

**Routine and Rapid HIV Testing?!**  
**XVI International AIDS Conference**  
**August 16, 2006**

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**SISONKE MSIMANG:** Good afternoon and welcome everybody. You are in the session entitled "Routine and Rapid HIV Testing?! Are we ready to throw out human rights from HIV testing policy?"

I am sure that everyone is here because it is such a hot topic. It is something that clearly has emerged in this conference as being a matter for significant debate. The objective of the session is to learn from programs that have adopted the routine testing approach, whether through an opt-in or an opt-out strategy, so we have got a number of presenters who will talk to us about those issues. My name is Sisonke Msimang. I work with the open society initiative for Southern Africa and I will ask my co-chair to introduce herself before we go straight into the session.

**RACHEL ONG:** Good afternoon, everybody. I hope everyone has had time for lunch. My name is Rachel Ong. I am an advisor for the Asia Pacific Network of People Living with HIV and AIDS. I am also sitting on the program coordinating board for UNAIDS.

With no further ado, I will introduce Joanne Csete. She is going to talk about routine testing. Are we ready to throw human rights out of HIV testing policy? Joanne is the executive director of the Canadian HIV/AIDS Legal Network, an

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organization that addresses human rights/concerns raised by AIDS.

**JOANNE CSETE:** Good afternoon, everyone. The campaign for universal access has highlighted the need for scaling up of all parts of the response to AIDS. My presentation, can we get that one up please? Thank you. It is a matter of urgent concern that so many people living with HIV, as we have heard so many times, are unaware of their HIV status. The question though, of course, is how a scale-up of testing should be undertaken and how scaling-up testing is linked to other elements of the AIDS response. I beg your pardon on the technology.

The approach to HIV testing adopted by most countries and recommended up until now by the World Health Organization usually known as voluntary counseling and testing (VCT), reflects a concern for safeguarding the rights of those tested. In the early years of the epidemic, it was understood that protecting the privacy of those who would be tested and giving them basic information about dealing with HIV before the test might be the only means possible of encouraging them to seek testing, hence the so called three C's that are listed here: Confidentiality, consents - that is, informed and specific - and counseling before and after the test. Again, these were meant to build in some

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protection of two people who were in many cases already marginalized, stigmatized, and sometimes criminalized.

In recent years, as I don't need to tell you, influential clinicians and policy people have called for approaches that would rather emphasize initiation of HIV testing by health service providers. These approaches may take the form of offering testing, even recommending it, in a routine way in some circumstances. It is not always clear in these cases whether routine offer includes a well-developed process of informed consent or counseling.

For routine testing, on the other hand, there is in theory the ability to refuse the test but not an emphasis on informed consent. I think Dr. DeCock, and I beg forgiveness if I misheard him this morning, talked about testing approaches where informed consent is actually defined as the right to refuse, I guess I would like to submit that informed consent and the right to refuse are two very different things.

I am reporting today on a consultation of front line service providers, people living with HIV from 11 countries, researchers, and UN officials that was held last October in Montreal. A full report of that meeting is available at [aidslaw.ca](http://aidslaw.ca) as is a human-rights analysis that my organization was requested to write. The questions I will attempt to treat briefly, much more briefly than I was informed that I

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would have, are these. What are the criticisms of VCT that have been raised by those who are calling for provider initiated approaches? What are the human rights concerns that go along with that? And also, as I have time, what is the research that is needed to inform this debate?

As was reiterated to us by a WHO official yesterday at the well-attended testing roundtable, current WHO policy is to encourage routine offered for some populations, notably pregnant women in some circumstances but to emphasize that routine offer includes sufficient pretest counseling so that informed consent can really be thought of as an informed and there even is a definition of the information required for informed consent in 2004 policy statement and that would include some notion of the consequences of being HIV positive, some notion of the treatment and care that are available in a given setting, and other elements. People also, according to WHO, must know that they have a right to refuse a test.

A widely sited *Lancet* article by Dr. DeCock and colleagues that was published at the time of the Barcelona conference laid out a case against overreliance on traditional VCT. I think it is still worth considering these arguments since this piece is so often cited and since many of these same arguments continue to be used. They said, and I will be brief, what VCT with the three C's has not proven

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itself agile, fast, rapid enough to respond to the urgency of AIDS as it is today that, especially in highly affected countries, HIV awareness was already very high so perhaps the need for pretest counseling in particular would be not what it was at the time early in the epidemic. It is also, I think, sometimes suggested that pre-test counseling may be less necessary in an era when treatment is available. Thirdly, that human rights protections only add to stigma and that routinizing or normalizing testing would decrease stigma. And finally, that VCT and its proponents may be said to be undermining social justice if we restrict people's access to testing by insisting on these elements.

There is obviously the implicit suggestion that social justice is a greater good than human rights. All of the rights, all of the elements of the three C's are well enshrined in human rights and I have given a very brief synopsis here of what that means. Informed consent is derived from the right, what we call the right to security of the person, the right to have control over what happens to one's body as well as the right to receive information. These same rights, which are well enshrined in international treaties, are important as a justification for pretest counseling. Post-test counseling obviously addresses the right to information and confidentiality is about, again, the well enshrined right to privacy. There is an important

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consensus that the right to health is not just about access to services but to services of a well-defined quality and a core element of that is that services should be designed as much as possible to minimize human rights abuse including discrimination that may actually be associated with the intervention or the service.

WHO has reviewed the literature or commissioned the review of the literature looking at what really are the human rights abuses that are associated with HIV disclosure and testing around the world, in this case with a focus on Africa and Asia. I am not going to read these figures. They are, to me, shocking figures and it seemed in the Montreal consultation that this led very directly to this question. If pretest counseling, as these authors, suggest can help minimize these abuses or allow women and others to deal more effectively with them, why are we not scaling up pretest counseling rather than seeking to minimize it?

Many of the evaluations of provider initiated testing have focused on a single outcome, namely the uptake or the rate of HIV testing. Again, a concern that emerged from our consultation is, what if in raising the rate of HIV testing, we are including in the net a great number of people who are not well prepared to be tested who don't have information to deal with the possible abuses that may be associated with disclosure of their status and don't even know how to speak

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about disclose, all things that are addressed in good pretest counseling? Again, a successful testing policy and one that, in my view, is consistent with our goals of universal access would seek to minimize these negative outcomes as well as to instill in people confidence in the health system that they will indeed need for longer-term care if they are HIV-positive.

I think I am going to have to skip over that one because of time but we can come back to some of those things in questions. Again, this question, to get back to some of the initial concerns about VCT, about whether routinizing testing will reduce stigma, is an empirical question that merits research. It does strike me as a challenging thing to research in an ethical way, but it also strikes me that in the places where we have more or less routine testing, such as in entering the military in some countries, and getting certain kinds of jobs in some countries, those restrictions that should not apply but do, we don't really have any evidence that this kind of testing reduces stigma. Stigma and abuse, we must remind ourselves, are alive and well and there are relatively few good practice efforts that are pointed to as successes to address them. A lack of confidence in the health system must be part of the equation of this matter of routinizing testing.

