	Mr Binod Mahanty
	• Group 1: Testing and Counselling in health settings	
	• Group 2: Testing and Counselling in outreach and community settings	
	• Group 3: Testing and Counselling in regulated services	
15.00 – 15.15	COFFEE-TEA BREAK	
15:15 – 16:00	Continue with group session	
16:00 – 17:00	Feedback from break-out groups and discussion	Chairperson/ Rapporteurs

Day 3: Wednesday, 6 June 2007

OBJECTIVE 4: To identify and agree on key actions for follow-up at regional and country level for policy and programme implementation

08.30 – 08.45	Highlights of Day 2	Mr Ian MacLeod
8.45 – 10.15	Plenary discussion – draft conclusions and recommendations	Chairperson
10.15 – 10.30	COFFEE-TEA BREAK	
10.15 – 11.30	Continuation of plenary discussion	Chairperson
11.30 – 12.00	Closing remarks: • WHO – Dato' Dr Tee Ah Sian • UNICEF – Mr Ian MacLeod • UNAIDS – Mr Prasada Rao • Ministry of Health Cambodia – H.E. Dr Mam Bun Heng	Dr Ying-Ru Lo
12.30	PRESS CONFERENCE	

List of Participants

AUSTRALIA

Dr Kathleen Casey
Regional Senior Technical Officer
HIV Counselling, Testing & PMTCT
Family Health International
Asia and Pacific Regional Office
19th floor, Sindhorn Building Tower 3,
130-132, Wireless Road, Lumpini, Phatumwan
Bangkok 10330
Tel: (66 2) 263 2300 ext. 144
Fax: (66 2) 263 2114
Mobile: +6681 802 2491
E-mail: Kcasey@fhibkk.org

Mr William O'Loughlin
Freelance Consultant, Community Feedback Principal Investigator
6a Irving Avenue, Prahran,
Melbourne, Victoria, 3181
Tel: (61 3) 9510 9553
Fax: (61 3) 9510 9665
E-mail: billol@bigpond.net.au or billoloughlin@yahoo.com

Professor Daniel Tarantola
Professor of Health and Human Rights
School of Public Health and Community Medicine
Faculty of Medicine
Samuels Building, Level 2, Room 228
The University of New South Wales
Sydney NSW 2052
Tel: (61 2) 9385 8268
Fax: (61 2) 9385 1036
E-mail: d.tarantola@unsw.edu.au

CAMBODIA

Ms Siv Cheng
Cambodia Community of Women Living with HIV/AIDS
Phnom Penh
Tel: (855 12) 683 947
E-mail: pmnoy24@yahoo.com

Dr Chea Manita
National Centre for Tuberculosis and Leprosy (CENAT)
Street 95, Phnom Penh
Tel: (855 23) 219 274

Dr Sok Panha
Head of VCCT Unit
National Centre for HIV/AIDS, Dermatology and STI (NCHADS)
No. 170, Sihanouk Blvd, Phnom Penh
Tel: (855 23) 221 470
Fax: (855 23) 214 556
Mobile: (855 16) 851 595
E-mail: sokpanha888@nchads.org

Ms Mony Pen
Project Manager
Cambodia Community of Women Living with HIV/AIDS
Phnom Penh
Tel: (855 12) 683 947
E-mail: pmnoy24@yahoo.com

Dr Vong Sathiarany
PMTCT Programme Coordinator
National Maternal and Child Health Centre (NMCHC)
Street 47, Phnom Penh
Tel: (855 23) 724 257
Mobile: (855 12) 331 905
Email: sathiarany@yahoo.com

Dr Mean Chhi Vun
Director
National Centre for HIV/AIDS Dermatology and STI
Ministry of Health, No 170, Avenue Preah Sihanouk
Phnom Penh
Tel: (855 16) 830 242
Fax: (855 23) 214 556
Mobile: (855) 16 830 241
E-mail: Mchhivun@nchads.org

CHINA

Dr Wei Ma
Comprehensive AIDS Response Office
National Centre for AIDS/STD Control and Prevention
Chinese Centre for Disease Control and Prevention
27 Nanwei Road, Beijing 100050
Tel: (8610) 63039082
Fax: (8610) 63039082
Email: wei_ma01@sohu.com

FIJI

Dr Sophaganine Ty Ali
Senior Medical Officer In charge
Reproductive Health Clinic
Ministry of Health
Rodwell Road, Suva
Tel: (679) 947 4939
Fax: (679) 331 9144
E-mail: nin6085@gmail.com

