



health

Department:
Health
REPUBLIC OF SOUTH AFRICA

NATIONAL HIV COUNSELLING AND TESTING POLICY GUIDELINES

May 2015



TABLE OF CONTENTS

1.1.	HIV EPIDEMIC IN SOUTH AFRICA	6
1.2.	HIV COUNSELLING & TESTING RESPONSE IN SOUTH AFRICA	6
1.3.	RATIONALE FOR HCT POLICY GUIDELINES REVIEW	6
1.4.	AIMS AND OBJECTIVES OF THE REVISED HCT GUIDELINES	6
1.5.	TARGET AUDIENCE	6
2.1.	HIV COUNSELLING & TESTING POLICY GUIDANCE	8
2.1.1.	GUIDING PRINCIPLES FOR HIV COUNSELLING AND TESTING IN SOUTH AFRICA	8
2.1.1.1.	PROTECTION OF HUMAN RIGHTS	8
2.1.1.2.	RIGHT TO DIGNITY	8
2.1.1.3.	RIGHT TO ACCESS	8
2.1.1.4.	RIGHT TO REFUSE HIV TESTING	9
2.2.	INFORMED CONSENT	10
2.2.1.	Requirements of informed consent	10
2.2.2.	Informed consent for couples	10
2.2.3.	Age of Consent	10
2.3.	CONFIDENTIALITY	11
2.3.1.	Shared confidentiality	11
2.3.2.	Counselling and Disclosure	11
3.	APPROACHES FOR DELIVERING HIV COUNSELLING & TESTING SERVICES	11
3.1.	HEALTH FACILITY-BASED HCT APPROACHES	12
3.2.	COMMUNITY-BASED HCT APPROACHES	12
3.3.	SELF-TESTING	13
3.4.	RESEARCH: UNLINKED AND LINKED PARTICIPANTS	13
4.	NORMS & STANDARDS	13
4.1.	OPERATIONAL REQUIREMENTS FOR FACILITY-BASED HCT SERVICES	13
4.2.	Operational Requirements for Community-based HCT Services	13
4.3.	SUPPLY CHAIN MANAGEMENT	14
4.4.	HUMAN RESOURCES	14
5.	LINKAGE TO PREVENTION, CARE, AND TREATMENT SERVICES	15
5.1.	WHY IS LINKAGE IMPORTANT?	15
5.2.	STRATEGIES FOR STRENGTHENING LINKAGES	15
5.3.	DOCUMENTING LINKAGES	16
5.4.	ELIGIBILITY CRITERIA FOR INITIATING ART FOR ADULTS AND ADOLESCENTS	16
6.	HIV TESTING ALGORITHM	17
6.1.	SERIAL TESTING ALGORITHM	17
6.2.	DOCUMENTING AND MANAGING TEST RESULTS	18
7.	RE-TESTING AND FREQUENCY OF HIV TESTING	18
7.1.1.	HIGH RISK NEGATIVE INDIVIDUALS AND KEY POPULATIONS	18
7.1.2.	PREGNANT WOMEN TESTING HIV NEGATIVE IN EVERY ANC BOOKING	18
7.1.3.	RECOMMENDED INTERVALS FOR INFANT TESTING	19
8.	QUALITY ASSURANCE AND QUALITY IMPROVEMENT	20
8.1.	WHY IS QUALITY IMPORTANT?	20
8.2.	QUALITY ASSURANCE STRATEGIES FOR HIV TESTING	20
8.3.	VALIDATION AND SELECTION OF RAPID TEST KITS	20
9.	DOCUMENTING AND MONITORING HCT SERVICES	23
9.1.	THE IMPORTANCE OF DOCUMENTING, MONITORING AND EVALUATION	23
9.2.	DATA MANAGEMENT	23
9.3.	MONITORING AND EVALUATION FRAMEWORK AND OBJECTIVES	24
9.4.	HCT PROGRAMMES ESSENTIAL AND STRATEGIC INDICATORS	24
9.5.	DATA QUALITY ASSURANCE	26
10.	HIV COUNSELLING & TESTING GUIDELINES	27
10.1.	PURPOSE OF HIV COUNSELLING & TESTING GUIDELINES	27
10.2.	TYPES OF HIV COUNSELING AND TESTING	27
10.2.1.	Client-Initiated Counselling and Testing	27
10.2.2.	PROVIDER-INITIATED COUNSELLING AND TESTING (PICT)	27
10.3.	SETTINGS FOR PROVIDING HIV COUNSELLING AND TESTING SERVICES	28
10.3.1.	HEALTH FACILITY SETTINGS	28
10.3.1.1.	VOLUNTARY COUNSELLING & TESTING (VCT)	28
10.3.2.	PROVIDER INITIATED COUNSELLING & TESTING (PICT)	28



o	Health-care providers recommend and offer HIV counselling and testing to clients within an integrated health care package.	28
10.3.3.	COMMUNITY BASED SETTINGS	28
10.3.3.1.	STAND-ALONE VCT	28
10.3.3.2.	MOBILE AND OUTREACH SERVICES	28
10.3.3.3.	WORKPLACE AND EDUCATION INSTITUTIONS	28
10.3.3.4.	HOME-BASED HIV COUNSELLING & TESTING (HBHCT)	28
11.	HIV COUNSELLING AND TESTING SERVICE	32
11.1.	GENERAL POPULATION	32
11.1.1.	PRE-TEST COUNSELLING	32
11.1.2.	POST-TEST COUNSELLING	32
11.2.	HIV COUNSELLING AND TESTING IN SPECIAL POPULATIONS	34
11.2.1.	ADOLESCENTS AND YOUTH	34
11.2.2.	HIV COUNSELLING & TESTING OF INFANTS AND CHILDREN	37
11.3.	HIV COUNSELLING AND TESTING IN COUPLES	41
11.3.1.	RATIONALE BEHIND COUPLES HIV COUNSELLING AND TESTING	41
11.3.2.	TYPES OF COUPLES SEEKING CHCT SERVICES	41
11.4.	HEALTH CARE PROVIDERS AND WORKERS EXPOSED TO HIV	45
11.5.	SURVIVORS OF SEXUAL ASSAULT	45
11.6.	ALLEGED SEXUAL OFFENDERS	45
11.7.	PRISONERS	46
11.8.	MIGRANT AND MOBILE POPULATIONS	46
11.9.	POPULATIONS ABUSING ALCOHOL AND OTHER DRUGS	46
11.10.	HIV COUNSELLING AND TESTING OF KEY POPULATIONS	46
11.10.1.	MEN WHO HAVE SEX WITH MEN (MSM)	47
11.10.2.	SEX WORKERS	47
11.10.3.	PEOPLE INJECTING/USING DRUGS (PWID/PWUD)	47
11.10.4.	TRANSGENDER	48
11.10.5.	HIV COUNSELLING AND TESTING NEEDS OF KEY POPULATIONS	48
13.1.	Professional and Ethical Codes of Conduct	49



ABBREVIATIONS AND ACRONYMS

AFASS	Affordable, Feasible, Accessible, Safe and Sustainable
AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Clinic
BSS	Behavioural Surveillance Survey
CBO	Community-Based Organization
CCMT	Comprehensive HIV and AIDS Care, Management and Treatment
CDC	Centers for Disease Control and Prevention
CHW	Community Health Worker
CICT	Client-Initiated Counselling and Testing
CT	Counselling and Testing
CXT	Cotrimoxazole
DHS	District Health System
DHIS	District Health Information System
DoH	Department of Health
EBF	Exclusive Breast Feeding
ELISA	Enzyme Linked Immunosorbent Assay
FBO	Faith-Based Organization
FP	Family Planning
HBC	Home-Based Care
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
HWSETA	Health and Welfare Sector Training Authority
IMCI	Integrated Management of Childhood Illnesses
M&E	Monitoring and Evaluation
MDG	Millennium Development Goal
MSM	Men who have Sex with Men
MTCT	Mother-to-Child Transmission
NDoH	National Department of Health
NGO	Non-Governmental Organization
NHIS/SA	National Health Information System of South Africa
NICD	National Institute for Communicable Diseases
NSP	National Strategic Plan for HIV & AIDS and STIs (2007-2011)
OI	Opportunistic Infection
PCR	Polymerase Chain Reaction
PHC	Primary Health Care
PHCC	Primary Health Care Clinic
PEP	Post-Exposure Prophylaxis
PICT	Provider-Initiated Counselling and Testing
PMTCT	Prevention of Mother-to-Child Transmission of HIV
QA	Quality Assurance
QC	Quality Control
RT	Routine Offer of Testing
SANAC	South African National AIDS Council
STI	Sexually Transmitted Infection
TB	Tuberculosis
UNAIDS	Joint United Nations HIV & AIDS Programme
VCT	Voluntary Counselling and Testing
WHO	World Health Organization



FOREWORD



Responding to HIV and AIDS is one of the most important tasks facing South Africa (SA) today. The South African government has made the fight against this disease one of its top priorities. In order to guide the National response, the South African government has developed the National Strategic Plan for HIV, STIs and TB 2012-2016 (NSP) and a Health Sector HIV Prevention Strategy and Guideline 2013-2016 which outline the guideline on implementation of the combination HIV prevention strategies. The review of the National HCT policy is an important step for SA in keeping pace with the guidance and recommendations implemented following the NSP. The NSP outlines four strategic objectives that will form the basis of the HIV, STI and TB response for the country:

- Addressing the social and structural drivers of HIV, STI and TB prevention, care and impact
- Preventing new HIV, STI and TB infections
- Sustaining Health and Wellness
- Ensuring protection of human rights and improving access to justice

In line with the 20-year vision, the NSP has adopted several broad goals

- Reducing new HIV infections by at least 50% using combination prevention approaches
- Initiating at least 80% of eligible patients on antiretroviral treatment (ART), with 70% still alive and on treatment five years after initiation
- Reducing the number of new TB infections and deaths from TB by 50%
- Ensuring an enabling and accessible legal framework that protects and promotes human rights in order to support implementation of the NSP
- Reducing self-reported stigma related to HIV and TB by at least 50%

Knowledge of HIV status is critical to these prevention and treatment goals. Implementation of HCT programme within a legal and human rights framework is a key intervention towards the realisation of the goals of the NSP.

HCT is the key entry point to a comprehensive continuum of care. It is central to HIV programs and needs close linkage with other health services. Through linkages with care, treatment and support programs, HCT contributes to lessening the impact of HIV epidemic. The South African Government has embarked on a deliberate effort to scale up and strengthen the quality of HCT at all health facilities and non-health facilities. HCT has become increasingly available in South African public health facilities in recent years.

In accordance with the current local and international trends and recommendations, DOH emphasizes that while certain core elements of HCT remain unchanged, like 5C's Confidentiality, Counselling and consent, correct test results and linkage to care DOH also introduces approaches to HCT that will reduce the number of missed opportunities such as provider initiated counselling and testing (PICT), couple counselling and testing (CHCT), home to home HCT, infant and children HCT.

Implementation of Combination prevention not only requires that we strengthen the biomedical elements of prevention – the aspects that we know most about, like prevention of mother to child transmission or medical male circumcision. It also demands that we engage fully with changing the attitudes, beliefs, cultural practices and other barriers to individuals, couples, families and communities protecting themselves against HIV infection. Government recognises that prevention remains the cornerstone of all our efforts in the response to HIV and AIDS and that testing provides access to the continuum of prevention, treatment, care and support. We therefore continue to urge each and every one to do their part towards developing and HIV free generation.

The National HCT Programme will provide an integrated service at all levels of the public health service delivery system. It encourages and supports formal collaboration among public, private and non-governmental sectors. The programme seeks to ensure that people who test HIV negative are encouraged and motivated to maintain their negative status, and those who test positive are supported in living long healthy lives through positive health –seeking behaviour and the provision of appropriate services.

I strongly urge all HCT service providers to do all that is necessary to adhere to the recommendations outlined herein.

Minister of health
Dr A. Motsoaledi (MP)



ACKNOWLEDGEMENTS

1. INTRODUCTION

1.1. HIV EPIDEMIC IN SOUTH AFRICA

HIV continues to be a major global health challenge affecting approximately 33 million people worldwide. HIV remains the primary burden of disease in South Africa with an estimated national prevalence of 12.2% in 2013 . The HIV-incidence rate among individuals aged 15–49 years is estimated at 1.9%, and among youth aged 15–24 it is estimated at 1.5% .The country has a generalised HIV epidemic which has stabilised over the last five years . It has the highest number of people (6.4 million) living with HIV in the world. Although the prevalence of HIV in South Africa remains high, it has been stable over the last decade. This has been attributed to the rapid scale-up and success of the ART program. It is estimated that 31.2% (2,002,000 of 6,422,000) of people living with HIV are on antiretroviral treatment (ART), making it the biggest ART program in the world.

1.2. HIV COUNSELLING & TESTING RESPONSE IN SOUTH AFRICA

HIV counselling and testing (HCT) has experienced a rapid growth since it was launched in 2000. The program was originally known as voluntary counselling and testing (VCT) mainly implemented in public health facilities through “lay counsellors” and Professional Nurses. Lay counsellors delivered pre and post-test counselling whilst professional nurses would conduct the rapid test. In 2004 the country then expanded the models to include stand-alone VCT and non-medical sites in community settings. In 2010 first HCT policy guidelines were published officially published/ released expanding the then VCT to include Client-initiated Counselling & Testing and Provider-initiated Counselling & Testing. Provider Initiated Counselling & Testing (PICT) was mandated to be implemented in all public health facilities, prioritizing the following; ANC, STI, TB, FP and IMCI.

Since then, evidence based models have emerged, evolved and expanded targeting specific settings and population groups. Options include HCT through community-based health services; stand-alone, mobile services, workplace services, home-based (home to home and patient index models). These models can reach men, couples, children, adolescents, prisoners, migrant workers and other closed institutional settings where people will be unlikely to seek HCT on their own.

With increasing availability of HCT in many public health facilities in South Africa, uptake of counselling and testing is also increasing. The proportion of people who have ever had an HIV test and are aware of their status has increased from 50% in 2008 to 66.5%. Moreover, 92.3% South Africans are aware of HCT services and 66.2% had actually utilized them

in the past year.

The National Strategic Plan on HIV, STI and TB 2012 to 2016(NSP) is a coordinated response to the HIV epidemic in South Africa. The national HCT policy is aligned to several policies and plans including the NSP. It contributes towards the broad NSP goals of reducing new HIV infections by 50% using combination prevention approaches and initiating at least 80% of eligible patients on ART. The HCT policy is directly contributing to SO2 sub objective 1 of maximising opportunities for testing and screening to ensure that everyone in South Africa is tested for HIV and screened for TB, at least annually and appropriately enrolled in wellness, treatment and care programmes.

In order to achieve the goals of the NSP, HCT services must be improved and scaled up through combination of approaches and modalities targeted at specific populations as describes by the NSP and UNAIDS. The uptake PICT should also be scaled up in health facilities. Greater collaboration with the private sector is essential; all implementing groups must work in partnership with the South African government to achieve the NSP's goals.

The National HCT Program is tasked, with the help of civil society organizations and development partners, with ensuring that the HIV testing goals of the NSP are implemented. South African HCT Policy guidelines have always been based on international standards, including those developed by the World Health Organization (WHO) and other agencies like UNAIDS , Centers for Disease Control and Prevention (CDC). In 2000, the NDOH adopted brief guidelines on rapid HIV testing (Rapid HIV Testing: HIV & AIDS Policy Guideline, Testing for HIV: HIV & AIDS Policy Guideline). Minimum standards for counselling and training guidelines, which outline the selection and training procedures of counsellors, were adopted in the same year.

In order to provide continued guidance on HCT implementation, the National Department of Health (NDOH) developed guidelines, The South African National Voluntary Counselling and Testing (VCT): HIV Prevention and Care Strategy, in 2003. These guidelines catered for both the public and private sectors and addressed issues around counselling and testing in the context of HIV AND AIDS prevention and care interventions. Furthermore, they provided an approach for the implementation of VCT services in health and non-health facilities and built on the experiences accumulated during the previous utilizing documented practices from South Africa and other countries.

1.3. RATIONALE FOR HCT POLICY GUIDELINES REVIEW

Several approaches to delivering HCT to specific target populations across the range of community and facility-based settings have been tested and are now implemented. In 2011 the Minister of Health Dr A. Motsoaledi launched a

¹Shisana, O, Rehle, T, Simbayi LC, Zuma, K, Jooste, S, Zungu N, Labadarios, D, Onoya, D et al. (2014) South African National HIV Prevalence, Incidence and Behaviour Survey, 2012. Cape Town, HSRC Press

²Ibid

³Ibid

⁴Ibid



national HCT campaign which saw a rapid expansion of HCT and an increase in access to HCT by the general population, however despite the great success, the campaign revealed glaring gaps which led to the need to update the HCT policy. The campaign was successful in testing approximately 13million people in 18 months; however, this did not result in an increase in the number of people enrolled in HIV care or treatment. This demonstrates the gap between HIV testing and linkage to care or treatment. HCT program must not end at the post test counselling but it has to formally hand over clients who test HIV positive to the care and treatment program. It has to ensure successful linkage of clients. It was also not clear whether 13million people were tested or 13 million tests were conducted due to the confusion on prevention messages given to clients who test HIV negative in relation to window period.

The policy will therefore provide clarity on appropriate prevention messages in relation to the frequency of testing for each target population and based on risk this will cover a clear definition of what is meant by window period. The policy will also update HCT models and strategic approaches of delivering HCT to targeted population groups. It will also provide an update to personnel who can conduct HIV testing based on the 2011 circular; outlining minimum package of service and standards. This policy guideline will provide recommendations for improving linkages to care. Recommendations on quality assurance of testing will also be provided.

1.4. AIMS AND OBJECTIVES OF THE REVISED HCT GUIDELINES

The aim of the revised HCT Policy guidelines is to provide standardised guidance to HCT service providers and ensure universal high quality HCT services in SA through;

- Provision of HCT in different settings; community, workplace, health facilities, and in households.
- Provision of HCT in different populations; general,

- special, children and key populations
- Delivering HIV test results and messages for re-testing.
- Outlining requirements for HIV counselling and testing of infants and young children in health facilities
- Improving community based HIV counselling and testing services
- Monitoring and evaluating national HIV counselling and testing programs
- Strengthen children and couples HIV counselling and testing

The objectives of these policy guidelines are to facilitate:

- The expansion of HCT models of service delivery beyond health care facility-based HCT to increase access and coverage of services and to maximize efficiency, impact and equity
- The strategic choice and implementation of a combination of HCT models for service delivery based on an analysis of epidemiological, social and programmatic context in order to maximize impact and equity
- Provision of high-quality services and adherence to the guiding principles of HCT in expanding HCT service delivery approaches.

1.5. TARGET AUDIENCE

This document is intended for clinical and non-clinical HCT service providers. The HCT policy guidelines should be used by all service providers to understand the regulations regarding HIV testing. Service providers include National, Provincial, District, health facility managers, health care providers in private and public health facilities. It should also be used by Community-Based Organizations (CBO's) and Non-Governmental Organizations (NGO's), Private sector and educational institutions and any other service providers intending to or providing HCT services or any other HIV related services in South Africa.



2. SECTION A

2.1. HIV COUNSELLING & TESTING POLICY GUIDANCE

2.1.1. GUIDING PRINCIPLES FOR HIV COUNSELLING AND TESTING IN SOUTH AFRICA

It is the mandate of the South African Department of Health to deliver quality, affordable healthcare to all citizens of South Africa. The HCT Policy Guidelines derive their validity from and conform to relevant items of legislation and core ethical principles. It therefore upholds the basic human rights of individuals and families as enshrined in the Constitution of the Republic of South Africa, Act No. 108 of 1996, the Bill of Rights, Batho Pele, and from guiding implementation principles from National Strategic Plan, the Operational Plan for Comprehensive HIV and AIDS Management, Treatment and Care Guidelines and the PMTCT Guidelines. The conditions under which people undergo HIV counselling and testing must be anchored in an approach which protects their human rights and pays due respect to ethical principles. These principles are:

2.1.1.1. PROTECTION OF HUMAN RIGHTS

The South African government has made the response to HIV and AIDS one of its top priorities. The implementation of the National HCT Programme is a key intervention towards the realisation of the goals of the NSP.

HIV counselling and testing must be ethical, based on human rights, and conducted within a supportive environment. Health and human rights are inextricably intertwined. Safeguarding human rights is an essential part of effectively responding to the HIV epidemic.

2.1.1.2. RIGHT TO DIGNITY

(Constitution of the Republic of South Africa, Act No. 108 of 1996 Section 10; National Health Act No. 61 of 2003 Sections 7, 8 and 9). The Bill of Rights provides every person with the right to dignity, equality and non-discrimination, privacy and fair labour practice. There shall be no mandatory HIV testing. All testing will remain voluntary with informed consent, even when HCT is initiated by the provider. An exception is provided for in the case of alleged sexual offenders (Criminal Law (Sexual Offences & Related Matters) Amendment Act No. 32 of 2007). Clients are entitled to seek recourse regarding poor quality or bad service from the head of the health institution in line with the Patient's Rights Charter.

○ Right to Privacy and Confidentiality

(Constitution of the Republic of South Africa, Act No. 108 of 1996 Section 14; Article 17 of the International Covenant on Civil and Political Rights (ICCPR); National Health Act, No. 61 of 2003 section 14).

All information concerning a client, including information relating to his or her health status, treatment or stay in a health establishment is confidential. No one shall be subjected to arbitrary or unlawful interference with his or her privacy. Clients

information shall only be released if ordered by the court of law and if necessary for the advancement of client's care and treatment.

