Increasing HIV Testing and Counselling in the Kingdom of Swaziland

The Epidemic

Swaziland has the highest HIV prevalence in the world, currently estimated at 26% among adults aged 15-49 years. In all, an estimated one in three women (the highest female prevalence in the world) and one in five men are HIV+. With a high HIV incidence rate of 2.9%, the epidemic continues to grow. Although Swaziland is a small country (1,167,834 people), the HIV population is over 190,000. The National Emergency Response Council on HIV and AIDS (NERCHA) describes the country as one at war against HIV. Strong leadership from the public sector and the activities of multiple private, community and nongovernmental actors have contributed to a vibrant national response. This has been led by key government frameworks and initiatives including The National Strategic Framework for HIV and AIDS (NSF 2009-2014). In combination with HIV, Swaziland is also facing an alarming tuberculosis epidemic and currently has the world's highest TB incident rate (1198/100,000), as well as an 80% rate of TB/HIV co-infection.

A Renewed Focus on HIV Testing and Counselling

HIV testing, combined with high quality and effective counselling, is a crucial component of strong response to HIV. HIV testing and counselling (HTC) is critical for establishing HIV positive status and subsequently identifying patient CD4 counts in order to determine treatment needs and link HIV+ individuals with antiretroviral therapy (ART). HTC is also an acknowledged key prevention strategy which can reinforce positive behaviours among HIV- individuals and assist HIV+ patients to keep their partners and family members healthy. With the growing availability of ART and a renewed focus on HIV prevention, HTC has emerged as a central strategy to strengthen the continuum of HIV services and encourage more people to know their status and access care.

Unfortunately, the rates of HIV testing in Swaziland have not kept up with the growth of the epidemic or matched the expansion of treatment services. In 2006-2007 only 22% of women and 9% of men were tested for HIV and received their results. These figures are a clear testimony to the fact that the vast majority of the population does not currently
know their HIV status and that many opportunities to counsel and test individuals for HIV are being missed.

Starting in 2002, Swaziland adopted a Voluntary Counselling and Testing (VCT) program, which focused on increasing access to testing through a client-initiated approach. In 2006, in response to the severe unmet need for HTC, the Ministry of Health (MOH) adopted a paradigm shift to emphasize provider-initiated HIV testing and counselling (PIHTC). As opposed to VCT, PIHTC allows patients to access HIV testing whenever they seek care while maintaining the choice to “opt-out,” thus significantly reducing missed opportunities for HIV identification and creating more entry points for all clients attending clinical care to access HIV prevention, treatment, and support services.

**The Partners**

The Centers for Disease Control and Prevention (CDC) Global AIDS Program (GAP) began providing assistance to Swaziland in 2004. CDC works as part of a unified US Government HIV/AIDS team and provides technical assistance and financial support to develop and expand innovative HIV testing and counselling approaches and strengthen TB/HIV programs. CDC works closely with the Swaziland National AIDS Program (SNAP) to implement the Health Sector Response Plan (2006-2008), including strengthening national laboratory network and monitoring and evaluation, surveillance, and health information systems.

On June 4, 2009, the U.S. Ambassador to Swaziland and the Prime Minister of the Kingdom of Swaziland signed the Swaziland Partnership Framework on HIV and AIDS 2009-2013 (PF), further strengthening the commitment of US partners to combat HIV and TB in Swaziland. This PF was the second of its kind established between the US President’s Emergency Plan for AIDS Relief (PEPFAR) program and a host government. The Swaziland PF focuses on developing a comprehensive national HIV prevention program, improving the coverage and quality of HIV-related treatment and care, mitigating the impact of HIV/AIDS especially for children, increasing access to high quality medical male circumcision, and building the human and institutional capacity needed to achieve and sustain these goals. PFs such as this one provide a 5-year joint strategic framework focused on service delivery, HIV/AIDS policy reform, and shared financial and/or in-kind commitments.

**Best practice: HTC Collaboratives**

The URC HTC project uses the collaborative improvement approach, a data driven facility level approach to service delivery. The collaborative improvement approach is based on leveraging teams formed at the facility level to determine priority areas needed to improve HIV testing and counseling. These teams then develop improvement plans, detailing expected results, steps and processes to be undertaken to improve service delivery. Clear responsibilities are apportioned to individuals and targets are set. Each month the data of service uptake in PIHTC is analyzed and compared to expectations and targets. The team suggests changes and improvements and modifies the implementation plan. This exercise is repeated monthly with mentorship and supportive supervision from URC HTC officers.