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So in conclusion, we were in the Montreal consultation, I should say the participants were very much seized by the idea that ensuring access to HIV testing with counseling, informed consent and confidentiality is indeed well established as part of the human rights obligations of governments, that testing services should be designed to strive to minimize abuse and maximize benefits including the link to treatment and that indeed more documentation of experiences and routinization of testing is sorely needed.

In addition, we thought that - I should say the participants thought that - research is needed on exactly what kinds of elements of pretest counseling may in fact have the potential for helping people to reduce and deal with adverse outcomes of testing and disclosure. Obviously, as said already, whether there is a link between routinizing testing and stigma reduction and also, and I think that this is a key element of how we are evaluating the inevitably rolling out experiences of provider-initiated testing. How are those experienced in real life by people, especially in places where there are perhaps educational or class differences between those seeking testing and those offering it?

We need resources to be sure that these elements that protect human rights related to testing are well funded. If there is routine offer, it should be made with a clear policy

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and good practice of informed consent and pretest counseling. We need to monitor emerging experiences and that means governments must allow independent researchers to be part of that monitoring and especially as always we need to ensure that people living with HIV are part of this process. They are, after all, the experts in whether stigma and discrimination programs are really working.

Universal access really is impossible without human rights. Those who call for routine testing and say that they should be systems of protection against stigma and discrimination, I want to challenge them to show us where the good scale-up plans are for those programs and where the plans are that will lead to interventions that are robust enough to help deal with the human rights challenges of people who are deeply criminalized of an increasing trend of criminalization of HIV transmission and exposure in the world, and the entrenched horrific catastrophic human rights situation of sex workers, people who use drugs, and men who have sex with men.

I believe that this discussion hit a low point, actually, with the accusation that those who are in support of human rights protections around testing were against social justice. There is no need to pit social justice against human rights because there is no social justice without human rights. The Montreal consultation believed

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hardily that the case is compelling for scaling up HIV testing with every element possible for reducing the adverse outcomes of testing and disclosure.

Ladies and gentlemen, the debate on testing seems to me sometimes to be happening as though the problems of living with HIV-linked stigma and criminalization were solved and as though people's right to treatment and support were already guaranteed. Where, again, is the universal access strategy for strengthening real and concrete legal protections for the rights of those living with HIV and those affected and ensuring the enforcement of those protections? It is not enough to promote - oh heck, I lost my human rights now and forever, or whatever it was, slide. Sorry about that.

It is not enough to promote routine testing and add oh, there must be the usual vague stigma and discrimination programs. We need real leadership from governments, from the UN, from donors, and from civil society, for the massive resources that are needed to address the still neglected matter of the human rights of people living with AIDS and those at risk. Thanks.

[APPLAUSE]

**RACHEL ONG:** Thanks, Joanne. We will take questions at the end of the session, so let's allow each of the presenters to speak. Also, a number of people continue to arrive and so that it is less disruptive, if people sitting

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in the aisles could move one seat in at least so that you allow space for people as they come in. Our next presenter is Sunday Musa. He is a medical laboratory scientist specializing in virology and hematology. He serves as a public health educator amongst youth in Northern Nigeria, which he has been doing for the last nine years, working with the Fellowship of Christian Students. Thank you, Musa.

**SUNDAY AKAGWU UNYENE MUSA:** Thank you. Thank you for this opportunity to share our experience in the Fellowship of Christian Students with you on the facilitation of VCT guidelines for churches in Nigeria. The outline of the presentation, I will be telling you a little bit of the background of FCS and how to go into [inaudible] guidelines for churches, and then we will be looking at the background of the initiative and then the process that we undertook, highlight key results from the process, highlight the lessons learned and the challenges and recommendations.

The Fellowship of Christian Students, FCS, is a Christian youth organization that has been working among young people in northern Nigeria for the past 49 years. By next year, we will be celebrating our 50-year anniversary and the work covers 19 states out of the 36 and the federal capital territory. The population coverage for the membership is about 7 million people, essentially children and youth, the target groups, the target community in our

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schools, about 83 primary, 2,758 second grade, and 140 tertiary institutions. Regularly on a yearly basis, we cover about 200 churches. The Fellowship of Christian Students has a project called Aid for AIDS and design for a family with the goal to eradicate HIV/AIDS and with key strategies including capacity building, essentially [inaudible] education in schools, in churches, and in church mobilization and equipping for appropriate and comprehensive HIV and AIDS intervention, family life development, and another strategy being on advocacy. And it's under the advocacy strategy that we feature prominently voluntary confidential counseling and testing.

We are also grossly involved in partnership across the country and apart from the project that FCS has on HIV and AIDS, we also mainstream HIV and AIDS work in the regular evangelism and discipleship. The issues that led to this work, as churches are beginning to understand the importance of HIV testing, they are making HIV testing for people who are preparing for wedding mandatory, but they do not have system to counsel and to care. There is no confidentiality in giving test results. There is no church wedding for persons who test positive. No church policies clearly documented existing for the testing initiatives we are embarking on.

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This particular initiative was based on two churches, the CMML, the Christian Missions in Many Lands, with 105 congregations in four states out of the 36 states and with about 10,450 memberships, and the second is Christian Evangelical Fellowship of Nigeria, CEFN, with 346 congregations in 16 states with about 50,000 people. And actually I had to undergo the mandatory testing for one of the churches, CMML, before I got married.

So, the purpose of this project, of this initiative, is to promote [inaudible] voluntary confidential counseling and testing for HIV prevention and quality care and support for the infected and affected in the churches and communities. The process we are engaged in - We started by sensitizing church leaders by visiting them and essentially the management teams of each of the two churches that we worked with, and then we went on to do needs assessment using focus group discussion with peace decoders headquarters and I would like to tell you what we refer to as the peace decoders: Youth, who are directly affected by the mandatory testing, women who are from [inaudible] and [inaudible] the great part of the burden of children's pain and prizes, pastors who are directly involved in handling any prizes that comes with positive tests without the test counseling and without this test counseling in place, men who champion

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family decisions in those communities and church leaders who are the policy makers.

The next step, one of the challenges in the needs assessment was to engage in focus group discussions with these key stakeholders and find out how they feel, find out what they know about the system that the churches have in place, or whether there are local systems at all. We then went on to have consensus build in workshop, essentially bringing fewer members of the key stakeholders to interact in the workshop setting and then to get them to suggest the various guidelines that they will want. Because after the needs assessment, we have got to know that they were asking for guidelines that will foster a single common voice among the churches. And then we went on to feedback to the senior leaders in the consultation and then we went on to draft the policy because the leaders asked us to go ahead to use conventional guidelines to draft a policy for them and we did that, fed back to the leadership and then the management team went on to revise it and they reviewed it and then to push it forward for approval.