INDIA

Anand Grover
Advocate and Director
Lawyers Collective HIV/AIDS Unit, India
4th Floor, Jalaram Jyot,
63 Janmabhoomi Marg, Fort
Mumbai 400 001
Tel: 91 22 22852543
Fax: 91 98 20184788
E-mail: aidslaw@lawyerscollective.org; anandgrover@gmail.com

Dr Sushma Mehrotra
8 Horizon View
Opp. Sachivalaya Gymkhana
138 Gen. J. Bhosle Marg
Nariman Point
Mumbai 400 021
Tel: (+91 93) 13052691
E-mail: mehrotrasushma@hotmail.com

Dr Suresh K. Mohammed
National Consultant (ICTC)
National AIDS Control Organization (NACO)
Ministry of Health and Family Welfare
Government of India
9th Floor, Chandralok Building
36, Janpath, New Delhi 110001
Tel: (+91 11) 43509921
Fax: (+91 11) 23731746
E-mail: sureshmohammed@gmail.com

Dr Satish Powar
Joint Director (ICTC)
Maharashtra State AIDS Control Society
Ackworth Leprosy Hospital Campus
Behind SIWS Collete, R.A. Kidwai Marg
Wadala (West)
Mumbai 400031
Tel: (+91 22) 24113035
Fax: (+91 22) 24113123, 24115825
E-mail: drarchanasatish@rediffmail.com

Dr Chinkholal Thangsing
Asia Pacific Bureau Chief
AIDS Healthcare Foundation
S 7 Panchsheel Park, New Delhi 110017
Tel: (91 11) 41745541, 41745542
Fax: (91 11) 41745543
Mobile: (91) 98182 70687
E-mail: chinkholal.thangsing@aidshealth.org

INDONESIA

Dr Ratna Mardiati
Director, The Drug Dependence Hospital
Jl. Lapangan Tembak No 75, Cibubur
East Jakarta, Jakarta 13720
Tel: (+62 21) 877 11970
E-mail: ardiawika@yahoo.com

Dr Dyah Erti Mustikawati
Head of Guidance and Evaluation Section
Sub-Directorate STD-AIDS, CDC & EH
Ministry of Health
Jakarta
Tel: (+62 81) 689 2815
Fax:: (+62 21) 42 880231
E-mail: dmustika_2007@yahoo.co.id

Dr Dede Oetomo
Founder and Trustee
GaYa NUSANTARA Foundation
Jalan Mojo Kidul 1
No 11A Surabaya 60285
Tel: (+61 31) 591 4668
Fax: (+61 31) 591 4668
E-mail: doetomo@gmail.com

MALAYSIA

Dr Adeeba Kamarulzaman
Head, Infectious Diseases Unit
Department of Medicine
University of Malaya
Kuala Lumpur
Tel.: (603) 7949 2129
Fax: (603) 7949 4625
E-mail: adeeba@ummc.edu.my or adeeba@um.edu.my

Ms Rathi Ramanthan
Program Officer
CARAM Asia Bhd
8th Floor, Wisma MLS
31 Jalan Tuanku Abdul Rahman
50100 Kuala Lumpur
Tel: (+6 03) 2697 0708
Fax: (+6 03) 2697 0282
Mobile: (+6) 017 680 1236
E-mail: rathi@caramasia.org

MONGOLIA

Dr Byambaa Chultemsuren
HIV/AIDS/STI Project Officer
Global Fund-supported project on AIDS and TB
Ministry of Health
Olympic street 2
Government building 8, Room 407
Sukhbaatar District, Ulaanbaatar
Tel: (976 11) 326 155
Fax: (976 11) 319 732
E-mail: byambaa@aids.mn

NEPAL

Mr Bijay Raj Pandey
Coordinator
Youth Vision "From Margins to Mainstream"
Kopundol Lalitpur
GPO Box 8801
Kathmandu
Tel: (97 71) 5525 331, 5520 369
E-mail: bigjoy@wlink.com.np or yvbup@wlink.com.np

Ms Sarmila Shrestha
Executive Chairperson
Women Acting Together for Change (WATCH)
572/45 Ram Mandir Marga, Battis Putali
P.O. Box 11321, Katmandu
Tel: (+977 1) 4492644, 4494653
Fax: (+977 1) 4494653
E-mail: watchftp@wlink.com.np

PHILIPPINES

Atty Manuel Goyena
Lawyer, Freelance Consultant
No 23 F. dela Cruz Street
BF Resort Village
Las Pinas City
Tel: (632) 871 2878
Mobile: (63) 920 2191968
E-mail: mmgingeneve@yahoo.com