At the facility level, a URC HTC officer reviews improvement plans with staff members, occasionally assisting with service provision, and helps assess systems and compliance with guidelines and standards. A standard checklist monitoring tool is used. Facilities then meet at regular intervals to share experiences and best practices. This approach emphasizes collaboration between facilities to spread best practices in strategizing interventions and translating policies into action.

**The HIV Testing and Counselling Project**

Building on the growing momentum around PIHTC, in 2006 the CDC initiated a project to increase HTC in Swaziland and South Africa, implemented by University Research Co., LLC (URC). The URC HTC project provides critical technical assistance to the Ministry of Health to develop and undertake the paradigm shift from VCT to a dual approach that includes provider-initiated HTC. Due to the alarming overlap between the TB and HIV epidemics in Swaziland and the high rate of co-infection of TB patients with HIV (estimated at 80%), the project focuses especially on working within TB clinical care settings to increase the number of TB suspects and patients offered HTC and
referred onward for HIV care and treatment, at the same time contributing to a stronger integration of TB and HIV services. Since the project began in 2006, it has worked nationwide and currently provides direct support to 28 TB diagnostic centres throughout the country. Building from the success of this approach, the project expanded its focus in 2009 to include inpatient facilities, outpatient departments (OPDs), and hospital-based VCT in 5 large health facilities.

HTC provides an important platform for supporting activities to encourage sexual prevention of HIV and URC works closely with its regional and facility level partners to increase outlets for prevention messages and services. The HTC project works with clinics to ensure the availability of condoms and to build provider skills to promote consistent and correct condom use as part of testing and counselling services. Working primarily through the TB setting, the project also works to expand prevention efforts by encouraging the greater involvement of community-based organizations and NGOs in order to build referrals for testing and clinic-based HIV and TB services. Through involvement with these organizations, the project has also developed systems to expand home-based HTC. This is an important innovation which allows the family members and close contacts of index TB cases to be reached with testing and counselling in their homes, further reinforcing health-seeking behaviour and supporting a continuum of care for HIV and TB.

Strategies for Strengthening PIHTC

URC works throughout Swaziland with an array of public, private, and community partners to strengthen systems for provider-initiated HTC at the national, regional, and facility levels. Project staff use a mix of advocacy, training, supportive supervision, and on-the-job mentoring to introduce and expand evidenced-based methods to integrate HTC within clinical services. Some of the activities and approach that have been undertaken since the project began include:

National policy development

When the project started in 2006, there was still a good deal of scepticism about the practicality of PIHTC and doubts persisted at the national level regarding the feasibility of the shift from VCT to PIHTC. URC worked closely with SNAP, the National TB Control Programme (NTCP), and other major stakeholders build consensus around HTC and streamline the integration of provider-initiated HIV testing in TB clinical settings. This had led to the greater dissemination of the National HTC Guidelines as well as the development of strategic documents and HTC training manuals (see list of project documents at the back). The HTC project has also advocated for and facilitated the inclusion of HTC indicators within national HIV and TB/HIV monitoring and evaluation (M&E) frameworks, in order to contribute to the evidence-base for HIV interventions and support improved M&E systems. As a means of ensuring the institutionalization of successful HTC interventions, a National PIHTC Technical Officer was recruited and placed at the Ministry of Health, to coordinate activities between the HIV and TB programmes.

Regional expansion

The HTC project works closely with the Regional Health Management Teams and other partners at the regional level, within a framework of increasingly decentralised HIV and TB service provision. URC has assisted each region to develop a strategy for increasing uptake of provider-initiated HTC, taking into account local TB/HIV service requirements and available resources. The project’s region-based staff work directly with regional managers to facilitate the dissemination of the National HTC Strategy to adapt key training manuals and guidelines for uptake at the facility level. The HTC project functions as a mechanism to increase integration of TB/HIV services, and staff work closely with Regional TB Coordinators to ensure compliance with guidelines and build consensus around the adoption of PIHTC models in TB settings at the facility level and to set targets for healthcare workers trainings in PIHTC. The project also targets major employers and private sector
As a build up to the combined celebration of the World TB Day 2009 and the National HIV Testing Month in the Lubombo region, URC collaborated with a local organisation, HIV and AIDS Prevention and Support Centre (HASPAC) to target 4 communities with a door-to-door HIV testing and TB screening campaign over a 5-day period. This service filled a critical gap—despite the high rate of HIV, rural communities such as those targeted in Lubombo are frequently inadequately reached by HIV and TB services and as a result, HIV counselling, testing and referrals for treatment have remained low. The long distances required to access HTC facilities as well as perceived stigma and discrimination has created a serious disincentive to seek out testing. The sentiment expressed in the quote above was mirrored by many rural participants.