We came up with lots of needs that they identified but just to highlight a few. They happen to be that participatory needs assessment that we engaged in, [inaudible] there is need for comprehensive and sustainable education on HIV and AIDS in the two churches. Policy on HIV

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counseling and testing was needed for common voice and practice in the churches. Pastors need counseling skills for effective visiting services.

Key results included increased proponents to discussion, increased awareness of human rights among the key stakeholders. There was halt in mandatory HIV testing. Policy papers were developed for HIV to churches. Common voice on HIV counseling and testing essentially for personal voluntary confidential counseling and testing was obtained. [inaudible] church now has HIV/AIDS committee that is responsible for HIV/AIDS prevention initiatives and to put in place system for the voluntary confidential counseling and testing.

Let me just show you two, one each, for the churches as examples of policy statements. The CEFN has as number 2.10 of their policy statements that CEFN mission shall provide joint visiting services to prospective couples and married partners and shall not engage in involuntary disclosure of HIV and AIDS status to other family members, which is one of the things they were doing before. The CMML has this, CMML churches shall not refuse to provide church wedding services to members on the basis of their HIV-seropositive status.

Lessons learned: Involvement of peace decoders was [inaudible] process. Church leaders have good intentions for

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asking members to take premarital HIV testing, only that they need capacity building to do it well.

Capacity building of churches on HIV and AIDS remains a huge need. Churches are willing to adopt good practices and mobilization is a need. Churches have good structure for effective voluntary confidential counseling and testing services. The challenges, one of them is to get church leaders to see the place of children, youth and women in church policy development process. Another is inadequate funding to meet up with the capacity building needs and demands of the churches as they are going to see the need for this system to be in place, they are now asking us, come train our pastors, our church leaders on HIV and AIDS. And then they are asking us come train them on counseling skills, both the resources to do these works, we do not know where it could come from at the moment.

Increasing demand for similar process from other church denominations, recommendations to the [inaudible] community, projects to change mandatory testing should adopt [inaudible] process of consultation. Identify clearly that [inaudible] which to enter a church leadership in any welcome churches. The young and the women should be considered as key stakeholders in any church initiative. Rosemary [Inaudible], a woman participant [inaudible] I sincerely desired admission, that is the church should embark on [inaudible]

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and follow vividly every guideline we have provided, my expectation is met. I want to acknowledge [inaudible], Uganda, [inaudible] scripture [inaudible]. Thank you.

[APPLAUSE]

**RACHEL ONG:** Our third speaker is Dr. Miriam Taegtmeyer, who is an infectious disease clinician and former director of the Liverpool VCT project in Kenya. She will be addressing the International Scale-up of Voluntary Counseling and Testing in Kenya, which has potential for abuse in the counseling room.

**MIRIAM TAEGTMEYER:** Good afternoon and thank you. My name is Miriam Taegtmeyer and I am privileged to be presenting on behalf of the Liverpool VCT Center in Nairobi. It is a Kenyan NGO which is giving technical assistance to the establishment of VCT and currently has helped establish over 400 VCT sites in Kenya.

I'm mostly presenting on behalf of Christine Hamilton, a masters student from the Liverpool School of Tropical Medicine. This work was conducted in Kenya, where we have seen a very rapid scale-up of VCT from three to over 700 sites in the last five years. I have not included in this talk aspects of testing such as opt-out testing, prevention of mother to child transmission where Kenya has over 1,000 sites, diagnostic testing, or opt-out testing, as we've said. I've really focused on client-initiated or opt-

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in testing, the traditional voluntary counseling and testing with its three C's model. It is a one-stop service in Kenya where pre-test counseling, testing, and post-test counseling are conducted in the same private confidential space and it is regulated in Kenya by guidelines and a registration system.

There has been a lot of emphasis, I think, globally, not just in Kenya, on rapid scale-up and the rapidity of scale-up has been accompanied on the whole by quality assurance structures for testing and some very basic quality assurance structures for counseling and I would include amongst these the registration system in Kenya whereby nationally registered sites get free test kits in exchange for data from the government. There is also, sent out in the guidelines, selection criteria for counselors, a basic standard training, and counselors in Kenya can fail that training, even if they have paid to go on that course or their organization has sponsored them so it sets the standard there. Registration also demands that organizations opening VCT sites have a basic supervision system in place and by this, I don't mean administrative line management but I mean the counseling support supervision that is based on trust and on counselors getting counseling. There are also some quality assurance measures to deal with the counseling and I think this is a much more tricky area because we are very

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limited on our tools for assessing the quality of the counseling that goes on in the room.

Some sites, including most of the sites established by Liverpool VCT conducts client exit interviews but these in themselves are limited tool. Once that door is closed and the client is in there with a counselor, it is hard to know exactly what the quality of the counseling is.

We set out to explore some of these issues within quality of counseling, in particular the potential for abuse both with VCT providers and with VCT service users. Our other objective was to document some of the perceptions of best ethical practice in VCT but I am not going to mention this further in this talk. The thing that drove us to conduct a very rigorous study on this was that there had been some allegations within VCT sites, one irate client engaged that a counselor had raped her in the VCT room and one of the male VCT counselors doing breast examinations, unnecessary breast examinations, in a VCT room as part of the VCT process.

The study was conducted between November and April 2004 in three geographically very different areas of Kenya with a variety of VCT service models including sites in government health centers including stand-alone sites, including sites within churches. We interviewed 80 people in 49 interviews and we interviewed both service users and

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service providers. About half the site had been given technical assistance by the Liverpool VCT Center, so reflecting the national average.

Key informants that we interviewed included Ministry of Health people, NGO leaders, technical assistants, donors, service users were sampled by snowballing techniques starting with post-test clubs, natural groups formed within VCT sites and we also interviewed VCT counselors through the IC provision groups and the interviews were primarily conducted individually but some were conducted in pairs and some in triads [misspelled?].

A variety of different methods were used and I'm not going to spend a lot of time going into the trustworthiness of the data, but to say that the study did focus a lot on ensuring that this qualitative data was giving trustworthy results and the researchers themselves were trained in all aspects of counseling. In fact, there were professional counselors that we used.

Most of the respondents had very positive experiences at VCT. They said things like, "VCT has changed my life." "The counselor was so supportive." They commented specifically on the sensitive confidential handling of issues, the solution-focused sessions, the time that was given to them as individuals to help them make decisions. But a theme that came up quite frequently was that poor quality

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counseling led to negative experiences in VCT and varyingly people called these abusive experiences.