Ms Maria Lourdes Marin
Executive Director
Action for Health Initiatives, Inc.
58-H Kamias Road, Quezon City
Tel: (632) 434 0602
Fax: (632) 435 2019
E-mail: achieve_caram@yahoo.com or achieve@pacific.net.ph

PAKISTAN

Dr Nadeem Ikram
Senior Manager Serology
National HIV/STI Referral Laboratory
National AIDS Control Programme
Islamabad
Tel: (92 51) 9255367-8
Fax: (92 51) 9255214
E-mail: nadeemim@hotmail.com

THAILAND

Dr Somsak Akksilp
Director, Office of Disease Prevention and Control 7th
Muang District, Ubon Ratchatani
Tel: (+66 45) 245188
Fax: (+66 45) 255188
E-mail: akksilp_s@yahoo.com; akksilp@health2.moph.go.th

Dr Siripon Kanshana
Chief, Office of the Inspector-General
Ministry of Public Health
Tiwanond Road, Bangkok
Tel: (66 2) 590 1488
Fax: (66 2) 590 1460
Email: siripon@health.moph.go.th

Dr Praphan Phanuphak
Director, Thai Red Cross AIDS Research Centre
Co-Director, HIV-NAT
104 Rajdamri Road
Bangkok 10330
Tel: (+66 2) 2527888
Fax: (+66 2) 2547577
E-mail: ppraphan@chula.ac.th

Mr Shiba Phurailatpam
Regional Coordinator
Asia Pacific Network of People Living with HIV/AIDS (APN+)
176/22 Sukhumvit Soi 16, Klongtoey,
Bangkok 10110
Tel: (662) 259 1908 – 9
Fax: (662) 259 1910
E-mail: shiba@apnplus.org

VIET NAM

Dr Nguyen Thi Minh Tam
International Corporation and Scientific Division
Vietnam Administration of HIV/AIDS Control
135/3 Nui Truc Street, Kim Ma, Ha Noi
Tel: 84-4-7366 185
Fax: 84-4-8465 731
E-mail: minhtam71@yahoo.com

Observers/Representatives

INTERNATIONAL LABOUR ORGANIZATION

Ms Ema Naito
Technical Officer, HIV/AIDS and the World of Work
ILO Sub-Regional Office-Bangkok
10th Floor, UN Building
Rajdamnern Nok Ave.
Bangkok 10200, Thailand
Tel: (662) 288 2305
E-maiL: naito@ilo.org

INTERNATIONAL ORGANIZATION FOR MIGRATION

Dr Maria Nanette Motus
Regional Migration Health Manager
IOM Regional Office for Southeast Asia
18th Floor, Rajanakarn Building
183 South Sathorn Rd. Bangkok 10120, Thailand
Tel: (662) 343 9348
Fax: (662) 343 9399
E-mail: nmotus@iom.int

SECRETARIAT OF THE PACIFIC COMMUNITY (SPC)

Dr Gary Rogers
Deputy Section Head
Treatment Care & Counselling Cluster Coordinator
HIV & STI Section, Public Health Programme
BP D5, 98848, Noumea Cedex
95 Promenade Roger Laroque, Anse Vata
New Caledonia
Tel: (+687) 24 22 27
Fax: (+687) 26 38 18
E-mail: garyr@spc.int

SOUTH ASIA ASSOCIATION FOR REGIONAL COOPERATION (SAARC)

Dr Lochana Shrestha
Epidemiologist
SAARC TB-HIV/AIDS Centre (STC), Thimi
Bhaktapur, P.O. Box 9517, Kathmandu, Nepal
Tel: (977) 663 1048
E-mail: saarchtb@mos.com.np or shresthalochana@yahoo.com

THE 7 SISTERS

Vince Crisostomo
Coordinator
176/22 Sukhumvit Soi 16
Klongtoey, Bangkok 10110, Thailand
Tel: (66 2) 259 1908-9
Fax: (66 2) 259 1906
Mobile: (66 8) 9698 2432
E-mail: coordinator@7sisters.org

THE GLOBAL FUND TO FIGHT AIDS, TB AND MALARIA (GFATM)

Ms Inga Oleksy
Fund Portfolio Manager
Chemin Blandonnet 6-8
1214 Vernier, Switzerland
Tel: (4122) 791 1700
Fax: (4122) 791 1701
E-mail: Glenga@glenga.com; glenga@citylink.com.kh