○ Personal Responsibility and Commitment to Prevention of HIV

All people in South Africa have a responsibility to protect themselves and others from HIV infection, to know their status and to seek appropriate prevention, care, treatment and support.

2.1.1.3. RIGHT TO ACCESS

Access within the HCT policy must be understood in its broad sense to cover aspects of availability, convenience, quality, affordability and acceptability to all those who need the service. All essential commodities in HCT facilities, including rapid test kits, condoms and information, should be made available, affordable and accessible. Even if resources are available, people may not have access if these resources are not located in sufficient proximity to the people who need them. Access may also be low if there is a lack of adequately trained personnel to provide quality services. HIV positive individuals should receive appropriate counselling and assistance linking to prevention, care and treatment services.

○ Promoting Equality for Vulnerable Groups

The vulnerable position of women, girls, children, key populations and persons living with disabilities, with respect to HIV and AIDS and its social impact is recognised. Their access to HCT services has to be addressed by the policy and service providers should ensure that services are accessible to them.

○ Promoting the Best Interests of Children

The impact of HIV on the rights of children is considerable. Respect for the best interests of the child dictates that children's rights and needs must be at the forefront of all interventions for HIV prevention, treatment and support. The following principles should guide any interactions with children:

- Provision of relevant, appropriate and accessible information on the prevention, treatment and care of HIV during the counselling process in the language that the child is able to understand;
 - Ensuring full participation by the child in any decision-making and consent process regarding HIV testing and due consideration given to the views of the child;
 - HIV testing only when it is in the best interests of the child;
 - Providing post-test access to treatment, care and support; and
 - Ensuring confidentiality regarding HIV test results and support with disclosure of HIV status (Children's Act 2005 as amended, Criminal Law (Sexual Offences and Related Matters) Amendment Act, No. 32 of 2007)
- The South African National HCT policy is aligned with the Joint United Nations Program on HIV AND AIDS (UNAIDS) and the World Health Organisation (WHO) Policy Statement on HIV testing, which states



that: "The conditions under which people undergo HIV testing must be anchored in a human rights approach which protects their human rights and pays due respect to ethical principles".

- **HCT services should be made available** in all public health facilities, private healthcare facilities and NGOs who have been approved to offer HCT.
- **Duty and Responsibility of all health-care personnel**
It is the duty and responsibility of all health-care workers and health auxiliary workers to inform people about the dangers of HIV so that people can make informed decisions about getting an HIV test. Health-care workers shall offer HIV test to all patients in order to identify HIV positive men, their partners, HIV-exposed and HIV-positive infants, children and youth so that they can access HIV care. Practiced within a human and child rights framework, this critical intervention should prolong life and optimise maternal and child survival (NDoH PMTCT Guidelines 2008).
- **Challenging Discrimination**
Discrimination against people with HIV undermines human dignity and hinders an effective response to HIV and AIDS. The National HCT Programme should help reduce discrimination by creating knowledge and competence about HIV in communities.
- **Quality of HCT Services**
All HCT services (counselling, testing and testing kits) shall be subject to quality assurance according to defined national standards and should be monitored and evaluated. Lay counsellors should be trained to provide quality HCT services according to the national policy

framework.

- **Effective Partnerships**
All public and private sectors of government, all partners and all stakeholders of civil society shall be involved in the HIV and AIDS response.
- **Effective Communication**
Clear and ongoing communication (with appropriate messages) between government and all civil society stakeholders is necessary for the achievement of the aims of the policy. Effective communication also helps to inform those affected and infected with HIV as to what they need to do, what is available and of any new developments with regards to the policies around testing and treatment.
- **Strengthening Service Delivery and Integrating Services**
Strengthening health and social systems within a multisectoral approach, including the organizational capacity of NGOs, FBOs and CBOs, and ensuring integration between services, and is central to effective implementation of the policy.
- **Using Scientific Evidence**
The interventions outlined in the HCT policy shall, wherever possible, be evidence-based.
- **Leadership Role of Government**
The effective implementation of the HCT Policy Guidelines and the attainment of its goals depend on government leadership in resource allocation, policy development, and effective coordination of the programme and interventions.

Core Principles of HIV Counselling and Testing in South Africa

1. HCT clients(s) and patient(s) must be provided with sufficient information about HIV counselling and testing, so that they can give their explicit and voluntary informed consent to receive services;
2. HCT services shall be confidential, meaning that anything discussed between the client(s) or patient(s) and the HCT provider may not be shared with other persons; except in cases where client's results are shared for client's medical benefit or when ordered by the court or law. Even in such instances, the clients should be informed that their HIV results will be shared.
3. HCT services must include accurate and sufficient client-centred counselling that addresses the needs and risks of the HCT clients(s) or patient(s) and the setting in which the services being rendered;
4. HCT services must adhere to national quality assurance guidelines for testing to ensure the provision of accurate and correct test results;
5. It is the responsibility of HCT programs and providers to ensure that HCT clients and patients are linked to care. This includes prevention, care and treatment and other clinical services, as



2.2. INFORMED CONSENT

HIV testing must always be voluntary and free of coercion. In some cases HIV testing can be prescribed by the court of law. All HCT clients, where possible, should be given the choice of taking up the test or not. Consent shall be conducted in applicable official languages, and in child friendly-versions as applicable. Consent shall be verbal but documented in patient's record as applicable in all health settings. Informed consent should always be written and documented in the following settings/populations:

○ Infants and children

For all infants and children, HIV counselling and testing should be offered to guardians or parents as applicable, who should provide written informed consent. Where appropriate children may also provide assent.

○ Research settings

Informed consent within clinical trials and other research settings should always be written and documented as stipulated by NDoH Guidelines for good practice in conduct of clinical trials with human participants 2006.

○ Illiteracy or Inability to Write

Where the client cannot write, or has a disability that hinders his or her ability to write, the right-hand thumbprint can be used instead of the signature if the client wishes to take up the HIV test and give signed consent.

○ Inability to Make a Decision

According to the National Health Act, (Act No. 61, Section 7), if a client is unable to give informed consent, for example, in the case of unconsciousness or cognitive disability, such

consent can be given by a person authorised to give such consent in terms of any law or court order.

In adults: In the case of adults, the spouse, next-of-kin (parent, grand-parent, an adult child or a sibling of the person) in the specific order listed can give informed consent.

In children: In the case of children, refer to Section 11 of this policy.

○ Community-based settings;

Any client(s) or patient(s) that does not give consent for HCT services should still be provided with the best possible care and should not be denied other health services. Client(s) or patient(s) declining an HIV test should be offered assistance to access HCT in the future, and their decision to decline should be noted in their medical record so that a discussion of HCT can be reinitiated at subsequent visits to the health facility.

2.2.1. Requirements of informed consent

The information that HCT clients and patients require in order to give their informed consent may vary based on service delivery approach and setting, but should generally include:

- Benefits and implications of knowing one's status / reasons for recommending HCT
- Recognition of the client's right to withdraw consent at any time
- Availability of follow-up treatment, care and support, and prevention services
- Importance of disclosure and partner/family testing and availability of couples HCT services
- HCT process and procedures

2.2.2. Informed consent for couples

Informed consent can also be given by couples who are willing to be tested as a couple according to the CHCT.

National Health Act 14. (1) All information concerning a client/patient, including information relating to his or her health status, treatment or stay in a health establishment, is confidential

(2) Subject to section 15, no person may disclose any information contemplated in health status, treatment or stay in a health establishment, is confidential.

unless-

25

(a) the user consents to that disclosure in writing;

(b) a court order or any law requires that disclosure; or

(c) Non-disclosure of the information represents a serious threat to public health.

2.2.3. Age of Consent

Any person above 12 years of age with sufficient maturity and mental capacity to understand the benefits, risks, social and other implications of HIV testing may give consent for HIV counselling and Testing (HCT) services in South Africa.

CHILDREN'S ACT 38 OF 2005

- 129 (2) A child may consent to his or her own medical treatment or to the medical treatment of his or her own child if-
- a. The child is over the age of 12 years; and
 - b. The child is of sufficient maturity and has mental capacity to understand the benefits, risks, social and other implications of the treatment.
- 129 (4) the parent, guardian or caregiver of a child may, subject to section 31 (involving the child in major decisions), consent to the medical treatment of the child, if the child is-
- a. Under the age of 12 years,
 - b. Over the age of 12 years but is of insufficient maturity or is unable to understand the benefits, risks and social implications of the treatment.

⁹Department of Health, 2006. Guidelines for Good Practice in the Conduct of Clinical Trials with Human Participants in South Africa. Department of Health: Pretoria, South Africa.



2.3. CONFIDENTIALITY

HCT services should be offered in confidential and in a private setting. Clients' results and other identifying information should be handled confidentially; this includes information shared during the session. All clients must be assured of the confidentiality of their test records, of the system of record keeping and of their test results.

2.3.1. Shared confidentiality

Sharing clients' by service providers should be limited only to those who contribute directly to the continuity of the client's care. HIV status should never be shared with the client's employer unless the client specifically requests this action.

- Discussion about sharing confidentiality should explore the barriers faced by the client in disclosing. Where the client is in an abusive relationship, he/she should not be pressurised to disclose to an abusive partner and should be referred to appropriate service providers for support.

2.3.2. Counselling and Disclosure

- All HCT services must include accurate and sufficient client/patient-centred counselling that addresses the client's risks.
- All clients should be given their results immediately unless if the testing method does not provide results immediately. In such circumstances, the client should be informed to return for their results within 5 working days.
- Disclosure of client's results should be done in the best interest of the client or if ordered by the court of law, even in such circumstances the client should be informed prior that their HIV results will be disclosed.

2.4. ACCURATE AND CORRECT TEST RESULTS

All clients who test for HIV in any setting must be given accurate and correct HIV test results. All test kits must be validated according to the national QA guidelines. HIV Testing must follow Serial Testing, which is an approved national testing algorithm. Serial testing means samples tested by a first test. The results of the first test determine whether additional testing is required.

2.5. LINKAGE TO PREVENTION, CARE, AND TREATMENT SERVICES

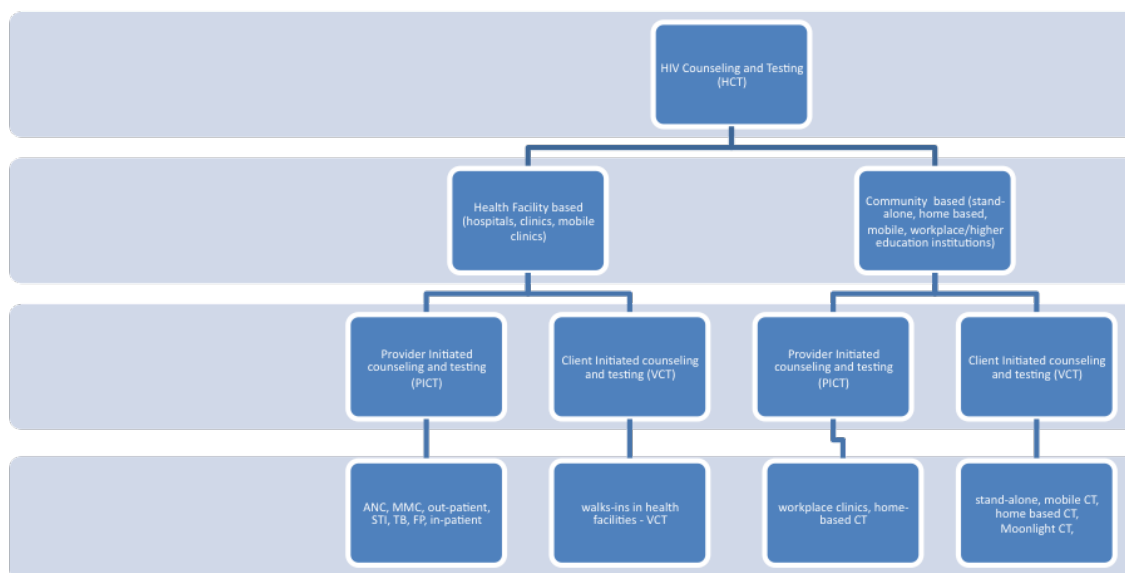
All clients accessing HCT should be linked to prevention, care and treatment services. It is the responsibility of HCT programs and all HCT providers to ensure that HCT clients and patients are linked to care. HCT alone is of limited value unless it is linked with other services. It is a key component of HIV prevention, care and support, and treatment services, and as such it is critical to ensure that HCT clients and patients are linked with additional services as needed. These may include, but are not limited to:

- Care and treatment for HIV positive clients and patients
- PMTCT for pregnant women
- Male circumcision for HIV negative men
- Support groups for discordant couples
- TB and STI screening and treatment
- Family Planning

Additional efforts are needed by HCT program staff and providers to ensure patients and clients are linked to follow-up services.

3. APPROACHES FOR DELIVERING HIV COUNSELLING & TESTING SERVICES

HCT services are delivered in health facilities and community-based settings. All approaches should be aligned to a national HCT policy. The diagram below depicts HCT implementation in the health facilities and communities.



3.1. HEALTH FACILITY-BASED HCT APPROACHES

3.1.1. Provider-Initiated Counselling and Testing (PICT)

PICT refers to HIV counselling and testing which is routinely offered by health care providers to persons attending health care facilities as a standard component of medical care. Provider-initiated HIV counselling and testing (PICT) should be offered to all persons attending clinical services in both public and private sector. Health care providers should recommend HCT to all patients in a health facility, regardless of whether they show signs or symptoms of HIV infection. This allows the health care provider to make specific medical decisions that would not be possible without knowledge of the patient's HIV status. Additionally, PICT contributes to increased rates of HIV testing and early identification of HIV-infected persons who may not otherwise know their HIV status.

3.1.2. Client initiated Counselling and Testing (CICT)

Client initiated counselling and testing also referred to as VCT are HCT services provided within health facilities for clients who present specifically for HCT services. Client(s) may voluntarily make the decision to learn their HIV status as an individual, couple, or family.

3.2. COMMUNITY-BASED HCT APPROACHES

The focus of HCT in these settings is for properly trained health care providers to reach out to communities outside of the health facility to increase access to HCT and normalize HCT services. Examples of community-based settings include:

3.2.1. Stand-Alone HCT

Stand-alone HCT sites are located within the community with the sole primary function of providing HCT services to individuals, couples, or families within the community. These are not attached to a health facility.

3.2.2. Home-Based HCT (including door-to-door and index case testing)

Home-based HIV counseling and testing (HBHCT) is testing offered in the homes by a trained health care worker. It is provided in two ways either systematic door-to-door HCT

services or services to households with a known index HIV-positive or TB patient, with consent obtained from the index patient prior to a home visit.

3.2.3. Mobile / Outreach services

Mobile or outreach HCT services are provided through vans or tents in the community to increase access to hard-to-reach populations such as rural communities, men, mobile populations, or key populations (KPs).

3.2.4. Workplace and education institutions HCT Services

HCT services may also be offered in school, higher education and workplace (public and private) settings.

- School-based testing increases access to HCT for sexually active youth who are at least 12 years old. School-based settings may also be targeted as part of a national HCT campaign.
- Higher education based HCT shall be offered on an ongoing basis to all young people attending higher education institutions and staff. In these settings, where possible, health clinics in these institutions shall motivate all clients for HCT. These facilities shall be aligned to the national HCT program. Outreach services shall also be targeted for higher education institutions and all HIV testing conducted in these settings shall be reported to the local health office.
- Many workplaces offer HCT services as part of routine, comprehensive workplace HIV programs that may also be available to family members of employees. Alternatively, HCT services may be introduced into a workplace on an ad hoc basis, for example during an annual family day event. Workplace HCT may be provided on-site through a workplace clinic or in coordination with a nearby HCT centre. HCT providers may visit the workplace and offer HCT services there, either in an office room, a mobile van, or in tents. Alternatively, a workplace may offer education about HCT and refer employees to a nearby HCT site to receive services there. As with any HCT model or approach, workplace HCT providers must adhere to the MOH's SOPs for HCT as outlined in this document and accompanying resources.

Unfair discrimination against an employee in any employment policy or practice, including discrimination on the grounds of HIV status, should be eliminated (Employment Equity Act No. 55 of 1998).



3.3. SELF-TESTING

HIV self-testing is when a person conducts HIV test on him or herself. HIV self-testing is currently not recommended and supported in South Africa. Further research is still required to support the implementation of self-testing.

3.4. RESEARCH: UNLINKED AND LINKED PARTICIPANTS

HIV testing often takes place while conducting health research. All research related to HIV testing may only take place after having obtained ethical approval from a Research Ethics Committee and with the knowledge of the health establishment where the testing is being performed.

Research involving HIV testing can be divided into two categories:

- Unlinked and anonymous population or behavioural studies that measure prevalence of HIV and screening in health facilities. In such cases:
- HIV testing is done on blood that has already been collected for another purpose such as for syphilis testing; and
- Additional individual consent for the blood to be tested for research purposes is not required. Linked studies involving individual participants. In this case:
- Individual consent in order to participate in the study is required from all participants or persons authorized to act on their behalf;
- All legal, ethical and quality standards outlined in this HCT policy should apply;
- Consent of community representatives for research studies may not be substituted for individual consent; and
- All research subjects must be informed about HIV prevention through practicing safe sex, and effective treatment or referral must be provided for STIs.

4. NORMS & STANDARDS

4.1. OPERATIONAL REQUIREMENTS FOR FACILITY-BASED HCT SERVICES

4.1.1. Requirements for Facility-Based HCT Service

HCT should be recommended for all patients attending health facilities, regardless of whether they show signs or symptoms of HIV infection. Operational requirements for facility-based services include the following:

- SOPs that detail all elements of the HCT process shall be available at every point where HCT is conducted.
- Staff shall be trained in the use of these SOPs.
- SOPs shall be updated as the need arises.
- Facilities must display signs or posters that inform clients about the availability and location of the service.
- Facilities must have relevant HIV and AIDS IEC materials in languages used by the facility's catchment population. Where possible, this information shall be available in

braille.

- Facilities must facilitate access to other HIV and AIDS preventative services and, where appropriate, facilitate linkage of clients to treatment, care and support services.
- Facilities must be accessible and convenient to all segments of the population, men, women and children, citizens, and foreigners alike, including people with disabilities and other marginalised and hard-to-reach populations.
- Facilities where children are tested should be child-friendly and ensure that children's rights are protected.

4.1.2. Infrastructure requirements for HCT Sites

Proposed counselling and testing space should have the following:

- Waiting area that's well ventilated
- A room or designated area that has:
 - adequate lighting, access to clean water
 - adequate privacy to ensure confidentiality
- Adequate storage space for supplies

4.1.3. Personnel Requirements

- All personnel shall be trained on HIV counseling and testing.
- Trained human resources are critical to the provision of high-quality HCT.

4.1.4. Waste Management

Facility-based HCT providers must have necessary supplies where HCT is conducted to properly dispose of waste. This includes having a sharps container for sharps (e.g. lancets) and a biohazard (red) bag for other clinical waste (e.g. used gloves, cotton wool, etc.) Each HCT site has to follow the infection control and prevention policy

4.2. Operational Requirements for Community-based HCT Services

Community based approaches must adhere to national policies and guidelines for HCT as outlined in this document and accompanying resources. Operational requirements for community-based services demand Advance preparation and strong collaboration with local health care workers, community leaders, and other key stakeholders to gain access to the community including;

- SOPs that detail all elements of the HCT process shall be available at every point where HCT is conducted.
- Staff shall be trained in the use of these SOPs.
- SOPs shall be updated as the need arises.
- Appropriate signage and mobilisation that inform communities about availability and location of the service.
- Service points must be accessible and convenient to all segments of the population, men, women and children, citizens, and foreigners alike, including people with disabilities and other marginalised and hard-to-reach populations.
- Service points where children are tested should be child-friendly and ensure that children's rights are protected.

It is the responsibility of all HCT Service providers to link every HIV positive client to prevention, care, treatment and support services.



4.2.1. Infrastructure requirements for HCT Sites

Proposed counselling and testing space should have the following:

- Waiting area that's well ventilated
- A room or designated area that has:
 - adequate lighting and ventilation
 - access to clean water
 - adequate privacy to ensure confidentiality
- Adequate storage space for supplies and temperature monitoring

4.2.2. Personnel Requirements

- All personnel shall be trained on HIV counseling and testing.
- Trained human resources are critical to the provision of high-quality HCT.

4.2.3. Waste Management

- HCT providers must have necessary supplies where HCT is conducted to properly dispose of waste. This includes having a sharps container for sharps (e.g. lancets) and a biohazard (red) bag for other clinical waste (e.g. used gloves, cotton wool, etc.) Each HCT site has to follow the infection control and prevention policy.

4.2.4. Safety and Security

- Adequate safety and security measures for staff and equipment in HCT services must be ensured.

4.3. SUPPLY CHAIN MANAGEMENT

- Procurement processes and procedures should be rigorous enough to minimise stock-outs of rapid test kits and related commodities. This is essential for ensuring the quality of HCT services.

4.3.1. Forecasting

HCT services may also be offered in school, higher education and workplace (public and private) settings.

- Accurate forecasting is necessary to ensure adequate and ongoing supply of HIV test kits and other consumables. Forecasting for HIV rapid test kits should be based on the HCT program's capacity to provide HIV testing.
- The provincial and district authority should ensure proper adherence to inventory management protocol including maintenance of quality records, timely reporting, accurate forecasting and adequate supply of tests and other essential commodities in order to prevent the disruption of HCT service provision.