Here is an example from a female service user. I'll just let you read it. Abusive counselors were also described by clients. For example, I had a male client who came in. When I came to the part on the condom demonstration he said, "madam, I hope to show you something." He just sat down on that chair and he pulled out his penis and I asked him why he did that now that he had come for an HIV test and the client said, "if I sit near a woman, I feel like having sex." Counselors also describe things like being pinned against the wall, clients coming in with a gun threatening them. It was quite difficult for the interviewees to come out and share firsthand experiences of sexual abuse but through supervision sessions, things came of that what might have been happening with counselor against clients.

You get counselors sharing what were happening, others were molesting some children or molesting girls who had come for services. All of the program managers had heard about sexual abuse and I've picked one of the most disturbing quotes but I would cite every single program manager has something similar to say. One of the most difficult experiences I had is when a client said she had been raped in one of our counseling rooms. She told me she had come to VCT and she was told, you know, there is another test which has

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to be done with my penis. Then the counselor put a condom on and he penetrated her and he came. She was so confused now.

We also set out to explore some of the reasons behind this in the research, and we discovered that this kind of thing is happening in other health care services and we heard about it in ENT surgeons, with gynecologists, with clinical officers. And the VCT interaction seems to reflect gender-empowered norms in health services and societies because ladies are vulnerable in the community. These very structures that we employ for VCT with the private sign, the closed door, could be contributing to making people vulnerable, and once you are in that private room with a closed door, you are discussing very sensitive issues around emotions, around sex, around sexuality, and those could also be contributing to these abusive experiences that are happening.

Out of the result of this research, we had quite a high level of concern as programmers. We started to try and change our practice, in particular increasing the number of ministry clients that we were using in our policy assurance and increased seeing, information we were giving to people in the community about what exactly is okay to happen in a VCT room. Finger-pricking is okay, penis tests are not okay.

I think I want to end on a sobering note. The abuse described and documented in the study was conducted in a

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supposed safe environment. It was primarily perpetuated by men against women, and it is quite scary that this could be happening as we are driving to scale up and it makes me want to give a note of caution to the [inaudible] of the scale-up and to say that let's do this carefully. Let's talk about things and let's really concentrate on the quality of the counseling services that we are scaling up here. I'd just like to make the following acknowledgments. Thank you so much.

[APPLAUSE]

**SISONKE MSIMANG:** Our next presenter is Dr. Francis Martinson, physician and public health scientist who is currently the country director of the University of North Carolina Project in Malawi.

**FRANCIS MARTINSON, MD:** Good afternoon. Thank you for giving me the opportunity to share with you some of my experiences in Malawi.

This afternoon, I want to share with you my experience on the impact of routine counseling and testing with an [inaudible] strategy compared to a VCT implementation of the MTCT services in Lilongwe, Malawi. I stand here on behalf of a number of organizations, the University of North Carolina at Chapel Hill, the UNC project in Lilongwe, and [inaudible] AIDS foundation, USAID program, and UNICEF.

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These are the groups that have been supporting the program that we have been doing.

The University of North Carolina has been in Malawi for over 15 years. Over the last four or five years, they have been talking to the Minister of Health regarding the PMTCT services which were all available in the country and by 2002 April the ministry had agreed with University to set up PMTCT services in Malawi using an opt-in strategy. Three years into the program, with the recommendation of the ministry again and in collaboration with the ministry, the strategy was changed from an opt-in program to an opt-out program.

The program provides services in four main sites. Once in [inaudible] which is [inaudible] and three health centers. The program currently provides services to about 20,000 new [inaudible] patients every year.

The overall objective of the program is to reduce the risk of maternal-to-child transmission of HIV through integration of health, education, special HIV and AIDS education, routine counseling and testing, [inaudible] prophylaxis to mother and infant, in addition to the existing maternal [inaudible] health care delivery system which is also provided by the system.

The program has a number of components. There is HIV educational component, which is given to every woman coming

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into the program. There is also the routine testing, which is available to pregnant women. The program also provides basic health care services like HB testing and syphilis testing in addition to supplemental vitamins and mineral are provided to everybody coming. These are luxuries in Malawi. In addition to this, in May 2006, the program has starting providing Bactrim to all HIV-positive mothers. Also since last month, the program has started providing CD4 counsel for women who are going through the program who test positive.

There is also a provision of comprehensive obstetric care for everybody who goes through this system. In addition, we provide single-dose Novaripine to mothers at week 32 of gestation and also to infants at delivery. There is provision of the comprehensive post-natal care to mother and child, [inaudible] vaccinations to all children who come through our units, and now over the last two months or so, Bactrim is being provided as prophylaxis to all children of mothers who are HIV-positive and to somewhere around 12 months to 18 months when we know their HIV diagnosis.

We are also currently providing support for a support group of infected women and also for breastfeeding groups so that they are able to keep those people who are taking this program.

Prior to April 2005, we had an opt-in strategy which involved daily sensitization of natal women in the waiting

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areas. Thereafter, women were put in small groups of eight to 12 and then counseling provided to them. Then we went further to see individual women and do a lot of one-on-one counseling with normally between 45 minutes and an hour, and then after, there was an oral consent process. Testing was then done on one basis and then post-testing done thereafter. All the women were advised to deliver in health centers that they were [inaudible].

The opt-out strategy which we introduced in April 2005 had a very slight different approach from what we are doing. Women who were seen in the waiting room were still provided with education and a newly registered woman was counseled in groups of eight to 12. However, there were various other changes that were put in place. After the group counseling, women were then offered HIV tests. Women who were not interested were offered opportunity to decline the test but they still received other UNC services that they needed for the day. Those who were interested received their testing one on one basis and then thereafter they had their post-test counseling. People who had opted not to take part in the test but came on later on in the pregnancy and were interested, we also offered this opt-out strategy.

For both processes, the rapid test was being used and they were used both determining [inaudible] and people who were concordant for positive for the two tests were, they

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thought had been positive and those who were concordant negative were designated as negative. The [inaudible] rapid test was used as the tiebreaker for those who were discordant. At week 32, mothers were given Novaripine to take at delivery. Also in the opt-out strategy, women who came in at week 32 were offered infant feeding counseling and were encouraged to come to the clinic as soon as they deliver for the [inaudible] and those who delivered in the clinics were offered the syrup as soon as they delivered within 24 hours.

I won't share with you the data that we collected nine months before we were started an opt-out process and compared to the nine months after we started the opt-out process. As I said earlier, on a yearly basis we have about 20,000 women come in through the system so for the opt-in process of nine months prior we saw about 15,000 women. Out of that, 76-percent offered to get tested and about the same number of people, 76-percent actually got a test. Out of those, only about 14.8-percent were HIV-positive.

When we switched over for the following nine months, once again with about 15,000 people who were interested in being offered a test and 98-percent of these people were counseled and offered the test. Once again, the number of people who were positive was about 14-percent.