In collaboration with HASPAC, the Regional Health Management Team, and community leaders, the HTC project identified four rural communities with a high volume of HIV and TB and low uptake of VCT, including Kamakhewu, Kamkwheli, Kangcamphalala and Kamaphilingo. Each community was visited once, though due to high demand from community members wanting to learn their HIV status, a second visit was conducted in Kamakhewu. The counsellors worked first to create rapport and build trust with family members before offering the HIV test. HIV testing was then done in a location within the homestead where the client was comfortable. However, in many instances clients expressed a willingness to be tested in the open and some families even invited passersby to come and test or listen to the education sessions. Sessions on HIV and AIDS, TB and the benefits of knowing your HIV status were conducted for individuals or groups in their households. The mobilization efforts extended beyond the campaign and included referrals for onward care. TB screening was provided to all individuals who tested HIV+ and to those who already knew their status. Clients who tested HIV+ and had a positive screen for TB were referred to health facilities for further medical management. The national HTV referral form was used to refer clients for HIV care and treatment services.

During the campaign, project staff collected many stories of individual successes. In one instance, several wives within the homestead of a traditional healer received a positive test, but were afraid to disclose their status to their husband, who refused to be tested. URC staff brought the issue to the attention of the home-based care team at the local hospital and follow ups were jointly made to the homestead to discuss the benefits of HIV testing, offer HIV and AIDS education to the husband, discuss the importance of disclosure, and to ensure that the wives accessed care and treatment.

The campaign demonstrated that home-based services can be well received and appreciated by communities when they are conducted in a respectful manner which...
takes into account community norms. The HTC project staff were surprised by the level of enthusiasm they encountered and the number of people who wanted to have an HIV test and screen for TB at the same time. In all, one hundred and sixty individuals tested for HIV and received their results (57 males and 103 females). Three hundred and sixty individuals (166 males and 194 females) were reached in a five day period with HIV and TB education. A total of 4000 pamphlets explaining the relationship between TB and HIV and 800 Know Your HIV Status pamphlets were distributed. The TB screening questionnaire was administered to 35 individuals. Condom education was provided and 7920 male condoms and 2000 female condoms were distributed by the counsellors during the interpersonal dialogues.

Home-based testing for TB patients

The HTC project is also working with partners and the CDC and local community-based TB programs to develop a successful model for reaching co-infected TB/HIV patients with home based HIV testing and counselling by focusing on TB index patients.

From September to December 2009, URC worked with the NTP in the Manzini region to assess the acceptability of integrating HIV testing and counselling and TB services into community-based care. Initially, TB patients who are HIV+, bedridden and on anti-TB injections at the TB centre in Manzini were followed up in their homes by a home-based team from the TB centre who administered their injections in the patient’s home. With assistance from URC, HIV testing and counselling and TB screening of contacts was introduced as part of this package. During the intervention, the team assisted in evaluating the impact of the new components including the acceptability of these services as measured by the proportion of family members who agreed to receive an HIV test, and the number of family members who were screened for TB using a standard TB screening tool. Twenty seven (16 females and 11 males) patients were enrolled into the home based care program and were followed up in seven different communities around the Manzini region by daily home visits. HIV testing and counselling, TB screening of contacts and HIV and AIDS education including condom education were conducted.

Results

Of the 27 families with index TB/HIV co-infected patients, 66 family members were reached with HIV counselling and testing and a 100% of those reached accepted HTC services. In total, 24% (16/66) tested HIV positive. CD4 samples were collected and sent to the laboratory. 106 family members were screened for TB, including 96 adults and 10 children less than 5 years using the standard TB screening tool. Of the children who were screened, 9 (90%) screened positive and were referred to the TB centre for further investigations. Of the adults, 80 (83%) screened positive for TB, and spot sputum specimen were done and another sample was collected on subsequent visits and sent for diagnosis at the TB centre.

Conclusion

The approach demonstrated the increased acceptability for home-based HTC services and a need to scale up service provision. There is a high acceptance of this type of care once confidentiality is assured and the home-based approach provides ease of disclosure.
organizations in each region to solicit their engagement and encourage greater involvement in meeting regional HTC targets through workplace testing and education.