4.3.2. Procurement of rapid test kits

- Rapid HIV test kits procured through the national tender shall be used in the public health sector and in other sectors where testing is undertaken. All other rapid HIV test kits used in other settings must be evaluated by the NICD.

4.3.3. Storage of HIV Test Supplies

- Rapid test kit quality assurance standards must be

followed. Refer to QA guidelines.

4.3.4. Distribution

- Distribution of test kits shall follow quality assurance standards.

4.3.5. Stock outs

- To avoid stock outs, proper forecasting shall be done.

4.4. HUMAN RESOURCES

- HCT sites should have adequate human resources (i.e., trained professional health workers, HIV and AIDS counsellors/community health workers and other support staff) to provide the required services.
- HCT must be carried out by trained community health workers or lay counsellors working under the supervision of a suitably trained professional health worker.
- Counsellor training should be conducted according to the National Minimum Standards for Counselling and Testing.
- HCT counsellor should counsel a minimum of five clients a day.
- Service providers should ensure a safe working environment for all HCT staff.
- HCT counsellors shall have appropriate training on counselling children.

4.4.1. HCT Training requirements

- HCT Training Curricula

HCT training curricula must be standardized and aligned to NDOH HCT curricula. HCT training shall be made available to all persons providing HCT in health facilities, stand-alone, mobile/outreach, home-based, or work-place HCT settings.

4.4.2. Qualifications of HCT Service providers

- Matric/equivalent
- HCT training (NDOH approved). HCT training includes counselling, rapid test and quality assurance.

4.4.3. Certification and Recertification

- Certification

Persons completing nationally approved HCT curricula will receive competency certificates upon completion of the course by recognised training institutions.

It is the responsibility of health care workers themselves to register with the Health Professional Council and present their HCT training certificates for licensing purposes. Non-health care workers are not required to register with the Council at this time, but should be prepared in the event that this changes in the future.

○ Refresher trainings

Periodic refresher trainings are necessary to ensure HCT providers have the most accurate up-to-date information, and that they are providing high-quality HCT services.

- Persons conducting HCT should receive refresher training on 36 months bases and recertification as HCT providers.
- Persons who have not conducted HCT for more than 12



months are required to be recertified before they begin practicing HCT again.

- Persons who have not provided HCT for more than 24 months are required to be retrained and issued with a new certificate of competency.

○ **Recertification**

The requirements for recertification are:

- Attending at least one refresher training every 36 months; and
- Conducting a proficiency panel testing at least once in 36 months with 100% concordance as approved by the national reference laboratory (NICD).

5. LINKAGE TO PREVENTION, CARE, AND TREATMENT SERVICES

5.1. WHY IS LINKAGE IMPORTANT?

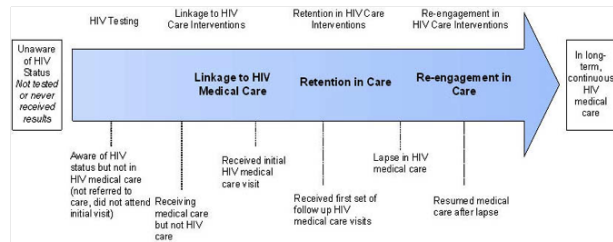
HIV counselling and testing (HCT) is the first step in a continuum of HIV prevention, care and treatment services. As a result, an HIV diagnosis without linkage to appropriate services (e.g. medical male circumcision or ART services) confers little or no benefit to the patient. Ensuring that individuals living with HIV are linked to and retained in HIV clinical care until they achieve full viral suppression is necessary to realize the full health and prevention benefits of ART. In addition, linking HIV-negative men to male circumcision services can help protect these men from acquiring HIV. However, many studies conducted in South Africa indicate that linkage between HCT services and HIV prevention and treatment programs is poor and many individuals are lost to follow-up before they reach these services.

5.1.1. HIV Counselling and Testing and the Continuum of Care

The HIV care continuum also referred to as the HIV treatment cascade, is a model used to identify issues and opportunities related to improving the delivery of services to people living with HIV across the entire continuum of care. This continuum has five main "steps" or stages:

- HIV Diagnosis:** The HIV care continuum begins with a diagnosis of HIV infection through HIV testing as outlined in this policy on Section x.
- Linkage and access to care:** Once a person is diagnosed with HIV, it is important that they are connected to an HIV healthcare providers who can offer care, treatment and support.
- Retention in care:** Ongoing clinical monitoring. Because there is no cure for HIV at this time, treatment is a lifelong process. To stay healthy, HIV infected clients need to receive regular HIV medical care.
- Antiretroviral therapy (ART):** Antiretrovirals are drugs that are used to prevent HIV from making more copies of itself. ART treatment guidelines shall be followed to ensure that all eligible patients are initiated onto the treatment
- Viral suppression:** Achieving a low amount of HIV virus is an optimal goal for ART. Lowering the amount of virus in the body with medicines can keep an infected client healthy, help them live longer, and greatly reduce their

chances of passing HIV on to others.



- Helping people diagnosed with HIV to navigate the HIV care continuum is a shared responsibility of the government; healthcare providers; community groups; faith communities; people living with HIV; and others. By working together to engage more people living with HIV along each stage of the continuum, we can achieve the goals of the NSP.

○ **5.1.2. Who Is Responsible for Linkage?**

- HCT programmes have typically measured the success of their programmes by measuring the numbers of people tested. However, an HIV test should not be seen as an end point but instead should be viewed as the first step in a continuum of HIV prevention, care, and treatment services. Thus, the success of testing programs should be measured by the number of individuals successfully linked to HIV clinical care services following an HIV diagnosis or to medical male circumcision services for HIV-negative males.

- HCT providers must assume responsibility for linking individuals to these services. Once this linkage has taken place, HIV care and treatment programs can assume responsibility for retaining patients in care through assessment for treatment eligibility, ART initiation, and viral suppression. Similarly, male circumcision services can ensure that all men referred from HCT programs receive appropriate services once this linkage has taken place.

5.2. STRATEGIES FOR STRENGTHENING LINKAGES

- Strengthening the link between HCT services and other HIV prevention and treatment services will require close coordination between these services. HCT programs will need to develop a system for:
 - informing the ART clinic or circumcision program to expect the client,
 - verifying patients enrolment in the service to which they are referred, and
 - tracking patients who fail to self-enrol within 30 days of their HIV test.

Linkage to HIV clinical care may be particularly difficult for community and home-based HCT programmes given the physical separation between the HCT programme and the health facility. These programmes are particularly encouraged to develop systems for ensuring that all clients diagnosed as HIV-positive are linked to HIV care and treatment services within 30 days of their HIV diagnosis.



HCT programmes should also consider implementing strategies to strengthen linkage to other prevention, care, and treatment services. These strategies include:

- Intensified post-test counselling to highlight the importance of seeking services in a timely fashion;
- Identifying a focal person who will be responsible for strengthening linkage activities;
- Follow-up counselling provided by lay counsellors or community health workers to individuals who fail to self-enrol in services within 30 days of their HIV test;
- SMS or text message reminders;
- Use of peer navigators or mentors to assist clients to enrol in services;
- Integration of services to address the multiple needs of clients (e.g. HCT, ART, STI, FP, TB, MMC)
- Point of care CD4 testing to allow immediate

immunological staging after diagnosis; and

- Implementation of systems to track linkage including two-part referral forms.

5.3. DOCUMENTING LINKAGES

Documentation is the critical first step in developing a patient tracking system. Systematically documenting linkage in HCT registers allows programs to identify which patients need a follow-up phone call or visit to facilitate their enrolment in HIV care or other prevention services. The easiest method for documenting linkage to HIV clinical care is to record the patient's ART number in the HCT and/or HCT register. Similarly, programmes can document linkage to MMC services by documenting the date that the client was circumcised in the notes section of the HCT register.

5.4. ELIGIBILITY CRITERIA FOR INITIATING ART FOR ADULTS AND ADOLESCENTS

Eligible to start ART
▪ CD4 count ≤ 350 cells/mm³ irrespective of WHO clinical stage OR ▪ Irrespective of CD4 count ○ All types of TB (In patients with TB/HIV drug resistant or sensitive TB, including extra pulmonary TB) ○ HIV positive women who are pregnant or breast feeding OR ▪ Patients with Cryptococcus meningitis or TB meningitis (defer ART for 4-6 weeks) ▪ WHO stage 3 or 4 irrespective of CD4 count
Require fast track (i.e. ART initiation within 7 days of being eligible)
▪ HIV positive women who are pregnant or breast feeding OR ▪ Patients with low CD4 <200 OR ▪ Patients with Stage 4, irrespective of CD4 count OR ▪ Patients with <u>TB/HIV co morbidity with CD4 count < 50</u>
Patients with CD4 above 350, Not yet eligible for ART
▪ Transfer to a wellness programme for regular follow-up and repeat CD4 testing 6-monthly. ▪ Advise on how to avoid HIV transmission to sexual partners and children ▪ Initiate INH prophylaxis if asymptomatic for TB ▪ Provide counselling on nutrition and contraceptive and do annual pap smear



6. HIV TESTING ALGORITHM

There are two main HIV testing algorithms which are widely used; serial testing and parallel testing algorithms. In a parallel testing algorithm samples are tested simultaneously by two different rapid tests, whilst in serial testing, one rapid test is run as a screening test and if reactive a confirmatory rapid test is then run to confirm the result of the screening test.

The HIV testing algorithm that should be implemented for all HIV testing using rapid tests approved for a national tender in all settings as discussed in Figure 2. All specimens shall be first tested with one assay (Test 1 or screening test), and specimens that are non-reactive are considered HIV-negative and reported as such. Any specimens that are reactive on

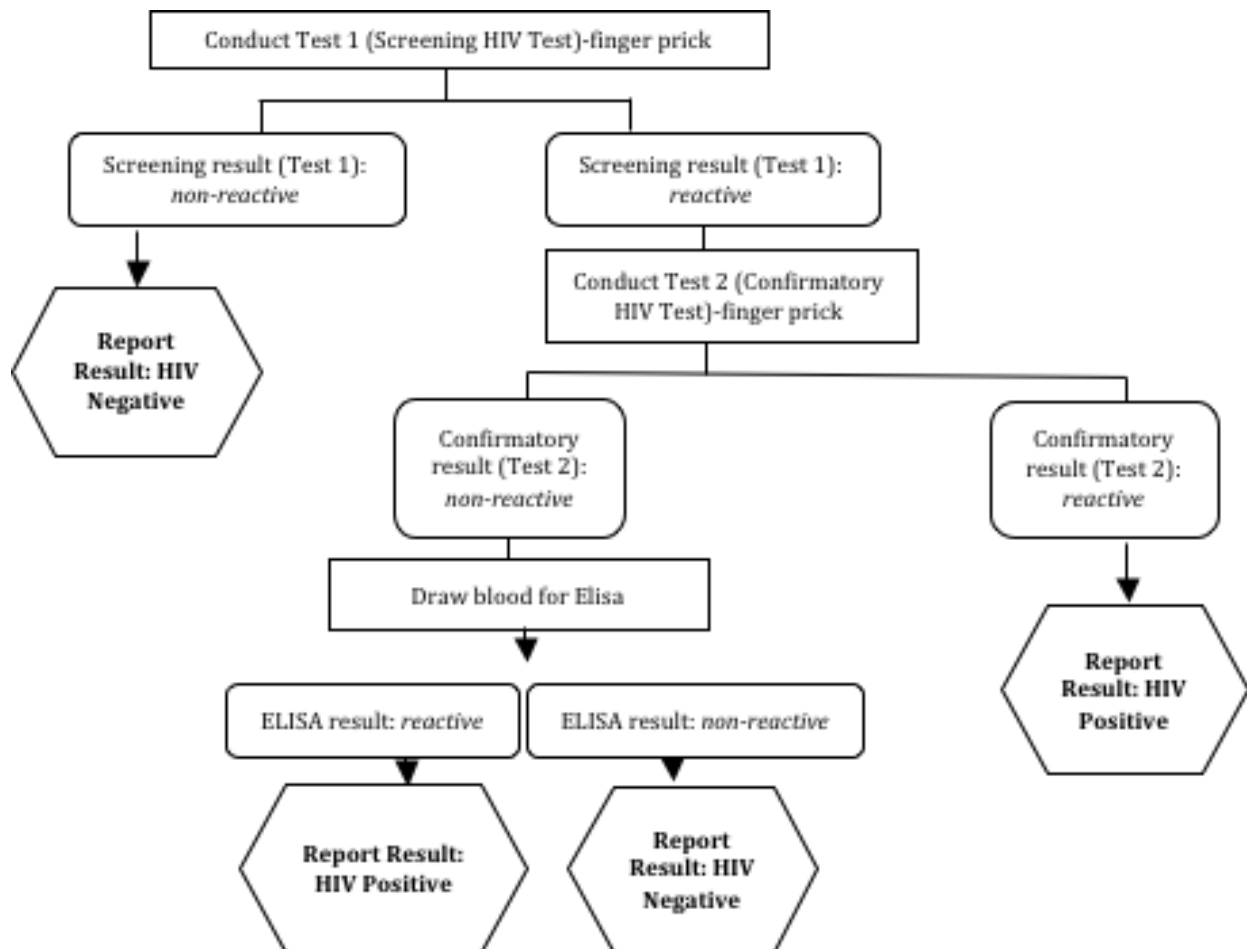
the first assay (Test 1) shall be tested again using a different assay (Test 2 or confirmatory test).

For specimens that are reactive on both the first and the second assays, the result should be reported as HIV-positive. Specimens that are reactive on the first assay but non-reactive on the second assay should subject to an ELISA laboratory test and be recorded as discordant. The individual should be asked to return in seven days (7) for their HIV results.

Babies over 18 months old should be tested using a rapid test following the serial testing algorithm.

Oral Fluid Testing is another rapid test currently not supported in South Africa.

6.1. SERIAL TESTING ALGORITHM



6.2. DOCUMENTING AND MANAGING TEST RESULTS

Key information should be collected for every HCT encounter in all approaches and settings, in order to monitor HCT service delivery in a standardized fashion and allow for useful analysis of HCT data. Completion of these data collection tools is key to monitoring performance and identifying trends in service delivery.

6.2.1. Issuing Written Confirmation of HIV Test Results

Patients/clients may request written results which can be issued irrespective of the HIV result. The HCT provider should write a letter indicating the patient's HIV results.

All written results should clearly identify the patient by name, the date of the HIV test, test result, signature and designation of the issuing provider. There should be a provider stamp on the document. It should be emphasised to clients/patients who test HIV negative that the written results are a documentation of the results at that specific point in time and are not a substitute for consistent periodic testing.

7. RE-TESTING AND FREQUENCY OF HIV TESTING

The frequency of testing and the need for retesting is based on the individual circumstances. All sexually active patients should be encouraged to test at least annually and this should be promoted as part of the culture of proactive self-care that individuals should adopt. However, repeat testing can be more frequent with clients/patients who are considered to be more vulnerable to exposure.

Recommendations for re-testing someone with an HIV-negative result is based on client's risk or a specific situation (i.e. being pregnant, recent exposure, etc.). If re-testing is recommended, the client should be scheduled to return for another HIV test in 6 to 12 weeks. In the case of client who has a recent exposure (e.g. occupational or rape) the client should be re-tested again within 72 hours after the exposure. The table below summarizes who should be recommended to retest if they have just received an HIV-negative result.

Re-testing is recommended for persons with an HIV-negative test result

Window period repeat test

1. All individuals should test for HIV; after the first initial HIV negative test, a repeat window period test to be conducted at 6 to 12 weeks.

Retesting

2. Clients with low risk and no exposure to retest once every year.
3. Clients at high risk to retest every 6 to 12 weeks
4. Pregnant women who have tested HIV negative in their initial ANC booking to retest on every scheduled ANC visit.
5. Clients who have an STI to re-test in 6 weeks.
6. Clients presenting with opportunistic infections (OIs) to re-test in 6 weeks.
7. Clients with continuing or ongoing risk of acquiring HIV; re-test in 6 weeks.
8. Have specific incidents of known HIV exposure within the past three months; re-test in 6 weeks.
9. Received an HIV-negative test result on a baseline HIV test for an incident of possible HIV exposure (occupational or rape) in the past 72 hours; in this case, and if PEP has not been initiated, re-test at 6 weeks after exposure, and if the results are still negative, the person should be re-tested again at 12 weeks after exposure.

7.1.1. HIGH RISK NEGATIVE INDIVIDUALS AND KEY POPULATIONS

Clients who are high-risk negatives are persons with a known HIV-positive partner, and persons with a partner of unknown HIV status.

Key populations (KPs) are persons who are at increased risk of exposure to and/or transmission of HIV, and who may not typically access health care services due to stigma and discrimination associated with behaviours that are illegal or

socially stigmatized (see section X for additional information about KPs). The following persons are considered key populations by this definition:

- o Persons who inject drugs (PWID);
- o Sex workers (SW); and,
- o Men who have sex with men (MSM).

High-risk negative clients and key populations should be tested for HIV at least quarterly and provided with their respective population-appropriate risk reduction counseling.



7.1.2. PREGNANT WOMEN TESTING HIV NEGATIVE IN EVERY ANC BOOKING

In order to prevent mother-to-child transmission (MTCT) of HIV, pregnant women should be tested as early as possible in each pregnancy. HIV-uninfected require specific counselling and advice on repeat testing every scheduled visit after a negative test, labour and through breastfeeding every 3

months. In the event that a woman does not return for testing during her third trimester, she should be recommended to test at labour or, if that is not possible, immediately after delivery. Mothers of unknown HIV status or who are HIV negative should be tested for HIV test at 6 weeks, 3 months, 9 months and one year postpartum, particularly if they are breast feeding. Refer to the <NDoH consolidated PMTCT Guidelines 2014>.

In South Africa, approximately 4% of women who initially test HIV-negative in early pregnancy test HIV-positive later in the same pregnancy. Therefore, regular repeat testing is essential to detect new HIV infections (sero-conversions) occurring during pregnancy or breastfeeding.

HIV sero-conversion results in a very high viral load and subsequent high risk of MTCT. If new maternal HIV infection goes undetected, there is up to 30% risk of MTCT. Detecting new HIV infections quickly enables the woman to be started on ART as soon as possible and the infant to be identified and managed as HIV-exposed. Repeat testing also addresses false negative results. Always ensure the HIV test is

Infants including:

- Low birth weight <2.5 kg
- Premature infants
- Infants of mothers who were on TB treatment for active TB at any point during pregnancy
- Infants born to mothers with VL >1000 copies
- Infants of mothers who were on ART <4 weeks prior to delivery
- Infants of mothers who were unbooked or diagnosed HIV-positive in labour or shortly after delivery
- Breastfed infant of a newly diagnosed HIV-positive breastfeeding mother
- Infants who are symptomatic at birth

These infants can be regarded as high-risk cases that need an urgent diagnosis so should receive HIV PCR as soon as possible after birth.

HIV PCR testing at 6 weeks should still be done on all HIV – exposed infants without confirmed HIV infection, regardless of earlier testing.

Any infant with a positive PCR should be urgently referred/ discussed telephonically for ART initiation by a paediatric HIV expert.

At 6 weeks:

- All HIV-exposed infants

At 16 weeks:

- All infants who receive 12 weeks of NVP prophylaxis

- All HIV exposed infants

Breastfed infants: (6 weeks post cessation of breastfeeding)

All HIV-exposed infants-age appropriate: if <18 months old-do HIV PCR, if >18 months old do HIV rapid testing
Family and social history (at all times)

- Parental request to test the child
- Father or sibling with HIV infection
- Death of mother, father or sibling
- When mother's HIV status is unknown, her whereabouts are unknown, or she is unavailable to be tested.

All children (at all times) with:

- Clinical features suggestive of HIV infection
- Acute, severe illness
- IMCI classification of Suspected symptomatic HIV infection
- IMCI classification of Possible HIV infection
- TB diagnosis or history of TB treatment
- Risk of sexual assault
- Wet-nursed or breastfed by a woman with unknown or HIV-positive status
- Children considered for fostering or adoption



8. QUALITY ASSURANCE AND QUALITY IMPROVEMENT

There are multiple points along the “diagnostic continuum” that can contribute to incorrect test results including poor quality HIV tests, limitations of the national testing algorithm, improper storage of test kits, not following standard operating procedures, or poor documentation. Every effort must be made to ensure that service delivery is of the highest quality. This

means quality assurance (QA) and quality improvement (QI) systems must be in place at all levels of the HCT program for both HIV counselling and testing. HCT managers and service providers must have a systematic and planned approach to monitor, assess and improve the quality of their services on a continuous basis. A variety of QA/QI tools and approaches have been developed. Numerous resource documents and tools are available in the WHO’s Handbook for Improving HIV Testing and Counselling Services.