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In conclusion, see that by offering or by switching over there was an increase of about 24-percent of the people who did agree to have HIV testing. There was also an uptake of Novaripine prophylaxis to mother and infant first during this period. A few recommendations that we gave to the Minister of Health following this experience that we had advised the Minister of Health in Malawi to change over to an opt-out process and also to have single dose Novaripine available to all women in these places.

We also asked that there needs to be a pre-packed Novaripine syrup system for mothers to take home to allow for those to deliver at home the Novaripine can be made available to them. There were a few goals that we set ourselves from the experiences that we have gone through.

We have advised the country to look at using our experiences in the long way as a model for the country to expand on and also we are also asking the system to move towards an opt-out program so that everybody in Malawi is able to enjoy their benefits of what we are doing. We have not only done that, we have also asked the ministry to help us get men involved in all that we do in this MTCT program. The safe motherhood program has also been incorporated into our program with an aim of making sure that every woman who goes through this system that they go to enjoy VCT.

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This is our modest place that we work out from. I would like to have [inaudible] for the people from this great place that the AIDS foundation, USAID, UNICEF, and all our other collaborators and especially people that we work with, the projects employees who have made this [inaudible]. Thank you.

[APPLAUSE]

**RACHEL ONG:** Our last speaker for today is Denise Serafim. She is a psychologist and technical assessor of the prevention unit of the national program on STD and AIDS of the Ministry of Health in Brazil. She will be addressing counseling and the use of anti-HIV rapid tests, the experience of the Brazilian AIDS program.

**DENISE SERAFIM:** Good afternoon [inaudible] have the opportunity to tell you about counseling, rapid testing in my country.

It is necessary to say first about the context in the 2004 year. Context: HIV diagnosis, low rates of HIV testing, late diagnosis, evaluation of rapid tests of [inaudible], for HIV diagnosis, a proven of access to HIV diagnose is a priority to the Brazilian national STD/AIDS program. Counseling: [Inaudible] diagnose of HIV and other STD is still concentrated in the specialized health facilities like VCT or HIV treatment centers. Risk evaluation and the anti-HIV tests offer [inaudible] ordinary

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health consultations. Adaptation to primary care facilities, possibilities and limits. Relevance of the anti-HIV rapid test increasing the offer of HIV diagnosis, especially in visions of restricted access [inaudible] laboratory, and health service networks and insufficient human resources, improvement in the rates of people who don't return to pick up the test results, research showing highest [inaudible] for the rapid test, requiring question, rapid test, should counseling also be rapid?

Implementation, a state of [inaudible] biggest estate in Brazil, access mainly by water [inaudible] and air, diagnosis concentrated in the states capital, selection, 12 municipalities and 14 health facilities, Brazil in South America, one idea, state of Amazons, the locals in red points, stage, development of specific training on counseling for our rapid test, 16 hours, elaboration of counseling protocol considering rapid test [inaudible].

Guiding questions, would there be difference in performing counseling when use a rapid test for diagnosis? What should the men challenges be? Training for two groups of 19 [inaudible] 20 people, professional profile, and multidisciplinary team. Most of the health professionals didn't have any experience with counseling or HIV/AIDS related issues; contents of training, health professionals' perception of the new technology, reliability availability,

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[inaudible] counseling, vulnerability, risks, objectives and contents of the counseling process. Particularities of the rapid test, where are the changes?

Dramatization of pre- and post-test counseling sessions, [inaudible] of the counseling protocol, development of [inaudible] for monitoring and evaluating the implementation in the health facilities [inaudible], script for counseling observation, interviews with health professionals, facilities, managers and patients, monitoring visits in 12 health facilities four months after implementation, conversations from training, the health teams' perceptions about the health facilities, confidentiality, high demand, priority given to pregnant women about counseling, same as the ability to deliver a positive test result, vulnerability, frequently interpreted as risks, fast delivery of test results seems to be more [inaudible] about training, expectations of [inaudible] contents, requests of observing or counseling session in the health facility, from monitoring, challenges of rapid tests, immediates delivery of test results, health professionals, few more [inaudible] and unsecured comfort to the traditional methods, some facilities postponement the delivery to the next day.

Counseling protocol, little use in the [inaudible] besides reading and practice, activities during training,

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difficulties non-specific from rapid tests, professionals with little or no counseling experience, dealing with subjectivity, counseling limited to information with evaluation done without considering specific vulnerabilities nor individual needs for testing, negative results, permanently develop related as opportunities for preventive approach, cultural and language barriers, the approach of [inaudible] indigenous and the Spanish speaking people [inaudible] about training, counseling, training when used in rapid tests is necessary, technical contents remains basically the same, special attention for handling the [inaudible] associate to deliver of the test results, case discussion and edematization should use real examples from the health professionals they practice.

Some recommendations about monitoring is essential, I think, to find the particularities of each local facility and technical skews, bring forth some of the information and discuss the barriers that have been found. Perspectives, process of implementation in other states, priority given to VCT centers in maternity clinics, development of distance learning course on STD/AIDS counseling.

Lessons learned: The use of rapid test technology has contributed to the debate on counseling [inaudible] types and [inaudible]. The test methodology does not change the need of understanding the subjective aspects of each patient.

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STD/AIDS counseling remains as an important practice for prevention in health facilities and for the promotion of comprehensive health care. Thank you.

[APPLAUSE]

I'm sorry my English.

**RACHEL ONG:** I would like to thank the presenters for their diverse and challenging perspectives which link disclosure as an impertinent factor in routine and rapid testing. They have provided a very broad perspective. We only have half an hour for questions and answers. I would like you to come up to the microphone, be as brief and concise as you can. If you would like to introduce yourself, and who you are directing the question to, we will take two questions each time and then we will answer the questions. Maybe we can start at microphone number 1. For the people upstairs, if you would like to have any questions, the volunteers can come upstairs and they will give you the question cards.

**ROGER DEATLES:** Roger Deatles from UCLA. I have a question that has been troubling me for some time. The epidemic is driven by people who do not know they are infected. One of the most vulnerable and powerless groups in the face of the epidemic are wives. My question is this: Does a gentleman who declines to be tested out of fear or for

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whatever reason then have the right to infect his wife? What are the rights of the wife in this situation? Thank you.

**RACHEL ONG:** I'm sorry, but when you are asking questions it would be good to know who you are directing the question to, if you have it directed to anyone.

**ROGER DEATLES:** I don't remember the names of the speakers, but the lady to your immediate right.

**RACHEL ONG:** The names are actually on the table in front of us so that would be Joanne. Thank you. I think we are alternating between mics so you go ahead at number 2.

**FEMALE SPEAKER:** I have a question for the woman from Kenya with the abuse in the counseling room. I just wondered, it seems like on a practical level, if we just had women counseling women and men counseling men, that might improve the quality overall. Can you comment on that? Is that not a practical solution in the setting that you are working in?