UNITED NATIONS OFFICE ON DRUGS AND CRIME

Mr Gray Sattler
Regional Adviser (HIV/AIDS)
United Nations Office on Drugs and Crime
Regional Centre for East Asia and the Pacific
United Nations Building, 4th Floor
Rajdamnern Nok Avenue
Bangkok 10200, Thailand
Tel: (+662) 288 2799
Fax: (+662) 288 1014
E-mail: gray.sattler@unodc.org

UNITED NATIONS POPULATION FUND (UNFPA)

Dr Chaiyos Kunanusont
HIV/AIDS/STI Adviser
Country Technical Services Team for East and South-East Asia
UNFPA Country Support Team
Bangkok, 10200, Thailand
Tel: (662) 288 1476
Fax: (662) 280 2715
Mobile: (66) 8 1832 2468
E-mail: kunanusont.unescap@un.org

Dr Chong Vandara
National Programme Associate
Adolescent Reproductive Health & HIV/AIDS
No 225, Pasteur St (51)
Boeng Keng Kang I, Chamkar Mon
PO Box 87, Phnom Penh
Tel: (855 23) 215519, 216295
Fax: (855 23) 211339
E-mail: chong@unfpa.org

UNITED STATES CENTRES FOR DISEASE CONTROL (US CDC)

Mr Thomas Heller
US - CDC
Centres for Disease Control Global AIDS Programs
Phnom Penh, Cambodia
Fax: (85523) 728 600

Secretariat

WHO/WESTERN PACIFIC REGIONAL OFFICE

Dato' Dr Tee Ah Sian
Director, Combating Communicable Diseases
United Nations corner Taft Avenue
1000 Manila
Tel: (632) 528 9701
Fax: (632) 521 1036
E-mail: teeas@wpro.who.int

Dr Massimo N. Ghidinelli (Responsible Officer)
Regional Adviser, HIV/AIDS and STI
United Nations corner Taft Avenue
1000 Manila
Tel: (632) 528 9714
Fax: (632) 52d1 1036
Mobile: (63) 928 501 2066
E-mail: ghidinellim@wpro.who.int

Ms Gaik Gui Ong
Technical Officer, HIV/AIDS and STI
United Nations corner Taft Avenue
1000 Manila
Tel: (632) 528 9718
Fax: (632) 521 1036
E-mail: ongg@wpro.who.int

Dr Wang Xiaochun
Technical Officer, HIV/AIDS and STI
United Nations corner Taft Avenue
1000 Manila
Tel: (632) 528 9731
Fax: (632) 521 1036
Mobile: (63) 921 693 7596
E-mail: wangxi@wpro.who.int

Dr Philippe Glaziou
Medical Officer, Stop TB
United Nations corner Taft Avenue
1000 Manila
Tel: (632) 528 9703
Fax: (632) 521 1036
E-mail: glazioup@wpro.who.int

WHO/CAMBODIA

Dr Michael O' Leary
WHO Representative
No 177-179 corner Pasteur (51) and 254
Phnom Penh
Tel: (855) 23 216 610
Fax: (855) 23 216 211
E-mail: olearym@cam.wpro.who.int

Dr Nicole Seguy
Medical Officer, HIV/AIDS and STI
No 177-179 corner Pasteur (51) and 254
Phnom Penh
Tel: (855) 23 216 610
Fax: (855) 23 216 211
E-mail: seguyn@cam.wpro.who.int

Dr Virginia Macdonald
Rapporteur for consultation report
No 177-179 corner Pasteur (51) and 254
Phnom Penh
Tel: (855) 23 216 610
Fax: (855) 23 216 211
E-mail: vmacdonald1972@hotmail.com

WHO/CHINA

Dr Wiwat Rojanapithayakorn
Senior Adviser, HIV/AIDS and STI
401 Dongwai Diplomatic Office Building
23 Dongzhimenwai Dajie, Chaoyang District, Beijing 100600
Tel: (86 10) 6532 7189 - 92 ext. 675
Fax: (86 10) 6532 2359
Mobile: (86) 139 1077 9192
E-mail: wiwatr@chn.wpro.who.int

WHO/SOUTH-EAST ASIA REGIONAL OFFICE

Dr Ying-Ru Lo (Responsible Officer)
Regional Adviser, HIV/AIDS
Department of Communicable Diseases
World Health House, Indraprastha Estate, Mahatma Gandhi Road,
New Delhi 110002
Tel: (91 11) 23309130 (direct)
Fax: (91 11) 23378412 (direct)
Mobile: (91) 9818 557312
E-mail: loy@searo.who.int