8.1. WHY IS QUALITY IMPORTANT?



Improving the quality of testing at HIV rapid test sites will ensure accurate and reliable testing, resulting in improved quality in all aspects of health care. The implementation of quality assurance systems in HIV rapid testing would serve to minimize the provision of incorrect test results

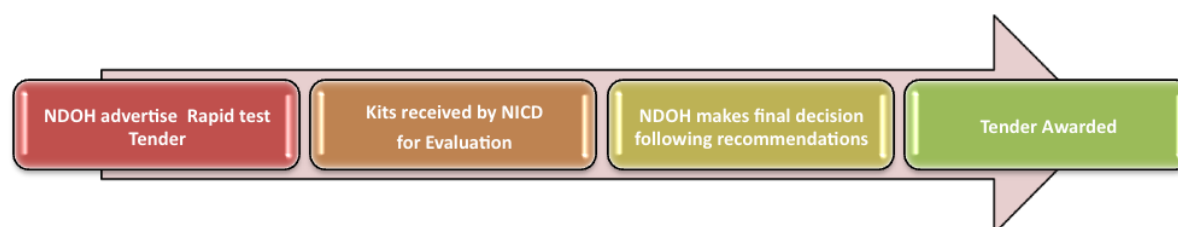
not guarantee accurate test results. Errors can occur at multiple points along the “diagnostic continuum”; therefore, measures must be in place to assure the quality of HIV testing. These include:

8.2. QUALITY ASSURANCE STRATEGIES FOR HIV TESTING

Quality assurance (QA) refers to a systematic and planned approach to monitoring, improving, and evaluating the quality of services on a continuous basis. In HCT, QA of testing can be defined those strategies employed by HCT services that ensure that the final HIV test results are correct. The availability of rapid HIV tests with high performance characteristics does

8.3. VALIDATION AND SELECTION OF RAPID TEST KITS

All test kits in use at public and private facilities will subjected to stringent evaluation and selection criteria following the advertisement of rapid test kits tender by NDOH. All kits will be received by the National Institute for Communicable Diseases for evaluation after which recommendations are made to NDOH which will then make the final decision on the tender to be awarded.



8.3.1. Post Marketing Surveillance

Post-marketing surveillance for HIV tests is a critical process for monitoring the quality of test kits procured and used within South Africa following an outcome of the NDOH national tender. New batches of test kits will be subjected to verification processes to verify consistency with pre-qualification validation and/or previous lot verification

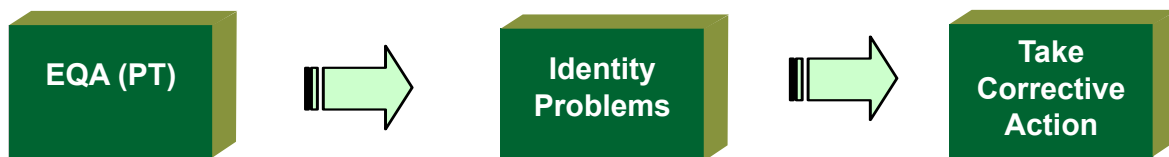
sensitivity and specificity before circulation to the sites and end users. Passed batches receive verification certification to indicate approval for use. Only passed batches are allowed to circulate. IQC data will also be used to monitor the performance of test kits that are being used at facilities. The number of false negative or positives and invalids will be evaluated to give a clear indication of performance of particular batches.



8.3.2. Quality Control (QC)

There are two types of quality controls:

- **Controls built into the testing device** – each test kit has a red line that develops in the control area of the test kit to indicate that the test result is valid. The appearance of the red line when a test is being performed indicates that the quantity of specimen is accurate and the kit is functioning properly. If the red control line does not appear, there may be a problem with the test kit itself, or with the way the testing was performed. The test should be repeated with a new device.
- **Internal (Independent) control test on known samples**
 - each site should validate their HIV test kits by running tests using standard operating procedures on known HIV positive and negative samples, to be sure the tests give accurate test results. This must be done:
 - At the beginning of every week;
 - Every time a new batch of test kits is used;
 - Every time a test kit may have been exposed to potentially damaging conditions such as extreme heat or sunlight; and,
 - Every time a new HCT provider starts at a site.
 - All HCT sites must have specific External Quality Assurance systems in place, including:



- **Proficiency panel testing** – HCT sites should receive a panel of blood specimens, known as a proficiency panel, on every 6 months from the national reference laboratory. HCT providers should perform HIV testing on the samples on a rotational basis, and they should record the test results on a standard form. The test results are returned to the reference laboratory, and are crosschecked for accuracy. Any errors or mistakes are reported back to the site, so that corrections can be made. All sites should receive the results of their proficiency panel testing, and facilities that do not pass need to receive technical support from the national, regional, or referral lab supporting that site.
- **Supportive Supervision, including site assessment and observed practice** – Quarterly assessments should be conducted by regional quality assurance officers, trained supervisors, or designate laboratory staff from the reference, regional, or referral lab supporting the site. Provincial supervisors should support health care managers and HCT providers at the district level. Ideally quarterly visits will be conducted by a Provincial and District supervisor as well as a District laboratory technician.

8.3.3. Quality Assurance indicators in HCT Register

Quality Assurance indicators in the HCT Register are used for recording the specific results of each individual HIV test kit performed, and allows for easier monitoring of the lot number, type, and number of test kits used. They also facilitate HCT providers to address test kit problems, such as expired test kits

or inconclusive results. Every HCT provider should complete the HCT Register immediately following the performance of a HIV rapid test with clients or patients. This should be checked regularly by HCT site supervisors.

8.3.4. Quality Assurance Strategies for HIV Counselling

While standard protocols for rapid testing provide the appropriate information for the testing component of HCT, it is the use of counselling skills that have an impact on the client's HCT experience. It is therefore important to have systems in place that assure the quality of counselling as well. Such approaches are important for ensuring that human rights are respected and the client's needs are met. Quality counselling is defined as non-judgemental, accessible, and client-centered. Counselling should increase knowledge of HIV prevention, benefits of early treatment for HIV positive individuals, and help clients to focus on achievable steps to reduce their risk. The following are the national standard operating procedures for QA of counselling that must be followed by all service providers:

- All counsellors must meet the National Minimum Standards for Counselling to ensure that quality counselling is conducted.
- QA (i.e., supervision, observations of actual counselling sessions, regular training and feedback to counsellors) of counselling must be performed regularly. These strategies are important in ensuring that quality counselling and testing is provided.
- All counsellors must be trained by an accredited service provider.



- **Supportive Supervision and Observations of Counselling Sessions**

Given the burden of the HIV epidemic in South Africa health care workers and lay counsellors have taken on added responsibility and additional work load to their normal duties. This could result in increased stress and burnout that sometimes compromise the quality of HIV counselling and testing services and may result in staff turnover.

Supervision by observation is intended as a continuation of the learning process, as such, should be supportive and not aimed at finding fault. With the consent of the client, a counsellor can request to be observed by their supervisor or experienced counsellor while conducting a session. Counsellor supervision programs should be implemented to provide systematic support and mentoring to all counsellors to enable optimum service delivery for all clients. Such a system will provide counsellors the opportunity to get feedback on how to improve the services they're providing and express their emotions in a safe environment.

- **Counsellor Self Assessments**

Since counsellors can not be observed continuously the ultimate responsibility for quality rests with the individual counsellor. Counsellors can monitor and evaluate their HCT sessions by completing a self assessment form after seeing a client. The self assessment form can be used by the counsellor to monitor steps a supervisor has

asked them to work on based on previous observations and may be shared with their supervisor or in group meetings where fellow counsellors share challenges they're facing in providing quality HCT services.

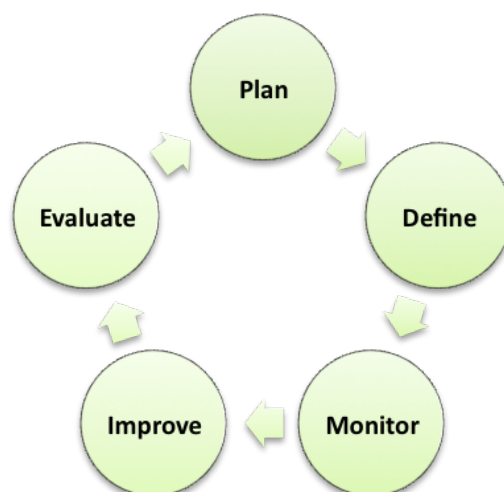
- **Counsellor Self Care and Support**

Self-care is making a deliberate effort to reflect on and address personal, emotional and work-related issues that may affect your mental and physical well-being and your performance as a counselor. Part of self-care is being aware of your own beliefs and values as a counselor. Supervision is essential for care and support of counsellors. Counselors are helped by reflecting on personal issues that may hinder their capacity to provide effective services to clients and at the same time receive support to manage such issues constructively.

8.3.5. Quality Assurance Cycle: Using Data to Improve Programs

HCT programs should consider adopting a quality improvement approach to improve and strengthen quality of counselling and testing, case finding, and linkage to care. The concepts of QI apply equally to all levels of the health system. At the national level, the vision for improving quality starts with planning and defining national standards. The provincial level takes on the national vision, using routine monitoring data to support facility efforts in monitoring, improving and evaluating quality. These five key stages of assuring and improving quality are illustrated in Figure 3.

Figure 3: Quality Assurance Cycle



9. DOCUMENTING AND MONITORING HCT SERVICES

9.1. THE IMPORTANCE OF DOCUMENTING, MONITORING AND EVALUATION

Monitoring and evaluation (M&E) is a necessary component of the implementation and management of the HCT programme, ensuring that the resources going into a programme are utilized, services accessed, activities occur in an efficient and guided manner, and the expected results are achieved. Routinely monitoring HCT programmes ensures that service quality is improved and the maximum health benefit for the population served is obtained.

Monitoring is the routine tracking of service and programme performance using input, process and outcome information collected on a regular and ongoing basis. This includes HCT programme tools such as registers, regular reporting systems and templates (e.g. the District Health Information System (DHIS) as well as health facility support visits, client surveys and to some extent, population-based surveys.

Evaluation is the periodic assessment of results that can be attributed to programme activities. It uses advanced data analysis and indicators that are not collected through routine information systems. It also assesses whether the programme is effective in achieving its objectives.

9.2. DATA MANAGEMENT

Data management is essential for the effective management and improvement of HCT services. HCT client data should be used to monitor HCT services at each site, in each district and region, and at national level. All HCT service providers will use a standardized HCT register as a data collection tool. Data collection will take place at the site or outreach setting where clients/patients are seen (point of service), and data entry will be done at the district level. This will then be collated at the regional level before data analysis, reports and dissemination will be done at the national level.

At each level, the collected data will be analyzed and interpreted to help improve the service and for planning and decision-making. Each district and provincial health information office should have a well-defined data management protocol and data flow protocol from different peripheral service points, including those in the private sector, to a central point. Only health workers, including lay counsellors and data

capturers/information officers permanently designated to work with health information, at all levels (facility, district, provincial, and national), should have access to data for verification and quality checks (completeness, correctness and accuracy). The confidentiality of clients' records should be maintained at all times.

9.2.1. Roles and Responsibilities for the Information Flow

All required information should flow from the HCT service points to and from the district, provincial, and national health offices ultimately to the South African National AIDS Council's (SANAC) M&E Unit depending on how frequently indicators are collected (monthly, quarterly, annually, etc.). Compliance with the data flow policy and the data user agreement must be maintained at each level. All HCT sites, including government and mission hospitals and health centres, NGOs, PLHIV organizations, and private and commercial sites offering HCT must follow these procedures.

At the Service Points

All HCT record-keeping forms and registers will be completed at the service points by the health-care workers and lay counsellors, consolidated by the facility data capturers and signed off by the facility or programme manager. Periodic reports will be completed at the service points and transmitted to the appropriate health districts.

○ District Office

Data collected from the service points and NGOs or private facilities within districts will be collated, captured on the DHIS database and reported to the respective provincial office monthly by the district health information officers and the district HCT coordinator.

○ Provincial Office

The provincial health information officer and HCT coordinator will compile all district data and report to the National Health Office.

○ National Office

Final compilation of national HCT service data will occur at the national office. Some indicators will be reported to the SANAC M&E Unit by the M&E and HCT manager in the HIV & AIDS and STIs cluster. The flow of information will also ensure that at each level, feedback is provided. The typical information flow of data is illustrated in the figure below.



9.3. MONITORING AND EVALUATION FRAMEWORK AND OBJECTIVES

The “input-output-outcome-impact” framework is used in most M&E environments. These stages represent the flow of interventions over time and are intended to capture the relationship. For an HCT programme to achieve its goals, inputs (policies, budget, staff, HIV-test kits), must result in outputs (HIV-test kit stocks and supply systems, new or improved HCT services and appropriate ratios of trained staff).

These outputs are often the result of specific processes, such as training sessions for staff and campaigns aimed at promoting HIV testing. If these outputs are well designed and reach the target populations, the programme is likely to have positive short-term effects or outcomes, such as an increased number of people testing for HIV from the target population. These positive short term outcomes should lead to changes in the longer-term impact of HCT programmes, possibly reflected in fewer new cases of HIV infection in a target population.

9.4. HCT PROGRAMMES ESSENTIAL AND STRATEGIC INDICATORS

HCT programmes should continuously monitor the minimum set of indicators established by the National HCT Programme. These indicators should be monitored at every service delivery point offering HCT services (ANC, TB, OI, STI, PEP, primary health care clinics, and

community/home-based HCT programmes). Indicators measuring referral to appropriate services (e.g., TB screening, STI treatment, ART, MMC, etc.) should also be collected. Table shows set of indicators recommended for the purpose of reporting on the implementation of the HCT programme and policy

A data collection tool should be available with a minimum set of data elements. The minimum set of data elements must include the following:

- Age
- Gender
- Location

There must be a minimum, essential set of indicators, which reflect policy goals and objectives. Indicators should be dynamic and should be revised periodically depending on availability of information and changing circumstances or technologies.

○ Indicator Relatedness

Programme monitoring activities (in-year monitoring) and periodic outcome and impact activities should be closely linked. Indicators that are logically connected (i.e., inputs, outputs and outcomes) should be used.

○ Reporting Requirements

For reporting, all facilities and community programmes providing HCT services will be required to comply with agreed reporting standards and schedules as well as to comply with the data flow policy outlined below.

TABLE 1: LIST OF HCT INDICATORS

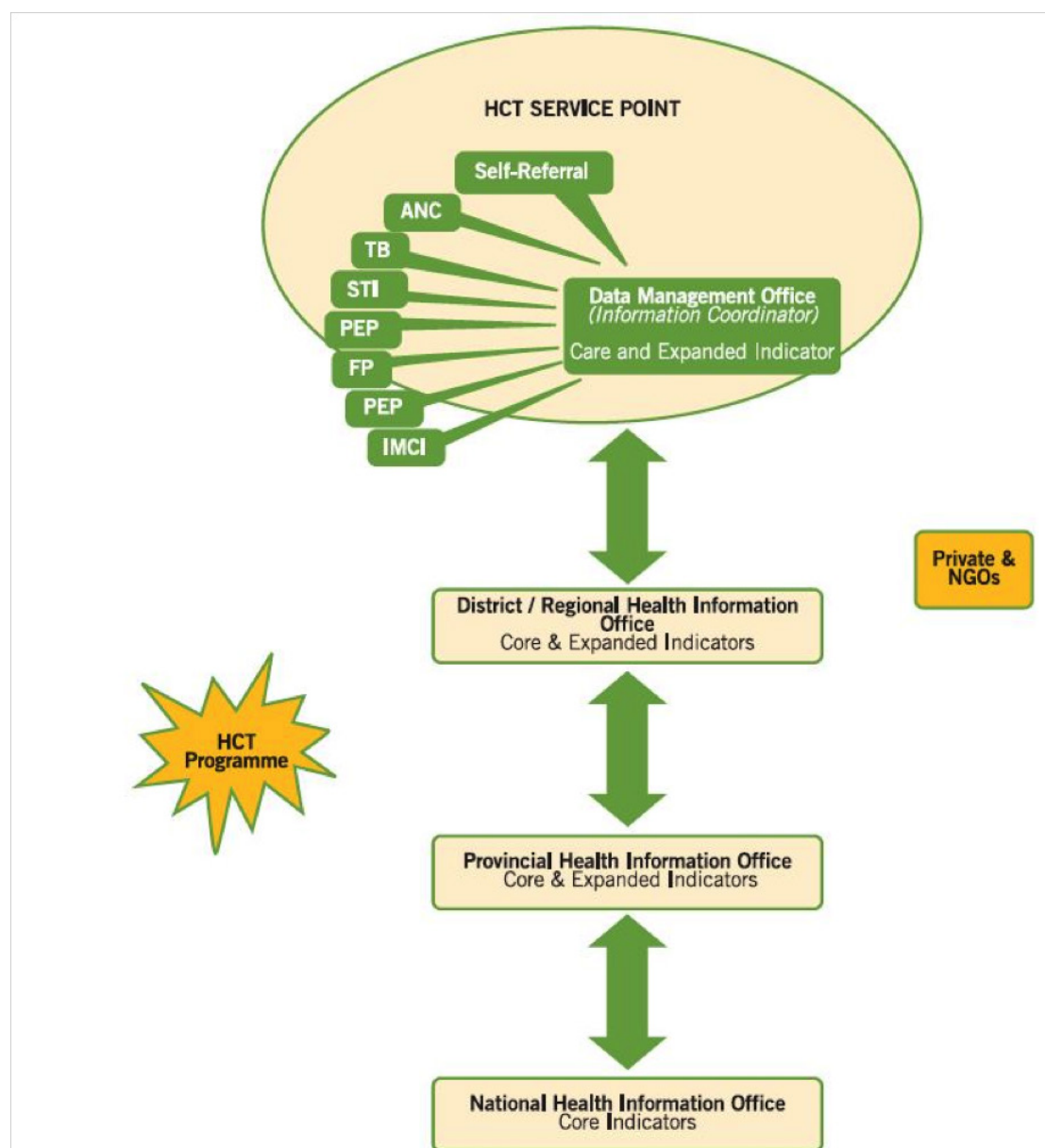
No.	Indicator	Type of Indicator	Measurement tool	Frequency of collection	Levels of disaggregation
1.	Number of public health facilities offering VCT services	Input	DHIS	Quarterly	Province, District & Facility
2.	Number of health and non-health facilities providing HIV testing	Input	Programme monitoring or DHIS	Quarterly	Province, District
3.	Number of campaigns aimed at promoting HIV testing.	Process	Programme monitoring	Quarterly	Province, District
4.	Number of trained lay counsellors on stipend.	Process	Programme monitoring or DHIS	Quarterly	Province, District & Facility
5.	Proportion of HIV positive clients referred for CD4 testing	Process	Programme monitoring or DHIS	Monthly	Province, District & Facility
6.	Proportion of HIV positive clients referred for TB screening	Process	Programme monitoring or DHIS	Monthly	Province, District & Facility



TABLE 1: LIST OF HCT INDICATORS

No.	Indicator	Type of Indicator	Measurement tool	Frequency of collection	Levels of disaggregation
7.	Number of clients pre-test counselled for HIV	Output	DHIS	Monthly	Province, District & Facility, Gender, Pregnancy status among females
8.	Number of clients tested for HIV	Output	DHIS	Monthly	Province, District & Facility, Gender, Pregnancy status among females
9.	Proportion of new TB patients tested for HIV	Output	DHIS	Monthly	Province, District & Facility
10.	Proportion of new STI patients tested for HIV	Output	DHIS	Monthly	Province, District
11.	Proportion of new pregnant women tested for HIV	Output	DHIS	Monthly	Province, District & Facility
12.	Percentage of facilities where the HCT policy guidelines are available.	Outcome	Programme monitoring or DHIS	Quarterly	Province, District & Facility
13.	Proportion of adults (15-49) who tested in previous year and received the results.	Outcome	Population based surveys (BSS or DHS)	Periodically	Province, District & Facility





9.5. DATA QUALITY ASSURANCE

To assure the quality of the data that is reported, the District, Regional and National level HIS officers should select visit sites for data verification every quarter. A data

verification tool should be developed to assist in this process.



SECTION B

10. HIV COUNSELLING & TESTING GUIDELINES

10.1. PURPOSE OF HIV COUNSELLING & TESTING GUIDELINES

HIV Counselling and Testing is the entry point to HIV prevention, Care, Treatment and support services. Different components of the populations require different HCT approaches in order to access HIV Care and treatment services. Programmatic evidence has shown that there is a need to prioritize specific areas in order to speedily identify individuals infected with HIV. These priority areas include;

- The need to prioritize counselling and testing of couples
- Testing of family members of HIV infected persons
- Strengthening PICT in health facility settings
- Strengthening of community-based HIV testing targeted a specific and key populations
- Testing of young women and girls

The purpose of these guidelines is therefore to provide national standards for all service providers in the provision of high quality HIV counselling and testing in South Africa.

10.2. TYPES OF HIV COUNSELING AND TESTING

Two main approaches to HCT are recommended in this guideline and should be implemented at every health facility. These include client-initiated counselling and testing (CICT) also referred to as Voluntary Counseling and Testing (VCT). The second approach is provider-initiated counselling and testing (PICT). The HCT Policy Guidelines does not support mandatory testing of individuals.

10.2.1. Client-Initiated Counselling and Testing

Definition: CICT (or VCT) involves individuals or couples/sexual partners actively seeking HIV testing and counselling at a facility- or community-based location that offers these services.

Settings: CICT is conducted in a wide variety of settings including health facilities, outside health institutions, in community-based settings through mobile vans, stand alone, and even in people's homes.

Procedure: CICT involves pre-test information sessions conducted individually, or with couples or in groups. Group information sessions are typically followed by a short individual session with each client. Pre-test counselling is followed by individual or couple post-test counselling. The process is voluntary, and the "five Cs" – informed consent, counselling, confidentiality, correct test results, and linkage to care – must be observed at all times.

Note: Counsellors should enquire into the existence of an abusive relationship before commencing couple counselling.

10.2.2. PROVIDER-INITIATED COUNSELLING AND TESTING (PICT)

Definition: PICT (also referred to as the Routine Offer of Counselling and Testing) is HIV counselling and testing that is initiated and recommended by health-care providers to all clients attending health-care facilities as a standard component of medical care.