**SISONKE MSIMANG:** So if you mind saying who you are?

**FEMALE SPEAKER:** I'm [Inaudible] from Johns Hopkins, Baltimore.

**RACHEL ONG:** Sorry, there are three microphones. Sorry, there are four mics. In any case, there is a microphone, there is one in the back but let's just use three for purposes of ease. So let's take three questions in a round and then we will answer them. So you ask the last question and then we will take another round.

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**ROBERT FLITZMAN:** For the speaker talking about the sexual abuse among the counselors, I am curious. I am Robert Flitzman from Columbia University in New York, by the way. I am curious about the training of the counselors. In other words, who the counselors were, what kinds of training they had. Would that have been immediately obvious if they were not sufficiently trained or were they thought to be sufficiently trained and engaged in the abuse anyway?

**RACHEL ONG:** Would Joanne answer the questions and then maybe Miriam?

**JOANNE CSETE:** I think that women have the right to be able to leave unsafe unions and that right is not granted to them under the law in many countries because they can't own property in the same way that men can and they can't initiate divorce in the same way that men can. And I think that there is a lot to be done in that area.

I don't think it is useful to think in terms of the right to infect anyone and I think that the scenario that your question comes from speaks to how inadequately, in spite of mountains of gender analysis, we have really seen resources flow to first of all address the whole matter of awareness of rights and people's legal protection of rights of men and women within marriage, within any other institution, we are really not there.

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What drives, I mean you depicted this in one way, I would say what is driving HIV in that case is the subordination of women, which is nowhere to be seen on policy agendas in most settings where that is, in fact, an important determinant of the epidemic. What difference has it made that there is a global fund for the matter of subordination of women as an important driving factor for HIV? Women seem to be missing from the coordinating mechanisms. I think that there is a lot to do and I don't think the kind of false application of human rights language helps us. I think what we really need is to see the gender inequity basis of HIV/AIDS and actually do something about it for a change.

[APPLAUSE]

**MIRIAM TAEGTMEYER:** To the lady from Johns Hopkins, same-sex counseling is one of the strategies we are suggesting and implementing. It is not yet a nationwide policy and that is because of discussions about human resource constraints, especially in government public health centers in villages where maybe only one government member of staff is doing VCT counseling at any one time.

On the question about training, Kenya has 126-hour training curriculum. It is a residential three-week course and most of the participants already qualified health care workers. There is also training for lay counselors. That is followed by compulsory period of observed practice and they

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have to be seen to counsel X number of clients and so many of them must have tested positive so many be couples. We have a 20-percent failure rate on the course, so the selection criteria that people make before the counseling training are getting more and more stringent because nobody wants to pay that money and have their candidate not pass.

The training takes into account a lot of issues around values and attitudes and sex and sexuality, as well as issues around gender and gender norms in society, it's quite a values-based training, as well as skill-based practical approach to training.

Again, it is a balance. You are making VCT counselors, you are not making professional therapeutic counselors, and it is about how long people can be released from government services who are meant to be providing other health care services. Remember, these are a minority of experiences, although the way I have presented it is maybe that it is happening all the time and I think regardless of the training, even if you had highly qualified professional counselors, this would be happening.

**SISONKE MSIMANG:** Thanks, Miriam. There are a few questions that have come from upstairs so I will pose this one, but then we will ask for two more speakers from the floor down here. The question is, what is your opinion about household testing and providing results to respondents in the

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house? This is being considered in Kenya and I think it is likely that is directed at Joanne. It was from Laurie Liskin and someone based in the U.S. Can we get this microphone, sorry, let's start with microphone number 1.

**IAN MCCLLOUD:** Thanks. My name is Ian McCloud. I work with UNICEF. I want to thank all of the presenters, to start off with. They were all very interesting presentations. The one thing I did notice was sort of the homogeneity in terms of the age or there was not discussed in terms of age around the rights to counseling and testing and I am wondering if we can hear a little bit from Miriam and Sunday about practical experiences ensuring that children/adolescents have the right to access counseling and testing. Thank you.

**MALE SPEAKER:** My name is [Inaudible]. I come from Kenya. I work with PPTF. My question goes to Francis. This experience in Malawi with routine testing, what is the quality of life of people who test positive after routine counseling? I mean routine testing. How is the family support, how is adherence to treatment?

I am thinking that these are people who may not have thought about HIV in the first place and here they come to a pre-natal and they are tested and they suddenly have to start thinking about a lot of things and disclosure and so on.

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Secondly, Francis, for whose benefit is routine counseling and testing? Because VCT is client-based. For whose benefit is routine testing?

[APPLAUSE]

**RACHEL ONG:** Could Sunday answer the question, followed by Miriam and then Francis?

**MIRIAM TAEGTMEYER:** The question on household testing?

**JOANNE CSETE:** Yes, household testing. I think we have seen this come up in a very active way in the suit to where if there isn't already there will soon be, as I understand it, a door-to-door campaign. I think we heard in the plenary session this morning the head of the AIDS program in Rwanda tell us that the majority of women in her country do not deliver their children in a health facility. I believe that there need to be strategies to be sure that people are offered tests.

Obviously, people should have good access to HIV testing but I believe that HIV testing contributes most to universal access when it has those protections of confidentiality, of counseling and of [LAUGHTER] sorry, I can't even remember the three C's up to, and consent, sorry, it is hard enough to monitor what happens in that regard in health facility. Monitoring how those things play out in a household will be a great challenge, so I think that this is

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going to be, in addition, I believe that there is a real confidentiality challenge for any kind of process like this that happens within a household, especially if we are in a place where women, for instance, are not allowed to have a one-on-one conversation in private without a male member of the family being present.

So I think we are talking here about a real concern about being sure that resources are there so that if in the household setting it is not possible to maintain confidentiality, there are ways to deal with that.

I think also, and I think this with respect to all of the routine provider-initiated models that have been proposed, that governments really do have to seriously allow for independent monitoring and that needs to be very well funded.

**MIRIAM TAEGTMEYER:** Since I've got a microphone and you can't stop me, I want to add some comments on the household testing. I think it could be a good idea provided that the quality assurance measures are there but I actually [inaudible] how is it paid for? It is so expensive. Is it sustainable? What does it mean in the long-term? We are trying to integrate these services into primary health care centers. They are a service like any other. Why is HIV testing so special it has been taken to people's homes and what does that mean in the future for the government and for

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sustainability of these services? I think it is a good idea if we can maintain the quality but I have question marks around it.

To fail to address the question from UNICEF, the VCT guidelines in Kenya enshrine the rights of mature minors. In other words, young people who are sexually active but there is a gap around children and I think Dr. [Inaudible] raised that this morning very well in the plenary. And I wouldn't say that the VCT guidelines have done much to protect the rights of children in testing and it is a gap.