Mr Samuli Seppanen
Junior Professional officer
Focal Person on Health and Human Rights
World Health House, Indraprastha Estate, Mahatma Gandhi Road,
New Delhi 110002
Tel: (91 11) 233 70910
Fax: (91 11) 233 70197
E-mail: seppanen@searo.who.int

WHO/INDIA

Mr Binod Mahanty
Short-term Professional (HIV/AIDS)
Office of WHO Representative to India
5th Floor, Shri Ram Bhartiya Kala Khendra
1 Copernicus Marg, New Delhi 110 011
Tel: (+91 11) 42595600
Fax: (+91 11) 23382252
E-mail: mahantyb@searo.who.int

WHO/HEADQUARTERS

Dr Kevin De Cock
Director
HIV Department
Headquarters Office in Geneva
Avenue Appia 20
CH – 1211 Geneva 27
Tel: (41 22) 791 1222
Fax: (41 22) 791 4834
E-mail: decock@who.int

Dr Joseph Perriens
Coordinator a.i.
HIV Prevention in the Health Sector
HIV Department
Avenue Appia 20
CH-1211 Geneva 27
Tel: (4122) 791 4456
Fax: (4122) 791 4834
E-mail: perriensj@who.int

Dr Siobhan Crowley
HIV Department
Headquarters Office in Geneva
Avenue Appia 20
CH – 1211 Geneva 27
Tel: (41 22)
Fax: (41 22) 791 4834
E-mail: crowleys@who.int

UNICEF/EAST ASIA AND PACIFIC REGIONAL OFFICE

Dr Anne Bergenstrom
Regional HIV/AIDS Specialist (Primary Prevention)
19 Phra Atit Road
Bangkok 10200
Tel: (662) 356 9469
Fax: (662) 280 3563
E-mail: abergenstrom@unicef.org

Ms Tippawan Na Lumpoon
Programme Assistant
19 Phra Atit Road
Bangkok 10200
Tel: (662) 356 9467
Fax: (662) 280 3563
E-mail: Tippawan@unicef.org

UNICEF/CAMBODIA

Dr Suomi Sakai
Representative
No.11, Street 75, Sangkat Sraschark
P.O. Box 176, Phnom Penh
Tel: (855 23) 426 214
Fax: (855 23) 426 284
E-mail: ssakai@unicef.org

Dr Haritiana Rakotomamonjy
Chief, HIV and AIDS Section
No. 11 Street 75, Sangkat Sraschark
P.O. Box 176, Phnom Penh
Tel: (855 23) 426 214
Fax: (855 23) 426 284
E-mail: hrakotomamonjy@unicef.org

Chin Sedtha
Project Officer, HIV and AIDS Section
No.11, Street 75, Sangkat Sraschark
P.O. Box 176, Phnom Penh
Tel: (855 23) 426 214
Fax: (855 23) 426 284
E-mail: schin@unicef.org

UNICEF/MONGOLIA

Dr Ider Dungerdorj
Chief, HIV and AIDS Section
United Nations Children's Fund
UN Bldg 2, UN Street 12
Sukhbaatar district
Ulaanbaatar 210646
Tel: (976 11) 312 183; 312 185 ext. 118
Fax: (976 11) 327 313
E-mail: idungerdorj@unicef.org

UNICEF/PAPUA NEW GUINEA

Dr Grace Kariwiga
Maternal Health and PMTCT Specialist
United Nations Children's Fund
14th Floor, Deloittes Tower
Douglas Street, P.O. Box 472
Port Moresby
Tel: (675) 3087368 (direct line) or (675) 3213000 Ext 368
Fax: (675) 321 1372
E-mail: gkariwiga@unicef.org

UNICEF/REGIONAL OFFICE FOR SOUTH ASIA

Mr Ian D MacLeod
Senior Adviser, HIV and AIDS
P.O. Box 5815 Lekhnath Marg
Kathmandu
Tel: (977-1) 441 7082 ext 224
Mobile: (977) 98510 82718
E-mail: imacleod@unicef.org

Dr Myo Zin Nyunt
HIV/AIDS Specialist
P.O. Box 5815 Lekhnath Marg
Kathmandu
Tel: (977-1) 441 7082 ext 224
Mobile: (977) 98510 82718
E-mail: mnyunt@unicef.org