Settings: In PICT, health-care providers recommend HIV counselling and testing to all adults, youth and children who visit health facilities. This applies to medical and surgical services, public and private facilities, in-patient and out-patient settings and mobile or outreach medical services. All aspects of care including trauma, casualty and specialist clinics should offer PICT. The clinical services where PICT shall be offered include; Family Planning (FP), Antenatal clinic (ANC), Tuberculosis clinics (TB), Out patient departments (OPD), In-Patient wards, Expanded Program on Immunization (EPI), Integrated Management of Childhood illnesses visits (IMCI), Casualty departments, Sexually Transmitted Infections visits (STIs), Medical Male Circumcision (MMC), Post rape care, Occupational exposure patients

Procedure: PICT Providers offer basic counselling or pre-test information to patients, even when it is being done for diagnostic purposes. This may be done in a group setting or with individuals or couples. Patients should never be forced to receive HCT against their will, and patients who decline to receive HCT should still be provided with high quality medical care. Results should be given to patients, along with post-test counselling and linkage to appropriate follow-up services.

Note: PICT aims at early identification of clients for whom there may be a strong likelihood of HIV infection, either because of their symptoms, or because of high-risk sexual behavior, or in areas of high HIV prevalence. PICT should be offered to all patients in the health facilities. In particular, PICT is emphasised but not limited to the following health service points: antenatal clinics, post-natal clinics, TB facilities, integrated management of childhood illness (IMCI) centres, Family Planning (FP) clinics, STI clinics, and centres offering treatment for opportunistic infections (OIs) and Post Exposure Prophylaxis (PEP). PICT is also recommended in all health services dealing with domestic or gender-based violence, child abuse and sexual violence



10.3. SETTINGS FOR PROVIDING HIV COUNSELLING AND TESTING SERVICES

10.3.1. HEALTH FACILITY SETTINGS

10.3.1.1. VOLUNTARY COUNSELLING & TESTING (VCT)

- Client(s) elect to receive HCT services of their own will, generally for the purpose of HIV prevention and personal life decision-making.
- For individuals, VCT utilizes personalized risk assessment and behaviour change counselling to help client(s) identify a plan for the prevention of HIV transmission and linkage to appropriate follow-up services based on test results.
- This counselling may be abbreviated for persons who have tested before, or who have substantial and accurate knowledge of HIV/AIDS.
- For couples and families, VCT may not include individual risk assessment, but rather the counsellor discusses the couple's HIV risk concerns, and focuses the conversation on the present situation and plans for the future.
- Health care providers may recommend their patient get tested for HIV by going to the onsite VCT. This is one approach to provider-initiated counselling and testing (PICT) discussed below.

10.3.2. PROVIDER INITIATED COUNSELLING & TESTING (PICT)

- Health-care providers recommend and offer HIV counselling and testing to clients within an integrated health care package.
- Based on the capacity of the facility offering PICT; different models of PICT could be offered;

10.3.3. COMMUNITY BASED SETTINGS

10.3.3.1. STAND-ALONE VCT

- With appropriate training for HCT providers, stand-alone VCT sites may integrate other health services in order to maximize the benefits of these sites, such as TB screening and referral, family planning services, or even CD4 testing and Cotrimoxazole provision for persons testing HIV-positive.
- Stand-alone VCT centres provide services to the general population, or can be tailored to meet the needs of specific populations, such as youth or key populations.
- Many VCT sites also choose to supplement their services by offering mobile, outreach, or home-based services in addition to stand-alone VCT.

10.3.3.2. MOBILE AND OUTREACH SERVICES

- With this model, HCT services may be provided in a variety of settings, including mobile vans, tents, sporting events, workplaces, churches, bars, prisons, bus stations, or schools.
- Mobile or outreach HCT requires advance preparation and strong collaboration with local health care workers, community leaders, and other influential community persons.

- The local community should help with prior arrangements including identifying a venue, conducting community mobilization, identifying sites and services for follow-up and referral, and supporting HCT providers during the mobile/outreach event.
- Some mobile/outreach sites incorporate drama, choir, or other forms of folk media in order to draw large crowds to these sites and educate them about HCT services.
- Mobile services may also be very important to the success of national HCT campaigns, such as World AIDS Day or national testing events, and can be provided at night as Moonlight VCT for specific target populations such as sex workers and taxi or truck drivers.

10.3.3.3. WORKPLACE AND EDUCATION INSTITUTIONS

- These guidelines encourage managers of all public and private sector workplaces to incorporate HCT as part of their welfare strategy for employees and their families.
- Workers should have sufficient information to make informed decisions about HCT services, and services must be accessed voluntarily; that is, workers or their families shall not be required to be tested by their employer.
- All personal data relating to an employee's HIV status or other personal information should not be disclosed to the employer unless the employee provides consent to do so.
- Where possible, workplace policies should also outline what care and support services are offered to persons living with HIV, and workers should not be discriminated against on the basis of real or perceived HIV status.

10.3.3.4. HOME-BASED HIV COUNSELLING & TESTING (HBHCT)

- HCT providers must carry all necessary HCT supplies and equipment with them, and adhere to the standards and quality assurance systems outlined in these guidelines.
- Home-based HCT also requires advance preparation and engagement with local leaders to gain access to the community and peoples' homes.
- Because the testing environment is less controlled in the home, particular attention should be paid to biosafety and waste precautions, appropriate lighting, temperature of the test kits and supplies, ensuring confidentiality, and maintaining high quality services under sometimes harsh conditions.
- Home-based HCT services may be combined with mobile or outreach sites to increase the reach of services.
- As with any HCT model or approach, workplace HCT providers must adhere to Department of Health SOPs for HCT as outlined in this document and accompanying resources.



- **Benefits of HBHCT**

There are many benefits to providing home-based HCT. These benefits include; Increased acceptability of HIV testing, Reduction in stigma and discrimination, Facilitated disclosure and support within families and couples, Facilitate linkage to care, Increased knowledge of HIV status especially in hard to reach populations, Early identification of HIV infected individuals including children, Systematic coverage of communities (80% coverage), Greater buy-in and involvement of community leaders in HIV issues, Improved accessibility of HCT, Reduce HIV infection rate through high HCT uptake, Removal of structural, logistic and social barriers to HCT And Timely access to treatment, support and care

- **Target population of HBHCT**

- HBHCT targets families in their homes with a specific focus on reaching men, women, children, couples including persons in polygamous marriages in line with the national HCT targets. Pre-sexual, engaged, married, cohabiting, and reuniting couples, as well as casual, short-term, and long-term couples, and same-sex and heterosexual couples

- **Services offered in HBHCT**

- Services offered in HBHCT shall be offered in accordance to the basic package of HCT service as described in this policy. This package includes; HIV information education, HIV counselling (incl. symptomatic screening of STIs & TB, FP), HIV Testing, Referrals to HIV treatment, care and support services(including referrals to FP, Immunization, PMTCT, TB, STI), and Follow-up on linkage to care

- **Considerations for HBHCT**

- The following considerations shall be taken into account when implementing HBHCT; Culture, Religion, age, gender dynamics, Violence in the home, Alcohol& other substance abuse, sexual abuse, key populations at higher risk of exposure, Confidentiality and privacy, Child headed homes, Family members with special needs (e.g. mental incapacitation) and Availability of referral services

- **Members of the HBHCT team**

- Team offering HBHCT shall be comprised of the following; Mobilizers, Counsellors/ testers and nurses

- **Planning for HBHCT**

- HBHCT implementation shall be carefully planned. The following shall be taken into account when planning to implement HBHCT; Training of providers, Choosing the location, Consulting stakeholders, Mapping of location, Determining availability of follow-up services, Planning return visits, Data collection, and storage, Supplies, Security and transportation, Biosafety and waste disposal, Linkage to care and reporting

- **Support for HBHCT**

- All provinces and districts should support the implementation of HHHCT and where needed, districts must support the implementing partners with commodities, registers and tools needed for the successful implementation of the programme.
- Partners are in turn expected to report on all the necessary indicators and data elements to the facilities in the districts where they are implementing on a monthly basis.

- **Implementation process for HBHCT**

- HBHCT is not a self-testing procedure. It is HCT approach of services offered by a recognised trained HCT service provider or counsellor or community care worker in line with the national HIV testing policies and ethical considerations within a home setting.
- The HBHCT programme will initially be implemented by Donor- funded implementing partners and implementing partners funded by other donors to implement the programme. For sustainability, the community care workers and the community re-engineering teams will be capacitated to implement the programme. Furthermore, the
- HBHCT model will have to be managed as part of the existing health system.
- Successful management of the model is dependent on its integration with health system priorities, the relationships and sense of ownership between the community and relevant agencies such as health facilities and on multisectoral collaboration.
- Gaining the support of the gatekeepers and opinion leaders in the community is the first step on implementing HBHCT. Programme managers should contact community leaders, religious leaders, and other local authorities to introduce the programme and obtain buy-in.
- Community mobilizers will ensure all households in a community are mobilised/sensitized about the services that are on offer.
- Mobile teams will offer counselling and testing services and symptomatic screening services for TB and STIs in homes.
- All those who test HIV positive will be referred to the nearest facility for CD4 count and clinical staging as well as further management and care
- The national HCT policy guideline will be adhered to in terms of HIV counselling and testing procedures.
- Initial group information will be provided to family members and peers, followed by private pre-test and post-test counselling for individuals and couples deciding to test.
- TB symptomatic screening will be offered to all individuals during pre-test counselling sessions.



- Written informed consent will be administered for everyone deciding to test.
- Appropriate referrals will be made for those who need them to appropriate services.
- Tools will be provided for appropriate referrals to the nearest facility and follow-up visits should be conducted to the homes to monitor referrals.
- Most people in communities will not have medical aid facilities and will have to be followed up to ensure that they did go to the clinic for further management.

- Through reducing barriers to testing, this strategy could expand HCT services to previously under-served groups and rural communities and increase couples testing. The minimum composition of the team that provides HIV counselling and testing in the homes should be a mobilizer and a counsellor or community care worker who is trained on conducting HCT including rapid HIV testing. Their roles and functions are clearly defined and suitable training will be provided.

• **Social mobilization for HBHCT**

Intense social mobilisation is critical in order to:

- Obtain buy-in from all the relevant stakeholders
- Increase awareness for HCT and mobilise communities for HIV testing

• **Mapping for HBHCT**

Mapping for HBHCT is critical in order to:

- Be familiar with the geography of the area
- Know the number of households in the area
- Know the existing services in the area
- Identify possible barriers such as safety issues

• **HBHCT follow up visits**

- HBHCT should work closely with PHC reengineering teams and community health workers to strengthen linkage to care and follow up visits.
- Where resources allow HBHCT team should conduct follow up visits to monitor linkage to care

• **HIV counselling and testing process for HBHCT**

○ **Pre-test information session for HBHCT**

A group information session should include the following key components beneficial to the client, as appropriate to the circumstances:

- Basic information about HIV and AIDS.
- Emphasis on the importance and advantages of early HIV testing to facilitate diagnosis, positive living and healthy lifestyle as well as preventing transmission.
- Importance of couple HIV testing and testing of children under 5 years
- Emphasize importance of support amongst family members.
- Information about the HIV testing & the TB screening

process.

- Discussion on confidentiality and shared confidentiality.
- Option not to take the test.
- Demonstration of male and female condom use.
- An opportunity to test at a later date should the client decline the test.
- Referral and linkages to HIV and AIDS related services such as nutrition, TB screening, STI screening, CD4 count, OI management and clinical staging.

• **Pre -Test Counselling Session for HBHCT**

- Information should be available to all clients considering taking the HIV test, in their preferred language.
- The components of the pre-test counselling session include:
 - Assessment to determine if the information provided in the group session has been absorbed.
 - Answering remaining questions, and seeking to clarify any misunderstanding.
 - Discussion of :
 - Specific issues pertaining to client or couple and assessment of risk, including enquiring whether a history of domestic violence exists.
 - Prevention strategies including delayed sexual debut, abstinence and regular use of condoms.
 - TB and STI symptomatic screening.
 - Way forward and management options including STI and TB screening, clinical staging, CD4 count, pre ART management and healthy lifestyle, should the client test HIV positive.
 - Partner involvement and referral for testing.
 - Voluntary option of testing.
 - Obtaining of written informed consent for HIV-testing.

• **HIV testing for HBHCT**

- HBHCT teams to follow the national testing algorithm according to this policy.
- HIV rapid testing should be conducted by persons authorised to do so according to the National Health Act (61/2003) and the Government notice R401 Gazette No. 33188. These include trained nurses, lay counsellors and community care workers.
- HIV testing must be ethical, based on human rights, conducted within a supportive environment and be performed where there is adequate health care infrastructure.
- The testing surface shall be non-metal, clean and flat.
- The national quality assurance programme must be adhered to. This should cover the counselling process as well as the use of rapid test kits.
- Disclosure of test results and the implications thereof should comply with the promotion and protection of human rights.
- All clients who test HIV positive must be referred for CD4 cell count and IPT initiation.



• Post-Test Counselling for HBHCT

All clients, regardless of the outcome of the HIV test, should receive post-test counselling on an ongoing basis as appropriate. All results must be given clearly.

HIV-negative clients should be offered a comprehensive post-test counselling prevention package that includes information and advantages of MMC, TB screening, risk reduction, correct and regular use of condoms. They should be encouraged to repeat the test three months after exposure to exclude the possibility of the window period. Window period should be explained based on the client's recent exposure to HIV. If there is no recent exposure then client should be encouraged to test annually as per the HCT policy.

HIV-positive clients should be offered a comprehensive package including counselling about their HIV status based on reactive screening and confirmatory test. Clients who test HIV positive should be informed and counselled about possible emotional responses (e.g., denial and anger) and they should be guided as to when and how they can manifest and what impact these emotions can have on adherence to healthy lifestyle choices. These clients also need comprehensive information on how to reduce the risk of transmission, ongoing positive living, healthy lifestyles and nutrition and ongoing referral for psychosocial support (e.g., support groups), preventative package including correct regular use of condoms, and medical services when needed. Information on positive living and ART including qualification and adherence should be discussed.

• Referrals for HBHCT

- Referral may be needed for additional services not available from the provider.

- The referring provider should explain to the client the purpose of the referral and what takes place at the referral site.
- A referral form should be filled with both the client's name and the reasons for referral and the information should be entered in a referral register maintained by the service provider.
- For some services the client may need to bring written documentation of his or her HIV test results in order to access care at the referral site.
- Mechanisms for feedback between referral sites should be in place.
- All referrals should be addressed to institutions, departments or units rather than individuals.

After posttest counselling all HIV-positive clients must be referred to the nearest clinic for CD4 count test, clinical staging, IPT and further management then prepared for ART or referred to attend the wellness services provided (pre ART management) if they do not qualify for ART immediately. All clients who are TB suspects must be referred to the nearest clinic for diagnosis and further management.

Point of care CD4 testing would be an added advantage for the comprehensive implementation of HHHCT where the services go beyond testing to strengthen linkage and are offered in a home situation where the client is only referred to the facility for further management in terms of pre-ART or ART. Partners that have enough funding should consider point of care to strengthen linkage to treatment. Furthermore, in areas that are remote and have poor access to the laboratories, point of care testing will improve the management of the patients and facilitate early access to treatment for those who need treatment.



11. HIV COUNSELLING AND TESTING SERVICE

11.1. GENERAL POPULATION

- The counselling process for PICT and CICT conducted in public health facilities is illustrated in Figure 1. It should always be conducted in the language that the client understands. Pre-test information sessions may be conducted with groups, couples or individuals. These must be followed up with brief individual sessions that address individual HIV risk.

Note that:

- The results of the client should be documented in the client's file/record and may be communicated to other members of the health-care team involved in the management of the client, with the client's consent.
- Disclosure to sexual partners should be encouraged; however, the decision to disclose should be taken by the person undergoing the test.
- In a couples HCT session, both partners agree to keep one another's HIV test results confidential, until they decide together to disclose to another person. This is also referred to as shared confidentiality among the HCT provider and both partners in the couple.
- All personnel with access to client or patient medical records should be trained in procedures to maintain confidentiality of HIV test results and should adhere to the code of conduct. Only staff with a direct role in the client or patient's management should have access to their medical records.

According to the National Health Act (Act No. 61, 2003, Section 14):

- All information concerning a client including information relating to his or her health status, treatment or stay in a health establishment is confidential.
- No person may disclose any of this information unless:
 - The client consents to that disclosure in writing.
 - A court order or any law requires that disclosure.

11.1.1. PRE-TEST COUNSELLING

In public health facilities, other high volume settings, and home-based settings the pre-test information and education session are typically conducted in a group information session. Settings that don't have long queues may prefer conducting individual pre-test counselling sessions. Information sessions and IEC materials should be available in the local language to all clients considering taking the HIV test.

Pre-test - Group Information Session

In high volume settings such as health care facilities and community testing events a health-care worker should conduct a general group information session to shorten individual counselling sessions which will shorten the time clients wait to see an HCT provider. In health care facilities the health

care worker should incorporate HIV and AIDS related issues into their general health talk for ALL clients in the following wards and clinics: TB, STI, FP, antenatal care (ANC), IMCI, OIs, PEP, care and treatment, OPDs, malnutrition, under 5, and inpatient on a daily basis. Audiovisual and information, education and communication (IEC) materials (e.g., television, videos, DVDs, posters) should be utilised when the health-care worker is not available.

A group information session should include the following key components beneficial to the client, and used as appropriate to the circumstances:

- Information about HIV acquisition and transmission.
- Emphasis on the importance and advantages of early HIV testing to facilitate diagnosis, positive living, and healthy lifestyle.
- Information about the HIV testing process.
- Discussion on confidentiality and shared confidentiality.
- Discussion on the option not to take the test.
- Offer an opportunity to test at a later date should the client decline the test.
- The importance of TB symptomatic screening during pre- and post-test counselling.
- Referral to HIV and AIDS related services such as nutrition, TB screening, STI screening, CD4 count, OI management, and clinical staging.
- Importance of partner testing, especially in ANC settings.
- Information about effective HIV prevention measures, including consistent and correct use of condoms, partner reduction, and other options.

The education session should also be followed by shorter individual counselling sessions where the provider may ask some additional questions about the client's understanding of the testing process and willingness to test, the client's recent risk to inform post-test counselling session and answer questions the client may have about testing. Provider should obtain written or verbal informed consent from client for HIV testing.

Pre-Test - Individual Counselling Session

If a group information session was not conducted the individual counselling session should cover the same elements noted above. In addition if time permits the provider may also discuss the following components as appropriate to the circumstances:

- Assessment of individual risk and when a possible exposure may have occurred.
- Determining whether there is a history of domestic violence.
- Discussion on partner involvement and referral for testing.
- Assess who will provide client with support.

11.1.2. POST-TEST COUNSELLING

All clients, regardless of the outcome of the HIV test, should be offered and receive post-test counselling based on their test result. All results must be given clearly. The length of the post-test counselling session will vary based on the type of HCT provided (CICT or PICT) and the test result.



HIV-negative CICT Post-Test Counselling Sessions

HIV-negative CICT clients should be offered a comprehensive post-test counselling/prevention package that includes information and advantages of MMC, TB screening, risk reduction and correct and regular use of condoms. Providers should also recommend that the client's sexual partners also be tested for HIV since couples sometimes have different HIV results. Client may be encouraged to bring their partner in for couples testing. Depending on the client's circumstances there may be a need for them to re-test for HIV. See section 4.5 for when to recommend re-testing.

HIV-negative PICT Post-Test Counselling Sessions

HIV-negative PICT clients should be given their test result and given an abbreviated post-testing counselling which may include advantages of and referral for MMC (men only), TB screening, and need for partner testing. Client may be encouraged to bring their partner in for couples testing, particularly in ANC settings. Depending on the client's circumstances there may be a need for them to re-test for HIV. See section 4.5 for when to recommend re-testing. Client may also be referred for additional prevention counselling if client reports ongoing risk.

HIV Positive CICT & PICT Post-Test Counselling Sessions

All HIV-positive clients must be given their test results in accordance with the national algorithm and offered comprehensive post-test counselling that includes TB screening, importance of early care and treatment, whether they are eligible for treatment if POC CD4 testing is conducted, disclosure and partner/family testing, and how to reduce the risk of HIV transmission (i.e. abstinence, correct and consistent use of condoms, starting treatment if pregnant, not sharing needles, etc). Clients who test positive should be informed and counselled about possible emotional responses (e.g., denial and anger) and they should be guided

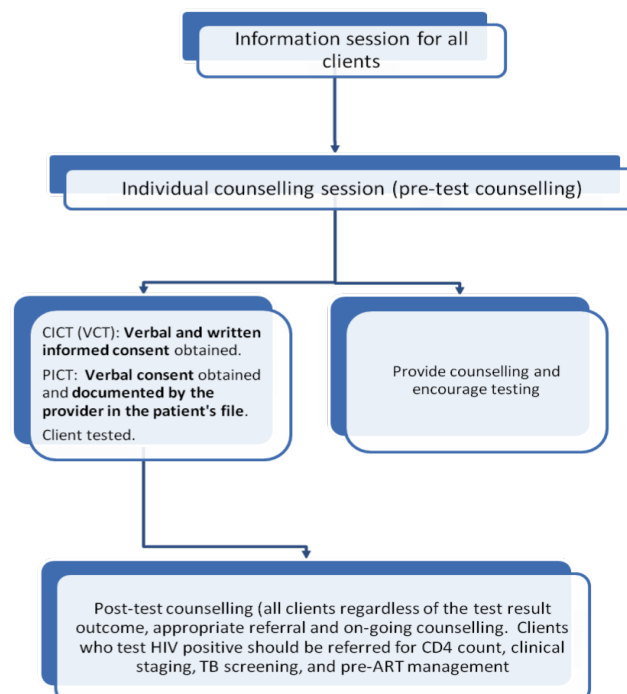
as to when and how they can manifest and what impact these emotions can have on adherence to healthy lifestyle choices. These clients also need comprehensive information about the importance of positive living, healthy lifestyles and nutrition. Referrals for psychosocial support (e.g., support groups) and drug and alcohol rehabilitation should also be provided when needed. Clients who screen positive for symptomatic TB signs should be referred for diagnosis if suspected of having TB. After post-test counselling all HIV-positive clients must be linked to care and treatment services where they will receive laboratory staging by CD4 count and clinical staging by a clinician trained in HIV and AIDS clinical management.