**Facility expansion**

URC assists each TB facility to establish a PIHTC expansion team. These teams comprise TB facility staff, regional TB coordinators, and the clinic supervisor and are responsible for developing facility-level strategies for PIHTC expansion through integration of HTC within TB clinical services. Project-supported facilities are empowered to review HTC performance data and develop linkages with home-based care providers and community-based care organizations working in the clinic catchments areas to increase acceptance of PIHTC among target groups. In clinics that lack the requisite number of staff, URC has advocated for the placement of more staff to roll out the HTC services. In some cases, lay counsellors were recruited directly to support implementation of PIHTC in TB diagnostic clinics.

**Results**

In addition to collecting program performance data, URC has supported the development of data capturing and evaluation skills among all of our program partners, especially at the facility level. This includes developing and rolling out an HTC register and developing a monthly TB/HIV reporting form, which also captures HTC data, to streamline reporting from the health facilities to the regional and national levels. The project also facilitated the development of TB/HIV M&E indicators which are part of the TB/HIV policy guideline.

This emphasis on building provider skills to improve the quality of data has further shed light on some of the impressive results of the project to date. Some of the results are demonstrated in the following table and graphs.
Next Steps for the HTC Project

URC’s implementation model for the HTC project has allowed our staff members to build strong relationships with service providers and gain the trust of public, private, and community stakeholders throughout Swaziland. This has been built on a foundation of supportive dialogue to continually identify needs and collaboratively develop solutions, in an effort to develop strong local ownership for HTC. Moving forward, the project will focus on maintaining the momentum for HTC in order to sustain the successes to date and ensure that HTC is routine practice in all settings. For example, building from the enthusiastic response of the community testing campaigns, the project is participating with the CDC and several community organizations in a pilot programme to explore the expanded use of the home-based care model to reach additional clients with HTC. URC is working with these partners to identify best practices for home-based HTC, building from the work currently being done to strengthen home-based care for TB patients and to support community DOTS.

The HTC project will also continue to work with national partners to translate the successful introduction of PIHTC into the TB program to explore ways of introducing a routine offer of HTC to all clients presenting to all facilities for any reason. The project team will continue to work with the MOH and SNAP to build consensus around routine PIHTC (R-PIHTC) and advocate at the facility level in several key hospitals to initiate R-PIHTC programs, including pre-test information or counselling, HIV testing, and post-test counseling. The project team will work closely with managers to troubleshoot barriers and plan for routine HIV testing.

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While the URC HTC project works with partners on multiple levels to build a supportive environment for increasing provider-initiated HTC in Swaziland, a primary focus has been the direct support provided to clinics and hospitals. The HTC project began working with the Mbabane Government Hospital, the main national referral hospital in Swaziland, in 2006, following an initial baseline assessment. Sensitization meetings with the hospital managers and key health service teams were conducted to ensure buy-in and build consensus around PIHTC as a service model. An important aspect of the initial stage was to establish the HTC project as a support mechanism designed to assist the hospital to communicate the need for PIHTC to their staff and clients, and to work in partnership to identify priority issues affecting HIV testing uptake and develop solutions. From these discussions, the key challenges that emerged focused on the lack of understanding and awareness of PIHTC, lack of adequate space for consultations and concerns regarding the lack of time and personnel to counsel and test patients.

A URC staff member was dedicated to the hospital to provide regular ongoing support and an action plan was developed based on the model of “plan, do, study and act” to progressively scale up PIHTC services (see box on HTC Improvement Collaboratives on page 2). A program of training and mentorship for providers was enacted to facilitate the paradigm shift from VCT to PIHTC. Initial support focused primarily on the TB clinic and a program of HIV counselling and rapid testing was initiated. This was done by engaging facility management to advocate for increased staffing and assistance in coordinating staff activities around TB/HIV collaboration. In order to accommodate the increase in workload generated by the addition of PIHTC, the management of the Mbabane Hospital increased staffing in the TB clinic from two to three nurses. The HTC project also assisted the high volume sites with lay counsellors to provide HTC, enabling other nurses to focus on the other clinical work.

