Republic of Namibia,

Ministry of Health and Social Services

National Guidelines for HIV Counselling and Testing in Namibia

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Preface

The Government of the Republic of Namibia sees HIV counselling and testing (HCT) as an essential component in an effective response to the AIDS epidemic. HCT services can help clients make informed decisions about marriage, pregnancy and sexual relationships and can provide opportunity for receiving information about and referral to additional services. The purpose of these guidelines is to provide national standards for high-quality HCT services. They are intended for use in all models and settings where HCT occurs in Namibia: in health facilities (including government, non government, private, and mission facilities); in HCT services provided as mobile or outreach services; in "free-standing" or stand-alone sites for voluntary counselling and testing (VCT), not part of an existing health facility. They are intended to cover client-initiated and provider initiated testing.

It is internationally expected that no patient shall undergo an HIV test without counselling, confidentiality, consent and without getting the correct result. These guidelines reinforce the need for each of these conditions to be met in all settings where HCT is provided. When these conditions are met HCT services can help decrease the anxiety, stigma, and sense of hopelessness associated with fearing that one has AIDS. Clients who learn their serostatus and receive specific counselling based on their test results report an increased sense of hope in facing their situation openly and with adequate information. It has been said that "knowledge is power," and in the case of AIDS, a person's knowledge of their HIV status is a powerful weapon in the national HIV/AIDS response efforts. Knowledge of their partner's HIV status is equally important for making informed decisions on how to care for one's self, and one's family. The Government of the Republic of Namibia is committed to encouraging the provision of quality HCT services throughout Namibia, so that all Namibians who want to know their HIV serostatus are able to do so.

The development of these guidelines required the collaboration of numerous individuals, agencies, and organizations. As such, the Ministry of Health and Social Services wishes to recognize the contributions of development partners, NGOs, individuals and the Namibian people at large. Guidelines developed by colleagues in other African countries provided useful examples and we are most appreciative to learn from the experience of other countries. I urge all HCT providers, doctors, nurses, and other health care practitioners and workers to familiarize themselves with the content of these guidelines to be able to assist their patients/clients.

The development of these guidelines was possible through the financial and technical support of various development partners and stakeholders in Namibia's efforts to reduce in the short term and eliminate in the long term the spread of HIV and AIDS. The Ministry of Health and Social Services wishes to thank all other Ministry departments involved as well as the organizations and agencies that made contributions of one form or another in the development of the guidelines. Special thanks should also go to Dr Miriam Taegtmeyer of the Liverpool School of Tropical Medicine who, supported by Centers for Disease Control and Prevention, oversaw this process and coordinated stakeholders. Her tireless efforts are much appreciated.

List of Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Clinic
ARV	Antiretroviral
ART	Antiretroviral Therapy
CACOC	Constituency AIDS Coordinating Committee
CMS	Central Medical Stores
DACOC	District AIDS Coordinating Committee
DSP	Directorate of Special Programmes
D2D	Door-to-door
ELISA	Enzyme Linked Immunosorbent Assay
EQA	External Quality Assurance
HCT	HIV Counselling and Testing
HIS	Health Information System
HIV	Human Immunodeficiency Virus
IEC	Information Education and Communication
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MC	Male Circumcision
MTCT	Mother-to-child transmission of HIV
MoHSS	Ministry of Health and Social Services
NAC	National AIDS Committee
NAEC	National AIDS Executive Committee
NAMACOC	National Multi-Sectoral AIDS Coordination Committee
NGO	Non Governmental Organization
NIP	Namibia Institute of Pathology
NRL	National Reference Laboratory
PITC	Provider Initiated Testing and Counselling
PLWHIV	People Living With HIV & AIDS
PMO	Principal Medical Officer
PMTCT	Prevention of Mother-to-child transmission of HIV
POS	Point of Service
PWP	Prevention with Positives
QA	Quality Assurance
QI	Quality Improvement
QAO	Quality Assurance Officer
RACOC	Regional AIDS Coordinating Committee
RM&E	Response Monitoring and Evaluation
RT	Rapid Testing
SOP	Standard Operating Procedures
STI	Sexually Transmitted Infections
TAC	Technical Advisory Committee
TWG	Technical Working Group
VCT	Voluntary Counselling and Testing
OIs	Opportunistic Infections
CDC	Centers for Disease Control and Prevention
TB	Tuberculosis
CBOs	Community Based Organizations
PEP	Post-exposure prophylaxis
FBOs	Faith Based Organizations
WHO	World Health Organization
DCC	District Coordinating Committee
IPV	Intimate Partner Violence
HBTC	Home Based Testing and Counseling

Table of Contents

Chapter 1: Introduction

1.1 What is HIV counselling and testing

HCT is a service that is offered to clients who wish to know their HIV status. HIV counselling is a confidential dialogue between a counsellor and an individual, couple or family. It is a process of enabling individuals, couples, and families to understand and make informed decisions on whether to be tested for HIV, to understand the results and facilitate future planning. The common components are pre-test, testing, post-test and ongoing support. There are three approaches to HCT in Namibia.