Indeterminate CICT & PICT Post-Test Counselling Sessions

Indeterminate result is given if the screening test (Test 1) and confirmatory test (Test 2) are repeatedly discrepant (i.e. algorithm is repeated twice). The individual should be asked to return in 14 days for further testing. This situation should be rare. Discordant test results are more often the result of random or systematic error made by the health care worker, or due to the intrinsic properties of the assay. All HIV testing should be performed in accordance with the HIV test kit package insert and site-developed standard operating procedures to eliminate possible testing errors.

In most cases, sharing information about HIV status with partner, family, trusted friends and community members and medical staff may benefit the client and their families and should be encouraged. However, the counsellor should always take note of the following points:

- Sharing HIV status should always be voluntary and discussed with the client. The sharing or disclosure can only occur with the informed consent of the client specifying to whom such disclosure may be made.



11.2. HIV COUNSELLING AND TESTING IN SPECIAL POPULATIONS

11.2.1. ADOLESCENTS AND YOUTH

While the Children's Act no. 38 defines a child as anyone under the age of 18, the NSP broadens this category to include "young people" aged 10-24 years. The number of adolescents and young people living with HIV (ALHIV) is growing for two main reasons. The first is the "aging up" of children perinatally infected in the 1990's and early 2000's. The second is a population boom which has led to the largest generation of adolescents and young people in history. As a group, young people face particular risks for HIV including early sexual debut, sex with multiple sexual partners, unprotected sex, substance and drug abuse leading to unprotected sex, high risk of sexual coercion and abuse, high frequency of sex, age differences in relationships, and peer pressure. While 40% of new HIV infections occur in young people aged 15 to 24 years, the coverage of HCT services among adolescents and youth remains low.

HIV counselling and testing services and providers should address the needs of this target group in the following ways:

- Service provider training should include the following: a sound understanding of youth-friendly pre- and post-test counselling approaches; understanding adolescent development; and providing appropriate medical, psychosocial and developmental options according to age and maturity.
- HCT services should be youth friendly and allow young people to be at ease during the interaction and comfortably able to communicate their needs, questions and personal concerns.
- As far as possible, HCT services should attempt to provide services to young people in a "one-stop-shop" fashion. Whenever young people are sent to a further location for another service there is increased risk that they will not show up. These services should include adherence counselling and support, sexual and reproductive health services, and mental health support.
- Where comprehensive, "one-stop" service provision is not possible, it is important that HCT staff refer and link young people to responsible agencies that provide appropriate, youth-friendly support.
- HCT programs should involve adolescents in the design, delivery, and evaluation their services in order to ensure these programs address their unique needs.

11.2.1.1. Counselling Before and After HIV Testing

The Act says HIV testing in children must be accompanied by pre- and post-test counselling. This means that HCT programs offering services to children should:

- Employ staff who are able (through experience and/or training) to assess the developmental capacity of children and ensure that they are of sufficient maturity to understand the benefits, risks and social implications of such a test.
- Advise children with the maturity to undergo counselling on their own that they may voluntarily involve their

parents or care-givers in the counselling process.

- Inform children who are not mature enough to understand the implications of the HIV test that their parents or care-givers need to be involved in the counselling process to assist them.

11.2.1.1. Counselling Before and After HIV Testing

HIV counselling for children serves a number of purposes including:

- Helping them cope with the situations they face, challenges they experience and their emotions
- Helping them develop coping strategies to minimise the negative impact of the situations they face
- Helping them make choices and decisions that will improve their quality of life
- Equipping them with accurate and appropriate information in a way that they can understand
- Empowering them by involving them in their own care
- Assisting them to develop goals and to recognise and build on their own strengths
- Promoting their sense of self control and self-esteem and reducing anxiety

Counselling for children should protect the best interests of the child at all times and respect the child's thoughts, opinions and beliefs. Counsellors should adopt child friendly techniques for communicating with the child. Counsellors should provide children with opportunity to tell their own story and assist them to cope with situations they face. When possible and safe for the child, counselling for children should be done together with the family, in the same room, as a means of encouraging a common understanding and a supportive child-caregiver relationship.

11.2.1.3. Pre-Test Counselling Session

The pre-test counselling session for children has many of the same aims as pre-test counselling for adults.

The aim and content of this counselling session is determined by the child's age, development, current level of understanding, ability to cope with information about HIV and the caregiver's readiness to share information with the child.

The counsellor should first assess the child's understanding and communication level as that will determine the level of information provided to the child. Once this assessment has been completed, the counsellor should provide information to the child and caregiver on the following topics in an age appropriate manner:

- What is HIV?
- How could an HIV test help him?
- What is involved in the test?
- What would a negative result mean?
- What would a positive result mean?
- What would happen if they test HIV-positive? What could they expect?

Once this information has been presented, the child and caregiver should be encouraged to express themselves openly, ask questions and voice any concerns they may have. The counsellor should then obtain consent from the



child or caregiver according to the policy outlined in section 5.6.

11.2.1.4 Post-Test Counselling Session

The aims of post-test counselling session for children are:

- To assess whether the child and/or family are ready to receive the test results,
- To inform the child and caregiver of the test results in an appropriate manner according to the child's age, developmental stage, level of understanding and ability to cope with new information,
- To help the child and caregiver understand and accept the test results as appropriate,
- To assist the child and/or caregiver to cope with the implications of the test result,
- To assist the child and/or caregiver to make decisions regarding appropriate follow up care and support.

During the post-test counselling session, the counsellor should provide the test result to the child and/or caregiver, allow the child and/or caregiver to discuss his or her test result, and then plan the way forward for ensuring the child gets the care and services needed based on his or her test result.

Children over the age of 12 years and those under the age of 12 years and of sufficient maturity to understand the benefits, risks and social implications of an HIV test should be informed of their HIV status during an individual post-test counselling session. The parent, guardian, or caretaker may be present during this post-test counselling session if their presence is desired by the child. For children under the age of 12 years, disclosure of HIV test results should be provided to the parent, guardian, or caretaker ideally in the presence of the child. Children younger than 10 years of age should be told about their HIV status according to their ability to understand the information.

11.2.1.5. Disclosure Counselling for Children and Caregivers

At the time of HIV testing, not all children (especially those younger than 5 years of age) will be ready to be informed that they are being tested for HIV or to be told that they tested HIV positive. However, by 5-7 years of age, children should be told of their HIV status. Disclosure is the process of informing the child of his or her own HIV status or informing someone else about the child's HIV status. Disclosure of HIV status to a child is based on the need to protect the best interests of that child at all times. Disclosure is carried out in partnership with the family or caregiver and respects their views and wishes.

The first step in the disclosure process is to assess the readiness of the child for disclosure and the readiness of the parent or caregiver for disclosure. Counselling should continue at each contact with the family until both the child

and caregiver are ready for disclosure. Disclosure can then occur at home with a follow-up visit to the clinic soon after or be done at the clinic with the doctor, nurse, counsellor, or priest member present.

Often, after disclosure occurs, children do not have any questions at first and may need to process what they have been told. If possible, a clinic or home visit should be scheduled with the family to see how the child and family are coping. The child should be allowed to meet privately with a member(s) of the healthcare team in case they have question that do not feel comfortable asking with a parent or caregiver present.

11.2.1.6. Confidentiality Regarding HIV Test Results

The Act says that every child has the right to confidentiality regarding their HIV status. The HIV status of a child may be disclosed with the consent of the child, if the child is:

- 12 years of age or older; or
- Under the age of 12 years and of sufficient maturity to understand the benefits, risks and social implications of such a disclosure.

The HIV status of a child under the age of 12 years who is not of sufficient maturity to understand the benefits, risks and social implications of such a disclosure may be disclosed with the consent of:

- The parent or caregiver (regardless of whether the parents are alive or dead).
- A designated child protection organization arranging the placement of the child.
- The superintendent or person in charge of a hospital, if the child has no parent or care-giver and if there is no designated child protection organisation arranging the placement of the child.
- A children's court, if –
 - Consent is unreasonably withheld;
 - Disclosure is in the best interests of the child; or
 - The child or the parent or care-giver of the child is incapable of consenting to such disclosure.

The HIV status of a child may be disclosed without consent in the following circumstances:

- If the disclosure is within the scope of that person's powers and duties in terms of the law;
- If it is necessary to carry out an obligation in the Children's Act;
- During legal proceedings in which disclosure is necessary for those proceedings or in terms of a court order.

Children who are alleged to have committed a sexual crime may be tested without consent if the procedure laid out in the Criminal Law (Sexual Offences and Related Matters) Amendment Act no 32 of 2007 is followed.



11.2.1.7. Consent for HIV Counselling and Testing

1. Age of Consent for HIV Counselling and Testing

The Act states that consent for HIV testing may be given by either the child or specified persons. A child may consent independently to HIV testing if he or she is:

- 12 years old or older; or
- Under the age of 12 years and of sufficient maturity (as outlined below) to understand the benefits, risks and social implications of such a test.

A child is considered to be sufficiently mature if he or she can demonstrate that they understand information on HIV testing and can act in accordance with that appreciation. In deciding whether a child is sufficiently mature, factors that should be taken into account include:

- Age: The older the child the more likely it is that they will have sufficient maturity.
- Knowledge: Children with knowledge of HIV and its implications are more likely to understand its consequences.
- Views: Children who are able to articulate their views on HIV testing and whether it is in their best interests are likely to meet the maturity requirements.
- Personal circumstances: An assessment of the child's personal situation and their motivations for HIV testing may help in assessing their maturity.

If the child cannot consent to HIV testing then consent must be provided by:

- The parent or a care-giver (defined as any person other than a parent or guardian who factually cares for a child regardless of whether the parents are alive or dead).
- The provincial Head of the Department of Social Development.
- A designated child protection organisation arranging the placement of the child.
- The superintendent or person in charge of a health establishment or hospital.
- The Children's Court if consent from any of the persons listed above is withheld or the child or their parent or care-giver is incapable of giving consent.

2. Consent for Children in Special Circumstances

The decision to test children who do not have parents or legal guardians and are not in the custody of a child protection organization, such as orphans, abandoned infants, and street children, should be made by the healthcare worker and take into account the best interests of the child. If an HIV test is deemed to be in the best interest of the child, the healthcare worker, in consultation with another healthcare worker, can proceed to provide HIV counselling and testing to the child. The same procedures should apply to a child that is brought to a clinic by another child as in the case of child-headed households.

3. Caregivers consent

Circular minute no.2 of 2012, released by the National Department of Health through Child, Youth and School Health Directorate states that Children's Amendment Act (ACT No. 41 of 2007), Chapter 1, Section 1(1) defines a 'caregiver' as any person other than a parent or a guardian, who factually cares for the child and includes;

- A foster parent
- A person who cares for a child with the implied or express consent of a parent or a guardian of the child
- A person who cares for a child whilst the child is in temporary safety care
- The person at the head of a child and youth care centre where the child has been placed
- The person who is the head of the shelter
- A child and youth care worker who cares for a child who is without appropriate family care in the community and
- The child who is the head in a child-headed household. This circular also instructs HIV Counselling and Testing services should be offered to children and caregivers.

11.2.1.8. HIV Counselling and Testing for Child Survivors of Sexual Assault

4. Child survivors of sexual abuse are entitled to access the full package of services described above with a child-friendly approach including an experienced counsellor providing age-appropriate counselling.

The health-care worker should take note of the following facts:

- The informed consent of children must be obtained before testing as in 5.6.1 of this policy.
- In the case of children under 12 years who do not have sufficient maturity to understand the benefits of HIV testing, and mentally ill or disabled survivors, pre- and post-test counselling should be given to the parent, caregiver, or legal guardian of the child who should give consent for HIV testing.
- In cases where a person with a disability or mental illness is able to understand the consequences of HIV testing, then their personal consent should be obtained. (A caregiver/parent/legal guardian will only be needed where such a person cannot provide informed consent.)
- An HIV test must be performed on all child survivors of sexual assault before commencing PEP.
- If the test results are not available, the child should be started on PEP dosages appropriate for the child's weight with a three-day starter pack while waiting for results.
- If the results are negative, the full course of PEP treatment should be provided.
- If the results are confirmed positive, the parents/caregiver and child (if of sufficient maturity) should be counselled and referred to appropriate services for management and support.
- If the results are discordant, blood should be sent to the laboratory for an ELISA test which will be the tie breaker.
- Child survivors receiving PEP should be encouraged to test again at six weeks and 3-6 months after the initial exposure.
- All child survivors of sexual assault should be referred for psychosocial follow-up.



11.2.1.9..Mandatory Reporting of Abuse

According to Section 110 of the Children's Act (No. 38 of 2005, as amended), children must be protected from abuse, neglect, maltreatment or degradation. One of the protection measures is an obligation for any official (defined as a correctional official, dentist, homeopath, immigration official, labour inspector, legal practitioner, medical practitioner, midwife, minister of religion, nurse, occupational therapist, physiotherapist, psychologist, religious leader, social service professional, social worker, speech therapist, teacher, traditional health practitioner, traditional leader, or member of staff or volunteer worker at a partial care facility, drop-in centre or child and youth care centre) who, on reasonable grounds concludes that a child has been abused in a manner causing physical injury, sexually abused or deliberately neglected, must report this information to:

- a social worker in a designated child protection organisation,
- the Department of Social Development, or
- a police official.

The law also protects children from sexual offences such as rape, sexual assault, sex work, under-age sex or sexual exploitation in terms of the Criminal Law (Sexual Offences and Related Matters) Amendment Act, No. 32 of 2007. Any person who is aware of a sexual offence having been committed against a child must report this to the police or social workers. This means that any person counselling or testing a child for HIV who suspects that their client is a victim of sexual offence must report this information to the police or social workers. Failure to report is a criminal offence according to Criminal

Law (Sexual Offences and Related Matters) Amendment Act No 32 of 2007, Section 54. It should be noted that children over the age of 16 can consent to sex and, where no sexual offence is apparent, no reports should be made to the police.

It is crucial to identify infants living with HIV as early as possible – ideally in infancy – to prevent death, illness, and delays in growth and development. In the absence of antiretroviral therapy (ART), HIV infection is often a rapidly progressive and fatal disease in infants and children. Approximately 20% of HIV-infected infants will die by 3 months of age, half will die before reaching their second birthday, and three-fourths will die by 5 years of age. Research such as the Children with HIV Early Antiretroviral Therapy (CHER) study has shown that mortality among HIV-infected infants can be reduced by up to 75% if ART is initiated immediately upon diagnosis. Ensuring that all HIV-exposed infants and children receive an HIV test is, therefore, a critical element for their survival and for ensuring South Africa's ability to achieve the Millennium Development Goal (MDG) 4 of reducing under-5 mortality.

This section describes HIV counselling and testing strategies

for identifying infants and children infected with HIV. This section is based on the principles set out in the Children's Act (No. 38 of 2005, Children's Amendment Act No. 30 of 2007, Sections 130-133). References to "the Act" in this section are references to the Children's Act unless other legislation is expressly mentioned. Following the Children's Act no. 38, a child is referred to as anyone under the age of 18.

Mandatory reporting of abused or neglected children should be followed for all child survivors of sexual assault. The parents or caregivers of children who have experienced sexual assault, or the children themselves, may apply for testing of the alleged offender if:

- The application is made within 60 days of the assault,
- The offender is identified, and
- The procedure laid down in the standard operating procedure is followed.

Test results of an alleged offender may be disclosed to the child (if of sufficient maturity) and to the parent/care-giver. The parents/caregiver and child must be counselled on the implications of the results and encouraged to continue with PEP regardless of the outcome of the alleged offender's HIV test (National Sexual Assault Policy, 2005; Regulations to Criminal Law Amendment Act No. 32 of 2007, Government Gazette 31076, 22 May 2008; National Directives and Instructions on Conducting a Forensic Examination).

11.2.2 .HIV COUNSELLING & TESTING OF INFANTS AND CHILDREN

It is crucial to identify infants living with HIV as early as possible – ideally in infancy – to prevent death, illness, and delays in growth and development. In the absence of antiretroviral therapy (ART), HIV infection is often a rapidly progressive and fatal disease in infants and children. Approximately 20% of HIV-infected infants will die by 3 months of age, half will die before reaching their second birthday, and three-fourths will die by 5 years of age. Research such as the Children with HIV Early Antiretroviral Therapy (CHER) study has shown that mortality among HIV-infected infants can be reduced by up to 75% if ART is initiated immediately upon diagnosis. Ensuring that all HIV-exposed infants and children receive an HIV test is, therefore, a critical element for their survival and for ensuring South Africa's ability to achieve the Millennium Development Goal (MDG) 4 of reducing under-5 mortality.

This section describes HIV counselling and testing strategies for identifying infants and children infected with HIV. This section is based on the principles set out in the Children's Act (No. 38 of 2005, Children's Amendment Act No. 30 of 2007, Sections 130-133). References to "the Act" in this section are references to the Children's Act unless other legislation is expressly mentioned. Following the Children's Act no. 38, a child is referred to as anyone under the age of 18.



11.2.2.1 HIV Testing Among Infants and children <18 months.

Infants can be exposed to HIV during pregnancy, birth, and breastfeeding. All infants born to HIV-infected mothers should receive an HIV test four to six weeks after birth, even if their mothers received ART during pregnancy. Standard HIV antibody testing (e.g. ELISA or rapid tests) cannot be used to diagnose HIV in children less than 18 months of age since these tests detect maternal HIV antibodies passed onto the baby during pregnancy and breastfeeding. Instead, all HIV-exposed infants should receive a virologic test, such as HIV DNA PCR or viral load, at 4-6 weeks of age to establish their HIV status. This test can detect the HIV virus in the infant's blood and is necessary to diagnose infants infected during pregnancy or labour and delivery.

A dried blood spot (DBS) sample should be taken via heel-prick in infants or a finger-stick in older children by persons who have been appropriately trained in the procedure. This DBS specimen should then be sent to the testing laboratory for processing. Ideally, the results should be returned to the mother or caregiver within one month of the sample being collected. Children showing signs or symptoms of HIV infection (e.g. oral thrush, severe pneumonia, severe sepsis,

PCP, cryptococcal meningitis, cerebral toxoplasmosis, HIV wasting, or Kaposi sarcoma) may be initiated on ART while awaiting the results of virologic testing if the health care provider decides it is in the best interest of the child.

When the mother's HIV status is unknown, HIV rapid tests can be used to screen and identify those children less than 18 months of age who have been exposed to HIV.

Children < 18 months of age who test positive on an HIV antibody test have been exposed to HIV and should receive a DNA PCR test to determine their HIV status. Children under 18-months of age who test negative on an antibody test are considered HIV-negative and do not need to be tested by DNA-PCR.

If the infant is breastfed, a negative antibody or virologic test does not definitively exclude HIV infection since HIV exposure is continuing. Children should be re-tested after 18 months of age or six weeks after the cessation of breastfeeding with either a virologic (if < 18 months of age) or antibody (if ≥ 18 months of age) HIV test depending upon the age of the child.

The table below summarizes the use of HIV tests in children.

Test	Use for <18 months	Use for >18 months
Rapid antibody test		Determine if child is HIV-exposed
DNA-PCR	Determine if HIV-exposed infant is HIV-infected	Not for use in this age group.

STEPS FOR TESTING HIV-EXPOSED INFANTS

The following steps should be taken when testing HIV-exposed infants:

- The HIV exposure of every infant should be established at 6 weeks of age to identify infants requiring a PCR test.
 - Infants of HIV-infected mothers are considered to be HIV-exposed. This information should be documented on the maternal health chart,
 - Infants of mothers with unknown or undocumented HIV status should be screened for HIV using a rapid antibody test. If the child is tests HIV-positive on this rapid test, he or she should be considered HIV-exposed.
- All HIV-exposed infants should have an HIV DNA PCR test at six weeks of age.
 - **If the DNA PCR test is positive**, the child is likely to be HIV-infected and should be immediately referred to HIV care and treatment services. HIV infection should be confirmed with an HIV viral load test. A detectable viral load confirms HIV infection.
 - **If the DNA PCR test is negative**, the child should be retested:
 - 6 weeks after the cessation of breastfeeding with an HIV DNA PCR test if <18 months or a rapid antibody test if 18 months or older.
 - at 18-months of age with a rapid antibody test.
 - if the child shows signs and symptoms suggestive of HIV infection using an age appropriate test.
- All HIV-exposed infants should be started on Cotrimoxazole prophylaxis while awaiting their HIV test results.