UNAIDS/REGIONAL SUPPORT TEAM FOR ASIA AND THE PACIFIC

Mr JVR Prasada Rao
Regional Director
9th Floor, Block A, United Nations Bldg
Rajadamnern Nok Avenue
Bangkok 10200
Tel: (662) 288 1490
Fax: (662) 288 1092
E-mail: raojvrp@unaids.org

Dr Sun Gang
Regional Programme Advisor (Monitoring and Evaluation)
9th Floor, Block A, United Nations Bldg.
Rajadamnern Nok Avenue
Bangkok 10200
Tel: (662) 288 1272
Fax: (662) 288 1092
E-mail: sung@unaids.org

Ms Prapapan Supreyaporn
Programme Support Assistant
9th Floor, Block A, United Nations Bldg
Rajadamnern Nok Avenue
Bangkok 10200
Tel: (662) 288 2185
Fax: (662) 2888 1092
E-mail: supreyapornp@unaids.org

Ms Jeanne Hallacy
UNAIDS Media Consultant
E-mail: hallacy@loxinfo.co.th

UNAIDS/BANGLADESH

Mr Dan Odallo
Country Coordinator
c/o UNDP, IDB Bhaban (8th floor)
E/8-A, Begum Rokeya Sharani, Sher-E-Bangla nagar
Dhaka 1207
Tel: (880) 2 812 4051
Fax: (880) 2 811 3196; 812 4051
E-mail: dan.odallo@undp.org

UNAIDS/CAMBODIA

Mr Anthony Lisle
Country Coordinator
House No 221, Street No 51 (Pasteur)
Sankgat Boeung Keng Kang I, Khan Chamkar Mon
Phnom Penh
Tel: (855 23) 219 340
Fax: (855 23) 721 153
E-mail: lislet@unaids.org

UNAIDS/PHILIPPINES

Dr Ma Elena Filio-Borromeo
Country Coordinator
31/F RCBC Plaza Avenue, Ayala Avenue
Corner Sen Gil Puyat Avenue
Makati City 1226
Tel: (632) 901 0412
Fax: (632) 901 0415
E-mail: borromeom@unaids.org

UNAIDS/VIET NAM

Mr Eamonn Murphy
Country Coordinator
No 24, Lane 11, Trin Hoai Duc Street
Ha Noi
Tel: (844) 734 2824 ext 102
Fax: (844) 734 2825
E-mail: murphye@unaids.org

Next Steps Recommended by UN Agencies

For global/regional level:

- Officially notify national authorities on the need for intensified action to provide access to services for HIV testing and counselling in order to achieve Universal Access, accompanied by translated new PITC guidance, and 2004 notes on VCT;
- Develop key communications package for national authorities, Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and donors;
- Adapt and/or modify generic tools;
- Document regional best practises;
- Describe common regional pitfalls;
- Undertake cost effectiveness analysis of PITC for TB, STI and pregnant women;
- Develop regional discussion document on – protection of privacy, criminalization of HIV transmission;
- Update regional guidance note on best use of testing technologies;
- Identify upcoming regional and national opportunities to review national guiding documents e.g. national strategic planning;
- Identify financial resources to support inclusive national review process and adaptation of international guidelines;
- Adapt or develop step by step guide for national adaptation that sets out key elements to increase HIV testing and counselling;
- Articulate regional priorities for expanding access to HIV testing and counselling;
- Document list of key terms used in regions;
- Develop standardized simplified comprehensive monitoring framework and systems for HIV testing and counselling (programme level);
- Provide technical support to national adaptation process.

For national level:

- Plan for national stakeholder review of HIV testing policy and guidance:
    - Mapping existing legal and policy directives;
    - Document existing practice;
    - Listing and clarifying terms;
    - Gap/bottlenecks analysis;
    - Agreeing on priorities for scaling-up (based on epi/resources etc.);
    - Defining who pays for what services;
    - Clarifying roles and responsibilities by cadre and facility;
    - Estimating resource implications (human and financial);
    - Consultation with key partners;
    - Agreeing on targets and monitoring.

- Develop national road map with timelines and budget;
- Agree on essential enabling legal and policy frameworks for HIV testing and counselling (as check list);
- Identify vulnerable populations and articulation of additional protection prerequisites;
- Describe essential package for HIV testing and counselling by settings (pre and post test info/services);
- Advocate and prepare communication pack for opinion leaders, health care providers, NGOs etc.;
- Prepare community mobilization tools and orientation package for health care workers;
- Draft Memorandum of Understanding for service provision (public sector/private/NGO/prison etc.)
- Develop standardized simplified comprehensive monitoring framework and systems for HIV testing and counselling (programme level).