Several approaches were developed to tackle the problem of inadequate space for confidential testing and counselling. URC provided technical assistance to the TB clinic, laboratory and management to facilitate the opening of an additional room and the project supplied containers to further alleviate space constraints. Meetings were held between the ART program and the TB clinic to ensure coordination of care for clients referred onward for treatment. At the end of each quarter, the URC coordinator would work with the hospital to conduct an evaluation on the interventions and results in the last period and a new priority list of bottlenecks and solutions would be identified.

An important concern is ensuring a consistently high quality of HIV testing and counselling as the number of patients accessing services increases. As in many facilities, quality assurance (QA) systems at the hospital are generally weak, so URC worked with staff to incorporate project-developed tools including...
checklists for supervisors to implement and maintain QA systems and provide the necessary information to manage the proficiency testing. Though QA for HIV services is in its infancy, the URC project has advocated strongly to highlight this component, and as a result HTC has become the first thematic HIV area to sponsor a QI/QA coordinator at SNAP.

These activities successfully led to an increase in the number of patients testing for HIV, which rose from 349 in 2007 to 463 in 2008. The work being done collaboratively between the staff and managers at the Mbabane Government Hospital and the HTC project demonstrates the benefits of the collaborative approach in terms of accomplishing rapid and specific system changes with limited resources. The series of results-driven innovations implemented since URC support began helped to systematically improve program output through several phases of planning, implementing, and reviewing results with hospital providers.

Counselling and Care for Carers

The counselling component of HTC is vital to help clients understand the need for testing and outline what services are available, depending on their HIV status. However, frequently the nurses and lay counsellors who provide HTC are also called on to provide immediate emotional support to clients facing the difficult news of a positive diagnosis. This is a challenging task which needs to be handled with sensitivity, and which can be draining to the care giver over time. The stress involved with counselling HTC clients is one of the factors cited as a cause for the high “burn out” rate of HTC providers.

As PIHTC has been scaled up, URC has teamed up with several partners, including SNAP and the Wellness Centre (a health facility dedicated to healthcare workers and their families), to develop guidelines on the provision of psychological care and support for health providers. This has led to activities including periodic trainings for TB regional coordinators and facility staff aimed at increasing staff morale and production and helping them access the psychological care, as well as the professional development resources available through the Wellness Centre. URC has helped integrate components within the pre-service and in-service training manuals for PIHTC which tackle issues such as stress management and burn out. Building from the unique “Care for Carers” approach incorporated successfully by URC on several other HIV and TB projects in Swaziland and elsewhere, long term plans for increasing PIHTC are now taking into account this important consideration.
implementation, define patient flow, develop facility specific SOP, identify facility and unit/ward HTC focal person; set HIV testing targets and indicators. Part of the support provided by the HTC project will consist of training and mentoring for additional lay counselors and phlebotomists, facility mapping and coordination with the ART program and lab services to cope with the additional volume of patients and ensure smooth functioning of referral systems. These activities will be reviewed in conjunction with national partners to support a set of recommendations and best practices for rolling out routine PIHTC in facilities nationwide.

As the project has evolved, it continues to explore strategies for developing HTC as a link to HIV prevention programs in Swaziland. As partnerships with community groups and regional health managers have developed, project staff have played a greater role in advocating for additional services for HIV- clients and have worked to develop referrals from HTC to programs to support prevention, including condom promotion and behaviour change initiatives. Similarly, as PIHTC has expanded and referrals networks have increased, the project has helped bring to light the need to provide stronger services for non-ART eligible HIV+ patients enrolled in the pre-ART programme, including wellness support and “prevention with positives” methods.

As the project enters its last year, it will also continue to work with partners to build consensus around the “Care for Carers” approach (see box). There is a critical need to ensure that the trainings and support provided by the project are not undermined by the high turnover of staff in the health facilities and that providers are able to maintain the successes achieved over the last five years. An important part of ensuring sustainability is to address the causes which lead providers to burn out or lose enthusiasm for high quality HTC services. Approaches like the “Care for Carers” model which also emphasizes linkages to social and professional development programs for healthcare workers are important steps.

**Future Needs for PIHTC in Swaziland**

When the URC project began in 2006, early assessments showed that only one facility was providing PIHTC services to TB patients. With the help of the project 16,191 TB patients and 26,371 TB suspects have been tested for HIV. Much remains to be done, however, in order to meet the need for HTC and strengthen services sufficiently to make a real impact on the epidemic. Through discussion with project partners, some of the longer-term challenges which the project has helped bring to light include:

- The HTC project has shown the achievements that can be made to increase HIV testing for TB patients by instituting PIHTC. Going forward, it is essential that progress continues to be made towards ensuring that PIHTC is implemented as routine practice in all settings and that HIV testing and counselling is routinely provided to patients accessing general healthcare services. This is an important next step for HIV testing and counselling interventions in Swaziland and will play a key role in increasing knowledge of HIV’s status for more individuals in need of the services, promote early diagnosis of HIV infection and hence potentially lead to early enrolment of HIV+ patients into HIV care and treatment.