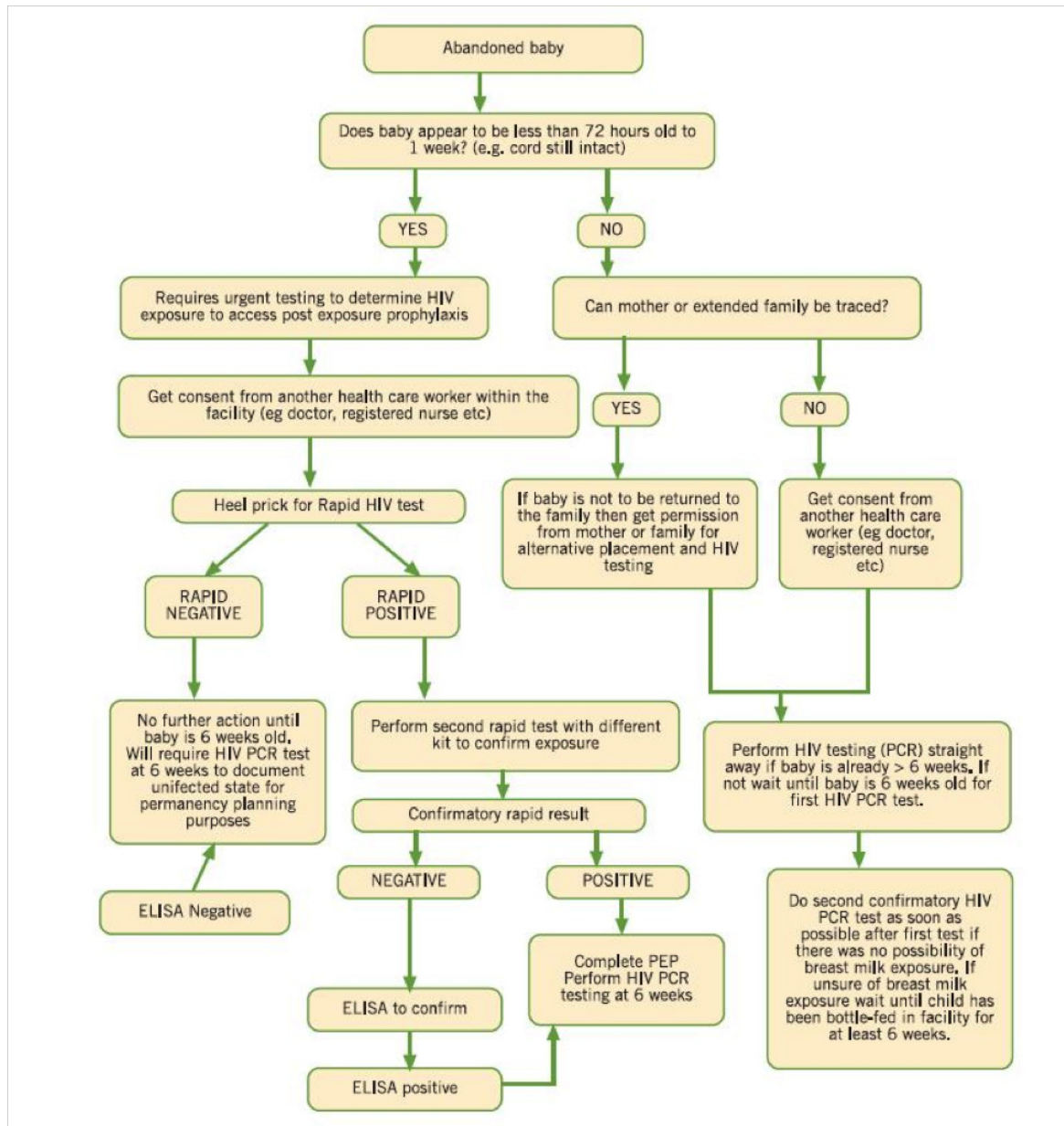


11.2.2.2. Testing Abandoned Babies

Abandoned babies should be tested when the status and whereabouts of the mother is unknown. The following steps should be followed when testing abandoned babies:

- Determine if the baby is less than 72 hours old.
- If the baby is less than 72 hours old, perform a rapid HIV test using a heel prick to determine if the baby has been exposed to HIV.
- If the rapid HIV test is positive, the baby has been exposed to HIV. The infant should be started on PEP and a DNA PCR test should be submitted to the laboratory. If the DNA PCR test comes back positive, then the infant should be referred for HIV care and treatment as soon as possible.
- If the rapid HIV test is negative, then the likelihood of HIV exposure is small. No PEP is required.
- If a rapid HIV test result cannot be obtained within 2 hours, initiate PEP. Many abandoned babies have been exposed to HIV and PEP given within 72 hours of birth can help prevent the infant from acquiring HIV. A rapid HIV test should be done as soon as possible. If the results of this HIV rapid test are negative, PEP should be stopped.
- All abandoned babies should have their HIV status determined to facilitate permanent placement.

The recommended algorithm for testing abandoned children is presented in the figure below.

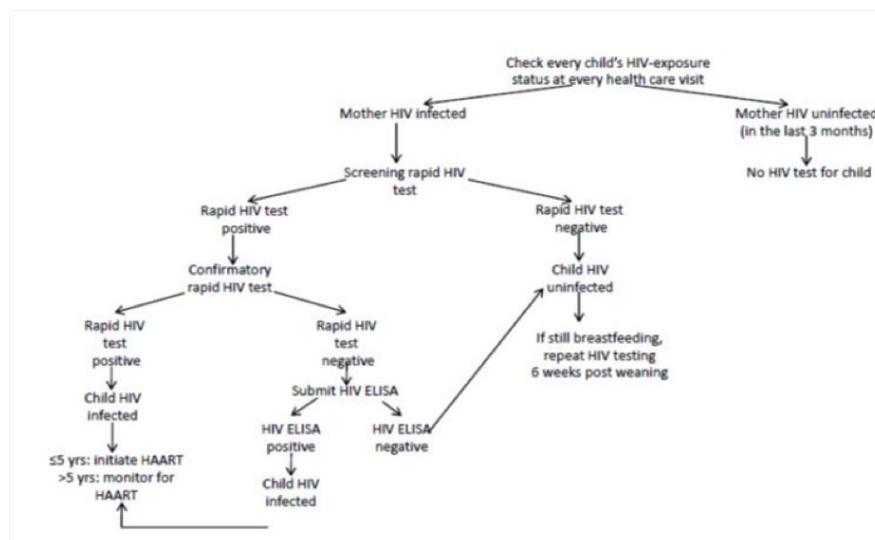


11.2.2.3. HIV Testing among Children ≥ 18 Months of Age

All HIV-exposed children, including those children previously untested or who tested HIV-negative on an HIV DNA PCR test, should receive an HIV rapid test at 18-months of age. The same testing algorithms used for adults can be used when

testing children over the age of 18-months (see section 4.2). This includes both HIV ELISA and rapid antibody tests. HIV viral detection assays, such as DNA PCR, are not indicated for children over the age of 18 months.

The recommended algorithm for testing children over the age of 18 months is presented in the figure below.



11.2.2.4. Active Case Finding Among Infants and Children

HIV counselling and testing is the first step in the continuum of paediatric care and treatment. Improved case finding of infants, children and adolescents exposed to or infected with HIV through implementation of systematic testing approaches is needed to maximize paediatric treatment efforts.

Strategies for improving active case finding among infants and children include:

Testing All Children of Adults Receiving Any HIV Service Through Either Facility or Home-Based Index Case Testing

Testing the children of HIV-infected adults receiving any HIV service (e.g. HIV care and support, ART, PMTCT, and TB-HIV treatment) is an effective strategy for improving early case finding for HIV-exposed and HIV-infected children. Family counselling can also facilitate disclosure and communication within the family and improve adherence and retention in HIV clinical care. Health care providers should reinforce the need for partner and family testing at every clinic visit with an HIV-positive patient. Family testing can be offered at the health facility or through home-based index case testing to improve children's access to HTC services.

Testing All Children Attending TB Clinics, Malnutrition Services, and/or Admitted to the Paediatric Ward

Routinely testing all children attending clinics where HIV is likely to be an underlying cause of illness is a highly effective

strategy to identify HIV-exposed and HIV-infected children who were either missed during the early postnatal period, or who acquired HIV later in infancy via breastfeeding. This includes testing children attending tuberculosis (TB) clinics, malnutrition clinics, or admitted to inpatient paediatric wards.

Screening Mothers or Infants Attending Immunization or Under-5 Clinics to Identify HIV-Exposed Infants

All infants should have their HIV exposure status assessed at their six-week immunisation visit to ensure improved early infant testing rates with DNA PCR. Health care workers should ask the mother's status and look at the Road-to Health Chart. If the mother's status is unknown or negative (determined from an HIV test performed more than 6-months previously), the healthcare worker should offer the mother a rapid test to assess her current HIV status. All infants whose mothers are known to be HIV-positive or who test HIV-positive at the under-5 clinic should receive an HIV DNA PCR test. If the mother is unavailable or refuses a rapid test, then the healthcare worker should offer to do a rapid test on the baby. If the infant's rapid test is positive, then the infant should receive an HIV DNA PCR test.

Testing Children Receiving Orphan and Vulnerable Children (OVC) Services Who Have Lost a Parent to HIV/AIDS or an Unknown Cause

Orphaned children are at high risk for HIV both from vertical and horizontal HIV transmission. Integrating HTC services into OVC programs can help identify orphaned children living with HIV.



11.3. HIV COUNSELING AND TESTING IN COUPLES

For the purpose of these guidelines, a “couple” is defined as two persons in an ongoing sexual relationship or who plan to start such a relationship and therefore wish to test together for HIV and or mutually disclose their test results. The term includes both heterosexual couples as well as same sex couples as recognised by the constitution of South Africa.

Couples HIV counselling and testing (CHCT) occurs when two or more partners are counselled, tested and receive their test results together. Another strategy for increasing knowledge of HIV status and disclosure among partners is partner testing. This is when one partner has already been tested, and the other partner is then tested separately. This would be a common scenario in antenatal settings, where women are routinely offered HCT and then encouraged to bring in their partner for partner testing. Partner testing may occur with or without disclosure. Whenever appropriate, feasible, and safe, mutual disclosure of HIV test results under the guidance of a counsellor should be encouraged and facilitated. In this document partner testing with mutual disclosure is considered a form of CHCT.

The table below compares individual and couples HCT services to further illustrate the benefits of providing HCT services to couples.

Individual HCT	Couples HCT
Individual learns only his/her own HIV status.	Individuals learn their own HIV status and the status of their partner.
Individual assumes burden of disclosing to partner.	Mutual disclosure is immediate.
Couple has to deal with issues of tension and blame on their own.	Counsellor can help ease tension and diffuse blame.
Only one partner hears the information	Partners hear information together, enhancing likelihood of shared understanding.
Counselling messages take into account only one partner's status; individuals may wrongly assume that their partner's status is the same as their own	Counselling messages are tailored, based on the test results of both partners.
Counsellor is not present to facilitate the couple's discussion about difficult issues.	Counsellor creates a safe environment and can help couples talk through difficult issues that they may not have discussed before.
Prevention, treatment and care decisions are more likely to be made in isolation.	Prevention, treatment and care decisions can be made together.
Individual bears burden of getting family members, children tested.	Decisions about family or child testing, as well as family planning, can be made together.

11.3.2. TYPES OF COUPLES SEEKING CHCT SERVICES

Most couples seeking CHCT services will fit into the following categories: pre-sexual, engaged, married or cohabiting, and polygamous. Depending upon where the facility is located and the population reached, there may be other types of couples seeking CHCT services, such as casual partners,

11.3.1. RATIONALE BEHIND COUPLES HIV COUNSELLING AND TESTING

Encouraging couples to test together and to mutually disclose their HIV status allows couples to make joint, informed decisions about HIV prevention and reproductive issues, such as contraception and conception. Studies have consistently shown that couples who test together are more likely to adopt HIV prevention strategies than individuals who test alone. Couples HIV counselling and testing has also been shown to increase uptake of interventions to prevent mother-to-child HIV transmission, to improve infant outcomes, and to improve uptake of and adherence to HIV treatment services. CHCT services are especially important for identifying HIV serodiscordant couples, where one member is HIV-infected and the other is not. Providing ongoing services to serodiscordant couples can prevent HIV transmission to the negative partner. In addition, CHCT is an important gateway for linking all couples to appropriate prevention, care, and treatment services based on the couple's serostatus.

non-cohabiting partners, sex workers and their boyfriends or clients, same-sex couples including men who have sex with men (MSM), or injecting drug users and their sex or needle-sharing partners. All couple types should be supported to receive CHCT in a nonjudgmental and inclusive way, as long as this is something that both partners want.



11.3.3..Pre-Test Counselling for Couples

The pre-test counselling session for couples should begin with an introduction of CHCT services including that it is a voluntary service and that both partners must consent to the process. Couples should be reassured that test results are confidential and that declining CHCT services will in no affect their ability to access other health services at the facility. The counsellor should then briefly review the benefits of CHCT and discuss the meaning of the different HIV test results. Couples can be either concordant negative (both partners are HIV-uninfected), concordant positive (both partners are HIV-infected), or serodiscordant (one partner is HIV-infected; one partner is HIV-uninfected). The counsellor should emphasize that sero-discordance is common and does not necessarily mean that one partner was unfaithful.

The next step in the pre-test counselling session is review the conditions that both partners must agree to in order to receive couples HIV counselling and testing. These conditions include:

- They will receive their HIV test results together

- They will make decisions about mutual disclosure to others outside the relationship together
- They will discuss their HIV risk issues and concerns together
- They will participate equally and support each other

Both partners must agree to these conditions and provide consent for HIV testing. If partners cannot agree to these conditions or the counsellor determines that one partner is unable to freely provide their consent, then the counsellor should not proceed with a couple's session. Instead, each partner should be offered individual HIV counselling and testing.

11.3.4. Post-Test Counselling for Couples

The messages provided to couples during the post-test counselling should be tailored to the couples HIV serostatus. The messages that should be given to concordant negative couples, concordant positive couples, and serodiscordant couples are summarized below.

Post-test Session: Discordant Couples

Advise of HIV test results.

- Results are different; inform the HIV-infected partner of their test result first

Explore couple's reaction to results.

- Validate feelings, acknowledge challenges
- Ensure couple understands results

Review discordance.

- Commonality of discordance
- May not indicate partner was unfaithful; partner may have been infected before relationship began
- Not important how HIV entered the relationship; need to focus on how the couple will support each other now that HIV status is known

Encourage mutual support and diffuse blame.

Advise to access care and treatment for HIV.

- Treatment can help people living with HIV lead long, healthy lives and prevent HIV transmission to partners/children
- Need to access clinic for preventive health care (e.g., Cotrimoxazole, IPT, etc.)

Discuss pregnancy status and desires.

- If pregnant or planning pregnancy, need to speak to PMTCT provider
- If do not desire a pregnancy, use contraception to prevent unplanned pregnancies

Discuss need for re-testing HIV negative partner.

- Because of possibility of acute HIV infection, HIV negative partner should be retested in 4 weeks
- HIV-negative partner should then be retested annually

Discuss the importance of testing their children (if the woman is the HIV-positive partner).

- Important to take care of the entire family
- Children should be tested for HIV so they can get care if they are HIV-infected

Advise on the importance of always using condoms.

- Assess knowledge on how to use condoms
- Demonstrate and distribute condoms

Discuss importance of not having unprotected sex with partners outside of the relationship.

- Encourage outside partners to be tested
- Always use condoms, if have outside partners

Advise on healthy living.

- Eliminate or reduce alcohol use
- Safe water, nutrition, malaria, TB services

Link with follow-up services.

- HIV care and treatment, PMTCT
- STIs, family planning, community support groups



Post-Test Session: **Concordant Negative Couples**

Advise of HIV test results.

- Both results are negative; neither partner has HIV

Advise on how to remain concordant negative.

- Use condoms every time they have sex
- Reduce outside partners, know status of and always use condoms with any outside partners
- Male circumcision can protect against HIV acquisition; provide information about where these services can be accessed

Discuss need for retesting.

- If recent exposure, re-test in 4 weeks
- If no recent exposure, re-test annually (as per national guidelines)

Demonstrate how to use and distribute condoms.

Link couple with follow-up services as needed.

Posttest Session: **Concordant Positive Couples**

Advise of HIV test results.

- Both results are positive; both partners have HIV

Explore couple's reaction to results.

- Validate feelings, acknowledge challenges
- Ensure couple understands results

Encourage mutual support and diffuse blame.

Advise to access care and treatment for HIV.

- Treatment can help people with HIV live longer and prevent HIV transmission to partners/children
- Need to access clinic for preventive health care (e.g., Cotrimoxazole)

Discuss pregnancy status and desires.

- If pregnant or planning pregnancy, need to speak to PMTCT provider
- Use contraception to prevent unplanned pregnancies

Discuss the importance of testing their children.

- Important to take care of the entire family.
- Children should be tested for HIV so they can get care if they are HIV-infected

Advise on the importance of always using condoms.

- Assess knowledge on how to use condoms
- Demonstrate and distribute condoms

Discuss importance of not having unprotected sex with partners outside relationship.

- Encourage outside partners to be tested
- Always use condoms if have outside partners

Advise on healthy living.

- Eliminate or reduce alcohol use
- Safe water, nutrition, malaria and TB services

Link with follow-up services;

- Care and treatment, PMTCT
- STIs, family planning
- Community organizations, support groups

11.3.5. Integrating Couples HCT into Other Health Services and Programmes

Integration can take different forms, but essentially means offering a package of services in the same place by the same provider. Integrating partner and couples HIV counselling and testing into facility- and community-based services can significantly increase the number of couples where the status

of both partners is known. Settings where CHCT can be integrated include; Antenatal and postnatal services, Medical male circumcision services, Tuberculosis, Family Planning, and HIV Care and Treatment Clinics, IMCI services, Inpatient services at hospitals, Infertility clinics, Standalone community VCT centres, Home-based HCT services, and Mobile and outreach HCT services



11.5.6. Creating Demand for Couples HIV Counselling and Testing

Creating demand for couples HIV counselling and testing services can be done through both facility-based promotion and community mobilization. Posters placed in the waiting rooms of health facilities can advertise the availability of couples HCT services. In addition, providers can mention that these services are available during group education sessions and during individual client exams. Radio spots can be used to promote CHCT services. Finally, community mobilization conducted by lay counsellors, community health workers, and/or community mobilizers can raise awareness of the availability and benefits of CHCT services and drive demand for these services.

11.3.7. Documenting and Monitoring Couples HIV Counselling and Testing Services

Couples HCT should be documented in the HCT register. HCT programs may also consider keeping a discordant couple register to allow tracking and follow-up with these couples, including annual re-testing of the HIV-negative partner. Appropriate training in data collection should be provided to counsellors and administrators as well as to data capturers who collate data for DHIS entry.

HCT programs should continually monitor their CHCT services to ensure they are of the highest quality. Regular evaluations of counsellors performance and patient satisfaction (testing processes, pre-test information, consent process, post-test counselling) can help improve the effectiveness, acceptability and quality of HIV counselling and testing services. Programs may also want to monitor the uptake of CHCT services by tracking the number and proportion of clients who test together as couples. This indicator can be further disaggregated to track the number of concordant negative, concordant positive, and serodiscordant couples identified.

The identification of HIV-infected women during pregnancy is critical to the success of the programme to prevent mother-to-child HIV transmission (PMTCT). All women attending ANC (first attendees and women attending follow-up visits) should be given routine information about HIV testing and the PMTCT programme during their first antenatal visit. The procedures outlined in Section 4 of this policy should be observed when counselling pregnant women.

Routine screening of all pregnant women should be done in line with other tests offered as part of basic antenatal care (ANC) including Rhesus factor, hemoglobin, and rapid

plasma reagin (RPR) for syphilis. HIV screening should be done during ANC as follows:

- All pregnant women should be offered PICT using an opt-out approach.
- Women who refuse to test should be counselled and encouraged to accept an HIV test. The benefits of testing for both the mother and child should be explained.
- If women chose to opt out of testing after this additional counselling session, they should sign a refusal/opt-out form. This form should be documented in their files.

HIV-negative: Women who test HIV-negative should receive post-test counselling on risk reduction interventions, focusing on how to maintain their HIV-negative status while continuing to receive routine antenatal care. Pregnancy is a risk period for HIV acquisition and women who are HIV negative at booking should be retested in the third trimester of pregnancy at or around 32-34 weeks to detect late sero-conversion and to allow time for initiation of ART.

Unknown Status: Women who present in labor without having received antenatal care (e.g. unbooked women) or whose HIV status is unknown should be offered HCT in the latent phase of labour, preferably during the first stage of labour. Women testing HIV-positive should be initiated on ART and their infants should be offered PEP.

HIV-positive: All HIV-positive pregnant women should have their CD4 taken on the same day that their HIV positive status is established, preferably at their first ANC visit (or the earliest opportunity). All HIV-positive pregnant women should also be assessed for clinical stage according to WHO staging. These women should also:

- Be screened for TB, in line with basic ANC procedures; and
- Receive ARV regimens prescribed by a registered health professional (i.e., registered midwives and professional nurses) in line with current PMTCT guidelines.

Women attending postnatal clinic at six weeks who tested negative in early or late pregnancy may continue to report negative status based on the results of an earlier test. However, due to high incidence rates among women in South Africa, a recent HIV infection may have occurred. These women, especially if they are currently breastfeeding, should be offered a repeat HIV test to screen her and her infant for HIV infection and exposure, respectively.

Women attending postnatal clinic at six weeks with an unknown HIV status should also be offered an HIV test by the health-care provider.