**SUNDAY AKAGWU UNYENE MUSA:** Okay, I think that it is a good idea to say it to engaging household counseling, especially the issue of couple counseling. I think it will be very helpful.

In terms of the rights of children and the issue of age, our course mainly concentrated on people preparing for marriage and who are married in the church, even though it is generally to promote healthy VCT in the church setting so for children it will be important that consent be sought from their parents.

**FRANCIS MARTINSON, MD:** Okay, regarding the issue of quality of life after testing, I think this has been a very dynamic process since the advent of testing. I mean, people who initially very scared, who went through a lot of abuse in the early stages. As life has progressed, as various

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treatment options, various options for people who are infected have come on board and quality of life for people who are getting testing and are testing positive has improved over time.

That is not to say that there is no problem. Yes, there is problem, but because there is a problem, that doesn't mean that we shouldn't try to solve the problem. There is a problem and we will continue to find ways and means of dealing with the issue of quality of life after testing until we have found the rights of [inaudible].

As to who benefits from routine testing, ask a clinician and probably health scientist as both individual and society. The individual because once the individual knows his or her status, he is able to lead a life that can help him or her live longer. As a society, yes, society is able to help that person also lead a better life. Society is able to know how many people need extra help so that they are able to help them in that direction.

As far as clinicians and public health care specialists are concerned, it gives them an opportunity to plan as to what kind of health service delivery are needed to help everybody.

**SISONKE MSIMANG:** Thank you. Okay, we have another question from the floor. This one is from upstairs. Could you tell who provides the VCT consultation in the churches?

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So I assume it is aimed at Sunday. Is it a health care specialist or is it a volunteer? Then we will take from microphone number 3 and then back to number 1.

**ALAN BERKMAN:** Alan Berkman from Columbia University. First, thank you in particular for putting the issue of rapid testing and routine testing together. I always have the vision of a pregnant woman being happy about being pregnant coming to the ANC and leaving a few hours later just having been told that she has a potentially fatal disease that she could transmit to her infant. So I think this issue of anxiety for rapid testing may be a problem for the provider, for the counselor. I think it is potentially a huge problem for the person who receives the result of rapid testing.

I guess my question is that in these discussions, there is an assumption that people who are positive change their behavior, and I guess I have a question for anybody on the panel that everything I have ever seen that documents that was a VCT. Now we are switching and that many people voluntarily wanted to be tested and by a behavior change analysis they were more ready to change their behavior. Now we are switching to a whole new paradigm and yet we are still using the same understanding from a whole different VCT model.

Has anybody ever seen any data that supports that?  
Or has anybody ever seen another example where we have done a

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huge natural experiment of subjecting people to stigma and the adverse events that might flow from that? Thank you.

[APPLAUSE]

**THEO LYONS [misspelled?]:** My name is Theo Lyons and I am a high school student in Canada, and my question relates again to the stories of abuse and it is really this. I am left a little bit confused, having heard these appalling stories and then recently been told that the counselors were reasonably trained and that apparently the abuse would most likely continue, even with professional counselors. So my question really is, what is the message? Is the system in Kenya, is it adequate in your opinion and what can be done to improve conditions if they need to be improved in the scale-up which is so clearly needed today? Thank you.

**RACHEL ONG:** Okay, maybe Joanne could take the first question from Alan and then maybe Sunday would like to take [INTERPOSING].

**JOANNE CSETE:** I don't think I can say much more than Alan Berkman has already said with that question, but I found it interesting. WHO has recently, I think, gotten a team from Johns Hopkins, actually, to review what they consider the experimental and good observational studies on various models of testing. And that was done prior to a consultation I think in June in Geneva about models of testing.

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And it is interesting that the only experimental design we have is indeed as you say with VCT and those are very few studies. The monitoring, evaluation and research questions, including the ethical questions on how we even begin to look at these things in routine models, I think, is an important challenge. But certainly in the consultation that I was reporting on, this came up again, the point that you made came up again and again, how is it that in the provider initiated situations the preventive value of the transfer of information or counseling can be preserved and is there really any interest in doing that?

Again, we have to keep asking ourselves what is the reason for this routine testing if the main or provider initiated testing, if the main motivation is to raise those rates of uptake, that is one thing, but when are we going to start looking in our research at what the behavior change outcomes look like?

**SUNDAY AKAGWU UNYENE MUSA:** I would be responding to the question on visiting church settings to provide professionals or volunteers. The church setting, from my experience, first as volunteers, will be effective in providing VCT, provided they are given adequate training, capacity building and there is a continuous monitoring and evaluation and mentoring going with that.

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**MIRIAM TAEGTMEYER:** Mine is to reply to Theo. I think you are right to be shocked but I think this is a much wider problem than Kenya alone and again, within Kenya, it is a minority open to actions that are happening and you need to keep that in mind. It is a minority, although it is a shocking story.

The reason I think it is a wider problem is that it touches on gender and power norms in society and on vulnerability and on vulnerable situations and Kenya is known for its very good quality VCT program and exceptional effort gets put into quality assurance with scale-up. And I would say specifically that Liverpool VCT has spearheaded some of that but it also takes a lot of bravery for a program or a country to come out and say that this is happening and it is happening.

And all I can think is that if it is happening to us, with the effort we have put in to quality assurance, it is happening much more widely and that needs to be titled through some of the different methods we have raised and other suggestions.

**SISONKE MSIMANG:** Can I just add a clarification to that as the chair? Because I think it is important in settings like this one for the question around the high school student, is that often in international settings when we talk about things that happen, especially in African

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settings. It is easy to take something out of context and misunderstand what is happening there and I think what people often get drawn to is the appalling, shocking story and I think it was used for illustrative effect in the presentation. And I think that is an important thing to keep in mind, that it is indicative of larger issues around sexual violence and so on, but that it could have just as easily have happened in any other context, given the gender-based violence as something that happens worldwide. So I don't want us to misunderstand why the example was offered.

Yeah? Okay let's take another round of questions. Let's start with microphone number 2 so that is this side, and then we will go to microphone number 3 in the center and then we will go to microphone number 1 over there.

**SHAMAN MUHAMMAD, JR:** Okay, hi, my name is Shaman Muhammad, Jr. I am from Toronto. I am a founder of letsstopaids.org, and my question is, first of all, let me just tell you as running a non-profit organization and returning last month from South Africa, our organization is now moving to a new step, which we are getting interested in HIV, rapid HIV testing, and what we have been doing more research on, since we work with children in rural environments and orphans, we are trying to see right now to analyze different reasons for safety concerns and just concerns about a procedure of how we can ensure, since our

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organization mainly operates in Canada and the work would be taught to wherever the Third World country would be. Would you have any direct advice, especially since our organization is growing and it is one big concern for us about the safety, especially since it would be dealing with children all the way from the age of 6 all the way to 21.