- Many facilities and partners continue to note that ongoing space constraints compromise the quality of HTC service delivery. In some facilities, for example, counselling is provided next to the delivery room in the obstetric ward or at the bed side in the inpatient wards, creating problems of privacy and confidentiality. This draws attention to the need for separate counselling rooms to be allocated for this HTC, which in many cases are not available.

- The expanded PIHTC programme has helped increase attention on the need for further developed referral networks for HIV and TB services and improved data systems to track patients as they move between them. For example, once patients access HTC and are determined to have HIV, a CD4 test is offered. For those with a CD4 count below the threshold minimum for treatment, enrolment in treatment services is offered. However, those who are above the CD4 threshold are entered into a pre-ART programme to be monitored and followed up. This often does not occur on a regular basis and patients are lost to treatment. The concern that clients above the threshold CD4 are not adequately catered to risks undermining the PIHTC programme as it can contribute to a perception that HIV testing will not necessarily lead to care or treatment.
The scale-up of PIHTC has also underlined the need for adequate and consistently maintained supply chains for key materials such as test kits. Currently, the weak system for monitoring test kit supply and use, including the lack of an adequate reporting system for channelling information to the Laboratory programme, has led to occasional stock outs of test kits. As the responsibility for monitoring, consumption, and use of test kits and commodities lies with the laboratory service, stronger linkages and greater collaborative planning is needed to reduce incidents of stock out.

To date, most strategies for scaled up PIHTC have focused on increasing the numbers adults tested. However, adolescent and paediatric HIV and TB/HIV is a growing concern in Swaziland and 5% of the youngest children (aged 2-4 years) are estimated to be HIV+. While there is a great need to test children and enrol them in treatment, health managers and healthcare providers working with the HTC project frequently point out the challenges in offering HTC to children under 18 years of age. Some of the challenges include legal issues around consent, lack of skills to provide contextualized counselling and age-appropriate testing, and disclosure, monitoring, and follow up for young children who do not remain with their biological parents. The HTC project has begun working with its partners to develop standard procedures for facility staff to address issues pertaining to consent and disclosure, but strong leadership is needed.

In order to meet the need for HTC, new models of service delivery need to be developed and implemented at scale. Strengthened provision of couples counselling and testing needs to be emphasized. Providing home-based HTC services linked to index clients is another promising method which needs to be scaled up. Improved systems are needed to encourage community-based counsellors providing follow up care to their index TB/HIV client to use the opportunity to reach couples and families with comprehensive HIV prevention messages and an offer of HTC services.

Sources
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3. WHO Report 2009, Global Tuberculosis Control - Epidemiology, Strategy, and Financial
5. HIV Prevalence Estimates, from the Demographic and Health Surveys, updated June 2010, Macro International Inc. Calverton, Maryland, USA
6. UNAIDS, Country Epidemiological Factsheets, accessed Oct 8th 2010

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Project Tools and Documents

HTC strategic documents developed
- Swaziland National Guidelines on HIV Testing and Counseling – November 2009
- HTC operational plan-2010
- Training Health Care Workers on Provider Initiated HIV Testing and Counseling 2010
- TB/HIV operational plan-2010
- National HTC SBCC Strategy May 2010
- TB/HIV communication strategy 2009 –Draft
- The Health Sector Response to HIV & AIDS plan 2009-2014

Recording & reporting tools
- HIV testing and Counseling Register
- National TB Program Register for TB suspects
- National TB Program Register for Patients
- Ministry of Health clinic TB register
- White card: National TB Control Program TB Treatment Card
- Blue card: Ministry of Health National TB Control Program Out Patient Treatment Card
- Yellow card: National TB Control Program Treatment Support Card
- National Tuberculosis Screening Tool – Tuberculosis screening for adolescents
- Tuberculosis screening for Children

SOPS developed
- Home based HIV counseling and Testing (HBHTC). Implementation plan & Quality assurance guidelines July 2010
- Procedures for HBHTC in the health facility
- Procedures for HTC in the home