11.4. HEALTH CARE PROVIDERS AND WORKERS EXPOSED TO HIV

In the case of health-care workers and providers who are exposed to HIV through a needle stick injury, it is important to establish the HIV status of the worker following exposure. If the health care worker or provider is HIV-negative, post-exposure prophylaxis (PEP) should be administered within 24-72 hours of exposure in order to minimize the risk of seroconverting to HIV. Such exposure should be reported to the employer as per guidelines.

In the case of accidental exposure, the following steps are recommended:

- The client should receive pre-test counseling as described in section 4.1.
- If a client is not ready to test after pre-test counselling, they should be started on PEP with a three-day starter pack.
- If, after testing, the results are HIV negative, the full course of treatment should be provided.
- If, after testing, the results are HIV positive, the treatment should be discontinued and the client should be referred to appropriate services for management and support.
- Counselling should precede and follow testing.
- Informed consent must be obtained before testing.

11.5 SURVIVORS OF SEXUAL ASSAULT

Survivors of sexual assault require an empathetic approach by health-care professionals. The routine offer of HIV testing is recommended as part of the comprehensive clinical management offered to sexual assault survivors. Survivors who test HIV-negative and present within 72 hours of the assault should be offered post-exposure prophylaxis in accordance with the South African National Guidelines for Antiretroviral Therapy.

HCT services offered to survivors of sexual assault should include the following steps:

- Counselling should always precede and follow testing as describe in section 4 of these guidelines.
- During pre-test counselling with rape survivors counsellors will also need to:
 - give additional time for the exploration of client's feelings,
 - perform a specific risk assessment (was it vaginal or anal rape, were there multiple perpetrators, etc.).
 - provide information about post exposure prophylaxis (PEP), STI prophylaxis and treatment, and emergency contraception
- Informed consent must be obtained prior to testing.
- If the results are HIV negative, the full course of treatment should be provided. Clients should be counseled about PEP adherence and provided appropriate referrals to other medical and legal support services.
- If the results are HIV positive, PEP should be discontinued and the client referred to appropriate HIV care and treatment services for management and support. Clients should also be referred to other medical and legal support services, as needed.
- If the client is not emotionally ready to be counselled and tested, they should be started on PEP with a three-day starter pack and encouraged to come back for an HIV test.

- Clients receiving PEP should be encouraged to test again at 3-6 months after the initial exposure.
- PEP should be administered in the context of a comprehensive support programme for survivors of rape that includes syphilis testing and treatment, pregnancy testing and emergency contraception, screening for hepatitis B and C, and a tetanus vaccination, where appropriate.

Note that the counselling needs of sexual assault survivors may be beyond the skill set of most HCT counsellors. Thus, HCT counsellors should refer clients to a counsellor experienced in assisting sexual assault survivors, when these services exist. During the post-test counselling session, counsellors should advise survivors that they may need several counselling sessions to cope with their assault and then provide a referral to a more experienced counsellor.

11.6. ALLEGED SEXUAL OFFENDERS

The Criminal Law (Sexual Offences & Related Matters) Amendment Act No. 32 of 2007 outlines procedures for testing sexual offenders for HIV. The requirements for testing alleged offenders are stipulated in the National Directives and Instructions on Conducting Forensic Examinations in Survivors of

Sexual Offences (Sexual Offences and Related Matters) Amendment Act, No. 32 of 2007 (Government Gazette 31957, 6 March 2009). The forms and procedures for testing alleged offenders are outlined in the regulations of this Act.

Any survivor or person acting on behalf of a survivor may apply to a magistrate for an order that the alleged offender be tested for HIV and that the results be disclosed to the survivor or interested person, and the alleged offender. If the application meets the necessary requirements, the magistrate must order that the alleged offender be tested for HIV in accordance with the state's prevailing norms and protocols and the prescribed time frame of 60 days (Criminal Law (Sexual Offences and Related Matters Amendment Act, No. 32 of 2007). A health-care worker may only test an alleged sexual offender when presented with a court order by an investigating officer.

HIV testing of alleged sexual offenders must follow these procedures:

- The health-care worker should offer the alleged sexual offender pre-test counselling or ensure that pre-test counselling has been done. In addition, the alleged sexual offender should be provided with all the necessary information with regard to HIV and AIDS.
- ELISA testing is used to test an alleged sexual offender and strict requirements apply to confidentiality of the results. The results may only be handed to the investigating officer (Criminal Law (Sexual Offences and Related Matters) Amendment Act, No. 32 of 2007).
- The survivor or the interested person who applies for the testing of the alleged sexual offender should be counselled prior to receiving the HIV results of the alleged sexual offender. The investigating officer must ensure that such counselling occurs before handing over the test results (Criminal Law (Sexual Offences and Related Matters) Amendment Act, No. 32 of 2007).



11.7. PRISONERS

Although there is little data on HIV prevalence rates among prisoners, however, HIV transmission is occurring among prison populations in South Africa. HCT services should, therefore, be offered to prisoners to help prevent the spread of HIV and to make sure that all HIV-positive prisoners are provided access to ART services.

No prisoner should be forced or coerced into having an HIV test. Instead, prisoners should be routinely offered HCT services at the time they enter and leave a detention facility according to the procedures outlined in section 4 of this document.

The following recommendations are made with respect to counselling and testing of prisoners. During admission to and release from a detention facility, authorities must:

- Screen detainees for STIs and TB and provide treatment as necessary.
- Offer HIV counselling and testing according to the protocols outlined in this policy.
- Advise prisoners of the risks of sexual transmission of STIs and HIV in a prison context and provide condoms to prisoners during pre- and post-test counselling. The difference between consensual and non-consensual sex should also be explained.
- Administer post exposure prophylaxis (PEP) following sexual exposure or abuse according to the national protocol and as summarized in section 7.3 above. Inmates should be informed about PEP at the time that they enter a detention facility.
- Provide basic antenatal care (ANC) including HIV testing and counselling in accordance with the approved PMTCT programme to pregnant prisoners. Female prisoners who deliver in prison, a local maternity facility, or midwife obstetric unit should have access to the full PMTCT programme throughout the breastfeeding period for both themselves and their infant.

11.8. MIGRANT AND MOBILE POPULATIONS

Mobile populations such as truck drivers, farm workers, miners, and migrant workers are at high risk for acquiring and transmitting HIV. In addition, refugees and migrants are vulnerable to HIV infection due to their economic and social insecurity. To reach these populations with HCT services, the following should be considered:

- Provide outreach/mobile HCT services to migrant and refugee populations as they are unlikely to seek health care at a health facility.
- Offer HCT and other prevention programs at convenient locations such as truck stops, harbours and workplaces to reach mobile populations.
- Address cultural issues by providing culturally specific education videos about HIV/AIDS and other STIs in the

refugees' local language.

- Refer all sexual assault survivors to appropriate services as described in 7.3 of this document.

11.9. POPULATIONS ABUSING ALCOHOL AND OTHER DRUGS

Both alcohol and drugs increase risk taking behaviours and have been associated with increased rates of HIV transmission. Populations who abuse alcohol and other drugs often suffer worse health problems than the general population but due to stigmatization, these populations often have difficulty accessing quality health services. To ensure that these populations have access to HCT services, HIV testing should be provided as a standard part of medical care for all patients attending specialized health facilities for substance abuse (e.g. drop-in centres, needle/syringe programmes, Opioid Substitution Therapy (OST) programmes, alcohol/drug dependence treatment services).

Implementation must include measures to prevent compulsory testing and unauthorized disclosure of HIV status. Staff at these services should also receive training to enable them to enquire sensitively about risk behaviours and to recognize the early symptoms of HIV-related disease. Provision of appropriate peer support at such services can also enhance access and ensure that individuals newly diagnosed with HIV are linked to HIV care. In addition, involving members of this population in the development of HIV testing and counselling protocols will help to ensure that the most appropriate and acceptable practices are followed.

11.10. HIV COUNSELLING AND TESTING OF KEY POPULATIONS

Several other populations need to be targeted for HCT services given their high risk of acquiring or transmitting HIV. The term 'key populations' or 'key populations at higher risk of HIV exposure' refers to those most likely to be exposed to HIV or to transmit it – their engagement is critical to a successful HIV response i.e. they are key to the epidemic and key to the response. In all countries, key populations include people living with HIV. In most settings, men who have sex with men, transgender persons, people who inject drugs, sex workers and their clients, and seronegative partners in serodiscordant couples are at higher risk of HIV exposure to HIV than other people.

Key populations in South Africa include truckers, men who have sex with men (MSM), female sex workers (FSW), long distance truck drivers, IDU's, prisoners etc. 9.2% of and 19.8% of new HIV infections are related to MSM and Sex work respectively. Improving access to and uptake of HCT among key population gay men and other MSM require a holistic approach. A true systems-level perspective is needed to address the multiple factors that.



11.10.1. MEN WHO HAVE SEX WITH MEN (MSM)

Although there is common assumption that all MSM are gay men, with similar values, lifestyle and dress, MSM is in reality a very broad term to describe a widely diverse group of men. The common thread is that these men have sex with men. Not all MSM see themselves as homosexual, many maybe married, have children and have sex with women.

HIV prevalence rates among men who have sex with men (MSM) are also much higher than men in the general population of South Africa. While there is no law against homosexuality in South Africa, many MSM face social stigma and, as a result, may be reluctant to seek HCT services.

HCT counselors should consider the following when designing MSM-friendly services:

- Provide additional training to health care providers and HCT counselors to sensitize them to the special needs of MSM and to ensure they are comfortable discussing sex between men during risk reduction counselling.
- Create safe spaces where men can talk openly and receive HCT services without fear of stigmatization.
- Integrate HCT into other services designed for MSM.
- Conduct outreach and education at centres, bars, and meeting places where MSM like to go.
- Provide lubricant and latex condoms for use during anal sex as part of all post-test counselling sessions.

HCT for MSM shall beyond testing for HIV. Counsellors are required to be skilled in tackling sexual behaviors/activities that MSM engage in for reducing the risk of acquiring/transmitting HIV. Activities such as kissing, hugging, masturbation, mutual masturbation, oral sex, anal stimulation or penile-anal penetration. Instead of focusing on HIV it is helpful to focus on sexually transmitted infections rather than HIV, MSM are often more likely to respond to preventive messages addressing STI rather than messages that confront HIV directly.

- Promotion of Condom and compatible water-based lubrication use should be the emphasis for anal penetrative sex. MSM needs to be educated about the benefits of using appropriate water-based lubrication and if possible such lubrication should be made available. The use of female condoms has become increasingly popular among MSM for anal intercourse, it is important to demonstrate the use of female condoms for MSM.

11.10.2. SEX WORKERS

The term 'sex worker' is intended to be non-judgmental and focuses on the working conditions under which sexual services are sold. Sex workers include consenting female, male, and transgender adults and young people over the age of 18 who receive money or goods in exchange for sexual services, either regularly or occasionally. HCT for female sex workers is important because female sex workers across developing countries are not aware of their HIV status and are less likely to get tested as they lack the knowledge about HIV/AIDS, HCT services available to them, and the fear of being seen accessing HIV services which can result in the loss of clients. Further, sex work is illegal in most African and, FSWs live in fear of being criminalized and are vulnerable to

physical abuse and rape from their clients as well as authority.

HIV prevalence rates among male and female sex workers are much higher than rates among men and women in the general population. However, access to HCT services among this population remains low. To improve coverage of HCT services among male and female sex workers, HCT counsellors should:

- Integrate HCT into other health services attended by sex workers (e.g. STI and FP services) and in activities or centres designed for sex workers (e.g. income-generating activities).
- Establish user-friendly HCT services targeting sex workers, their clients, shebeen and brothel owners, or managers. To improve the accessibility of these services, they should be open in the evenings ('moonlight HCT') and provided through outreach.
- Use mobilization and educational campaigns to promote HCT among sex workers. Whenever possible, peer workers should be used in these campaigns.
- Involve sex workers, their clients, health officials, law enforcement officers, community leaders, the media and the community in the process of establishing and promoting HCT services for sex workers.

Condom use plays a big role in the sex work industry as it determines the amount of payment and/or number of clients SWs will have access to if they have sex with or without a condom. SWs who have sex with occasional and regular type of clients are less likely to use condoms. In some cases clients can demand to have sex without a condom however, the SW can refuse to have sex unless with a condom. Evidence in China indicates that FSWs that have never been tested for HIV are significantly associated with higher rates of HIV risk behaviours such as inconsistent condom use with regular clients (Hong, Y., et al., 2012).

11.10.3. PEOPLE INJECTING/USING DRUGS (PWID/PWUD)

Injecting drug users are one of the most vulnerable populations as they are at higher risk of dying from both acute and chronic diseases mostly relating to abuse of drugs and infection from HIV and other blood-borne diseases transmitted through sharing of needles and syringes (Mathers B. M. et al, 2012). People who inject drug users are the fastest growing epidemic of HIV across the globe.

Like the other most-at-risk populations, there are factors that prevent IDUs from accessing and getting HCT services. These factors include fear of HIV positive result; stigma and discrimination; and the limited number of HIV prevention and care services intended for IDUs. In sub-Saharan Africa, less than 1% of IDUs have access to treatment services partly due to the lack of prevention and care services as well as the lack of knowledge about the risks relating to injecting drugs. In Thailand, where drug use is a criminal offense, IDUs are less prone to go for HIV testing for fear of being exposed as most government clinics require individuals to declare their risk behavior in order to receive free HIV testing.



11.10.4. TRANSGENDER

The transgender population are described as people that do not follow traditional gender norms and are commonly referred to as male-to-female (MTF) and female-to-male (FTM) to describe their gender identity. Transgendered people may include: transgenderists, drag queens, cross-dressers, intersex persons and transsexuals (Kenagy, G.P, 2002). There is evidence to suggest the HIV prevalence rate of the transgender population is significantly higher than those among other key populations (Jobson G.A, et. al, 2012).

Further, Kenagy G.p (2002) indicated that while there is limited research, the transgendered population has a high HIV sero-prevalence rate and are at high risk of HIV infection. The high risk of HIV infections may be a result of high risk activities such as inconsistent use of condoms, multiple sexual partners, and drug use, as well as unsafe injection practices, for instance injecting hormonal drugs to change appearance not supervised by healthcare providers and sharing syringes among injectors.

Although there is evidence to suggest the increased risk of HIV infection among the transgender population and the need to focus on HIV prevention, care and treatment for them; the transgender population remains 'invisible' in most African communities. This is particularly because same-sex behavior is criminalized in most African countries, as well fear of being exposed to violence and victimization (Jobson G.A, et al, 2012). High levels of stigma and discrimination from family, the community as well as potential employers; lack of knowledge about HIV/AIDS; lack of access to healthcare services are some of the barriers that contribute to the high HIV infections among transgender people and prevent them from accessing and getting HCT services.

11.10.5. HIV COUNSELLING AND TESTING NEEDS OF KEY POPULATIONS

The goal of HCT in key populations is to increase the proportion of Key populations to know their HIV status, to increase uptake of HIV care and treatment services and to assist those found to be HIV negative to develop risk reduction skills which ensure they remain negative (NDoH, 2012). Key populations have been identified as being disproportionately high risk for HIV/STI and TB. Whatever the testing model, 5 Cs of good testing practices should be applied. It is acknowledged that Sex, work, injecting drug users are criminalized activities in South Africa, despite this, the health provider is obliged to provide a human rights based public approach to all key population seeking help.

11.10.5.1. HIV counselling

HIV counselling in key populations at higher risk of HIV must be provided in line with what is provided to the general population, however, approach should be cognisant and adapted to accommodate risks of key populations at higher exposure for HIV. An emphasis shall be made on consistent condom and lubricant use and negotiation.

11.10.5.2.Pre-test counselling for key populations

- Education sessions may take place in the health facility during routine check-ups or symptomatic visits but may also be carried out or continued by outreach workers and peer educators in the community. Trained community members (peer educators) may be the most effective educators since they understand the social context of the all key populations.
- Pre-test counselling can be conducted individually or as part of group education. The purpose of pre-test counselling is to provide the individual with information on technical aspects of testing and to explain possible implications at a personal, medical, social, psychological, legal and ethical implication of being diagnosed HIV positive or HIV negative. The purpose is to further assess why the individual wants to be tested, to assess their past and present level of risk and the steps to be taken through risk reduction counselling.
- For key populations, the general guideline in assessing risk is to ensure that the provider creates an enabling environment to allow the individual to open up by ensuring privacy and confidentiality and use an open minded-non-judgemental approach and re-assure the individual about confidentiality of their sexual behaviour. Segmentation of key populations is an important concept that enables the health care worker to keep track of the individual, assess their risk profiles and levels of vulnerability and customize the pre- and post-test counselling accordingly. It also facilitates individual-level planning and follow up on prevention service uptake based on individual risk, vulnerability, profiles of sex workers and their partners. MARPS can be segmented as; new, low risk, high risk and living with HIV.

11.10.5.3.Post-test counselling for key populations

Post counselling should follow the standard procedure for general population outlined in section X and in addition highlight the need for:

- The need to change high risk sexual behaviour.
- Identifying barriers that the client may have to changing behaviour such as
- Lack of knowledge regarding the prevention of STIs and HIV infection
- Lack of access to condoms
- Inability to use condoms correctly and consistently ;
- Inability to negotiate condom use; and
- Use of drugs and alcohol.
- The need to treat sexual partners when STIs have been diagnosed ;
- The importance of regular routine facility visits for STIs, even when asymptomatic;
- Regular testing shall follow recommended retesting recommendations.
- Changes the client can and will make in his/her sexual behaviour noting that an individual risk for STIs and HIV depends on his/her frequency of exposure to unprotected sexual acts.



- Use safer sex practices such as hand sex, oral sex, thigh sex, or fantasy sex stories when partners or clients refuse to use condoms
- Lubricant and male and female condom distribution and information
- Demonstrate the procedure with a model using hand and oral ;
- Provide lubricants (water-based only); and
- Provision of male and female condoms.

11.10.5.4. Peer Education

- Peer Education is an essential component in working with key populations as they are able to reach members of the different key populations. Peers are said to be individuals from a key population and are from the same community, have similar age and cultural backgrounds to the population targeted for the service. They bring population members to service providers, in addition they offer the following services :
- Identify and recruit / register Key Populations in relevant programmes
- Provide condom and prevention commodity distribution, demonstration and promotion
- Provide lay counselling
- Conduct awareness programmes for the target populations
- Identify new sites for providing Key Population focused activities
- Facilitate information sharing and knowledge transfer among informal groups of the target population
- Use media such as community radio station programmes, street theatre and community drama as a means of communicating messages
- Develop strong referral network of service providers to facilitate peer education
- Sensitize service providers for better and Key Population “friendly” service delivery
- Provide linkages to access justice, translation services, educational services, support for survivors of gender-based violence, substance abuse support
- Behaviour Change/Human Rights

11.11. Communication strategies

Several numbers of strategies have been used to increase uptake of utilization of services. The most prominent and evidence based strategies specific to KP being through peer-mediated counselling, the training of peer educators and the use of referral vouchers.

- Information, education and communication (IEC) materials should always be available in the clinic, particularly at the time of counselling and outreach activities and should appropriate.
- Whenever possible, IEC materials will be provided by DoH.
- IEC materials should be translated into local languages and contexts if required.

12. References and Resources

Annex: Legal Framework

- The Constitution of the Republic of South Africa 108 of

1996

- National Health Act No. 61 of 2003
- Local Government: Municipal Demarcation Act 1998 (Act 27 of 1998)
- Children's Act No. 38 of 2005
- Children's Amendment Act No. 30 of 2007
- Human Tissue Act No. 65, 1983 (Until the adoption and implementation of the Task Shifting/Sharing Policy)
- Health Professions Act No. 56 of 1974
- Nursing Act No. 33 of 2005
- Occupational Health and Safety Act No. 85 of 1993
- Labour Relations Act No. 66 of 1995
- Basic Conditions of Employment Act No. 75 of 1997
- Public Service Regulations Amendments, 2001
- Employment Equity Act No. 55 of 1998
- International Covenant on Civil and Political Rights
- Criminal Law (Sexual Offences & Related Matters) Amendment Act No. 32 of 2007
- Promotion of Equality and Prevention of Discrimination (PEPUOA) Act

13. Appendices

13.1. Professional and Ethical Codes of Conduct

- Non-Discrimination

The National HCT Programme is committed to the normalisation of HIV testing and the eradication of discrimination and reduction of stigma by encouraging knowledge and competence about HIV in health facilities, tertiary institutions, workplaces and communities.

Discrimination against people with HIV undermines dignity, hinders an effective response to HIV and AIDS and is strongly discouraged. No person should be discriminated against because of their HIV status (e.g., in employment, school and other social environments).

All HIV counselling and testing procedures should be conducted according to the guiding principles and the legal and ethical procedures outlined in this policy guideline. Non-compliance by health-care providers constitutes misconduct and therefore should be reported to and dealt with by the relevant authorities. Procedures for laying complaints at all health facilities are outlined in the National Health Act No. 61 of 2003, Section 18. Complaints of unfair discrimination will be investigated and dealt with accordingly.

- Infection Control

Service providers should always practice universal infection control procedures in the management of clients regardless of their HIV status. The employer should provide an enabling working environment with the required resources in order to minimise the risk of HIV infection (Occupational Health and Safety Act No.85 of 1993, Employment Equity Act No. 55 of 1998 -- Code of Good Practice on HIV, Guidelines for Occupational Exposure to HIV).

Implementation of various measures relating to occupational exposure, non-discrimination, HIV testing, confidentiality, disclosure and access to PEP as well as the introduction of a health promotion programme is required. Section 20 (3) of the National Health Act specifically deals with the rights of healthcare personnel in this regard.



NOTES

[illegible]

NOTES

[illegible]