**SISONKE MSIMANG:** Okay, we'll take the next question. Thank you for that.

**MAE [INAUDIBLE]:** Mae [Inaudible] from the London School of Hygiene and Tropical Medicine. Allow me to paraphrase a couple of comments that were made by health care workers in a setting what we work with in South Africa regarding the effect of not routine testing but very recommended testing on the efficacy of treatment with patients. With this health care worker saying, this is again a paraphrasing of their comments, when the program started we were pushed to test and put on treatment as many people as possible. Many people were started on treatment too early. We have targets. Once we have targets, it will be quantity over quality. It will be a never-ending cycle of default or nonadherence.

I suppose my question to the panel is if they are aware of any studies that have evaluated the effect of routine testing on the adherence of patients later on and also on their retention to the programs, once they get

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started on treatment. This is especially considering that we all agree that people should have the opportunity to test, should have the opportunity to go to treatment, but also should have the right to succeed on treatment. Thank you.

**SISONKE MSIMANG:** Thanks for that question.

**MALE SPEAKER:** My name is [Inaudible]. I am at Santa Fe National Health University of Bergen. I have a comment and a question. The comment is that I think that routine testing is really the thing to come. Ten years from now it is going to be all over the place and in many places there is a maturation.

In the first place when you start with testing, nobody there is to really talk out, speak out about it and so on, and then with time when it becomes more of a routine, yeah the shoulders get down and people get at ease. And for instance, I am collaborating with McCary University Department of Pediatrics, where testing was not quite an issue. Severely malnourished children, we looked at them and we introduced routine testing for all of the children with the consent of the parents and the pre-test counseling and everything, and acceptance was almost 100-percent, I mean, about 90-percent. So people really wanted this and they were happy that it happened. And also looking in another end of the world, in Sweden, there was a poster the other day that the last mother-to-child transmission in Sweden happened in

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1999. Since then, they have had 230 deliveries without any transmission at all. Why is that? One reason is that there is routine testing opt-out for all pregnant women in Sweden.

The question is when you start with routine counseling and testing, there are worries that what happens to the women, for instance, in an [inaudible] setting where if they come out one hour later and they know that they are HIV positive. One of the problems in the PMTCT setting is that if the women are going to take drugs –

**SISONKE MSIMANG:** I'm sorry, we are running low on time.

**MALE SPEAKER:** Then, they need support, what about looking into the issue of couple counseling and pushing the issue of having somebody with the lady when the routine counseling is happening?

**SISONKE MSIMANG:** Thanks for that last question. I think people are clear on the questions that have been directed at them. I would like to add to the last question and Joanne is taking the first question that was asked. I would like to add to the question around couple testing, which came up in one of the presentations and it hasn't been addressed by anyone in the audience, which is what is the thinking around the group testing and the ethics and confidentiality issues that are raised there in the Malawi example that was provided? So, if we will kick off with

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Joanne again and take it down the row with the rest of the responses, we have five minutes left, depending on how quickly the panel is able to answer the questions. Then we will then take a last round of questions.

**JOANNE CSETE:** Very, very quickly, Shaman, I think you are actually very lucky because in my view, you are in the place that has the best experience and documented experience on rapid testing. And what that means for counseling and guidelines and that is the hassle-free clinic here in Toronto, one of the most established anonymous testing clinics in the world.

They documented with McMaster University in Hamilton, Ontario, an experience in a monograph that you can get on the McMaster University AIDS program Web site, a fabulous document and I recommend it highly to everyone as a complement to the many wonderful things also that Denise was talking about from Brazil. It is really an excellent document about what it means for the counselor, what it means for the person being tested, and can give you a lot of guidance.

The question of the group testing, of course, we probably want to hear from Francis. WHO has actually said at various times and guidelines that part of pre-test counseling should be a chance to be able to ask questions in confidence, including questions about sex and questions about HIV. I

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think that is my concern in the stories about group testing, which I have myself witnessed many times in the 12 or so years I worked in Africa. It may be in some settings that you have a group of women for instance who are comfortable enough with each other so that there is some level of being able to ask very delicate questions. It may be not, and I think that is also a challenge with couples counseling, which nonetheless I am sure holds great promise, especially for reduction of violence and abuse in some settings.

On the matter of routine testing is the thing of the future, you know, five years ago, six years ago, seven years, it was an acceptable idea in international policy discussions on HIV/AIDS that in resource limited settings people just won't have access to antiretroviral drugs, it's not feasible. We have been through 3 x 5. We certainly don't have that idea anymore. I think the thing of the future should be that people have a right in all countries, even resource limited countries, to good information, to information that comes to them in an accessible way from people they can have confidence in, from people who are well trained and well supported, and that is the thing of the future and I don't see why that needs to be incompatible with ratcheting up HIV testing.

[APPLAUSE]

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**SUNDAY AKAGWU UNYENE MUSA:** Couple counseling will really help in solving the problem of men who are the ones to disclose their status to their wives. This is a huge problem in the part of my [inaudible] where I work and it is important to note that it is effective from my experience, not all parts of Nigeria, especially in the Christian setting, couples see themselves as one and that makes it easier for them to accept couple counseling. The problem comes when the counseling is not comprehensive and when it is not offered in a progressive way.

**MIRIAM TAEGTMEYER:** Very briefly, I am not aware of any studies that look at follow-up and adherence following routine testing. I think the lady who asked that question has gone. I think it is a study that needs to be designed and we are working on it with the follow-up of diagnostic testing compared to VCT.

**FRANCIS MARTINSON, MD:** Addressing the [inaudible] epidemic, I think we are in a situation where we have something that we have never come across as humankind and just have to ask, as humankind, to fall on all the tools that we know and to modify them as we go along to move the tools more effective for dealing with the issue. There was VCT initially. Over the years, as treatment has got more available and other items in the fight have become more

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readily available, these tools are being sharpened in a way that can deal with a situation in various places.

Before, yes, we were doing individual counseling. Maybe other times, we didn't have the resources to deal with the numbers that were going to come in or we did have the resources to deal with the numbers that were coming in so that was an adequate tool.

After the years have gone by, we are noticing the use in group counseling as people have become more knowledgeable with HIV activities, becoming a more effective tool on the ground than having a one on one kind of transaction with people and that people tend to learn more from their peers in these discussions than having a one on one kind of interaction and as we move along we are sure that we will pick up more tools which may make this even more effective in the provision of ACT.

**RACHEL ONG:** I'm just going to thank the presenters for their presentations and your participation. I am sorry that we have run out of time, but we would like for you to properly come and approach the speakers afterwards. I am just going to let Sisonke wrap up the session.

**SISONKE MSIMANG:** I really don't think there is any need for wrap-up. Thank you all very much for coming.

[APPLAUSE]

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