These guidelines are structured around three different approaches to counselling and testing. ***Client-initiated*** HCT means that the client is the one that seeks out the services. The knowledge of status, and the counselling that accompanies it, can be a powerful catalyst for behaviour change. ***Provider-initiated*** means that health care workers recommend HIV testing to patients as part of routine health care services. The provision of provider-initiated HCT in health facilities and hospitals can improve diagnosis and save lives. Testing should be offered to patients in antenatal clinics, maternity wards, medical and surgical wards, outpatient departments, STI units, and TB clinics. Finally a third approach, ***home-based HCT*** brings HCT services into the home.

Throughout these guidelines we use the term VCT to describe the client-initiated approach, the term PITC for provider-initiated testing and coounseling the term home-based HCT for the home-based approach. For the purposes of these guidelines a couple may be defined as two individuals who are engaged in, or are planning to be engaged in, a sexual relationship together. This may be married, cohabiting, long-term partners, or it may also be non-married, casual, short-term partners.

1.2 Current HIV/AIDS and HCT situation in Namibia

Namibia covers a large area with an estimated population of 2 million people of whom about 1,033,192 are aged 15-49 central Bureau of Statistics/ National Planning commission (CBS/ NPC 2006). It has a generalized HIV/AIDS epidemic. Following the first reported cases in 1986, data compiled by the Ministry of Health and Social Services (MoHSS) show that AIDS became the leading cause of death in Namibia in 1996. The 2008 MoHSS HIV projections[1] show an estimated adult prevalence rate of 18%. Approximately 3,350 infants are infected with HIV per annum. The vast distances and low population density in Namibia make health care and HCT services inaccessible to many segments of the population who are at risk of HIV. Recent estimates indicate that 29% females and 18% males reported having gone for HIV testing within the pass12 months of the survey and knew their sero-status[2]. Only 5% of those attending HCT did so as couples. This situation poses a threat to prevention efforts, including

[1] UNAIDS and WHO 2007' EPP/Spectrum models
[2] DHSS 2006

missed opportunities by many eligible Namibians to access care and support services. Namibia has one of the best developed Antiretroviral Therapy (ART) programmes in sub Saharan Africa with free drugs available to 85% of those who are positive and need them.

Namibia has significantly expanded HCT services, through traditional VCT for people who seek to know their HIV status. It also has initiated PITC through HIV testing in antenatal clinics (ANC) through the prevention of mother to child transmission (PMTCT) programmes and through testing in TB and STI settings. Because of the critical shortage of qualified medical personnel in Namibia, the MoHSS trained and deployed lay HCT counsellors who are able to do both counselling and rapid HIV testing in public health facilities to complement the overburdened health care providers and provide both VCT and PITC services. The lay HCT counsellors, known as 'community counsellors', provide services such as HIV counselling, couples HCT, HIV rapid testing (if certified), male circumcision (MC) counselling and ART adherence counselling.

1.3 National Structures, Committees and Bodies that are HIV/AIDS specific

All public and private sectors, including civil society have been mandated to mainstream HIV and AIDS in their programmes, including the provision of HCT for their staff members. The Government of the Republic of Namibia has put in place structures to address the pandemic. These are summarized and their roles laid out in Chapter 3.

1.4 National Policies and Strategy Documents in relation to HCT

The 2007 National Policy on HIV/AIDS supports the provision of HCT services, which should be made available and accessible to every person in Namibia. Mobile and outreach VCT services have since been added to the above services and 2008 witnessed the introduction of the annual National Testing Day and the training of health care workers in PITC.

These guidelines are a result of a review of services, policies and strategies and are intended to replace the following documents:

- National Guidelines for Voluntary Counselling and Testing, NACOP, DSP First Edition 2006
- Guidelines for Outreach Counselling and Testing, NACOP, DSP First Edition 2007

They should complement and supplement:

- Guidelines and Standard Operating Procedures for HIV rapid testing Namibia Institute of Pathology (NIP), October 2008
- The Namibia National Guidelines for the Prevention of Mother-to-Child Transmission of HIV, Dept of Reproductive Health, July 2008

1.5 An integrated approach to quality assurance and improvement

Quality of HCT services is a key concern in Namibia. Quality assurance and a value system of continuous quality improvement are integral to these guidelines, which lay out the standards expected in HCT sites and from HCT service providers in the country. The fundamental elements of quality are incorporated in all aspects from counselling to testing, data management and logistics. Clearly defined roles are laid out for all those who take part in HCT from national down to community level. The purpose of these guidelines is to ensure that HCT services are provided with the highest quality in all settings where testing is conducted.

Chapter 2: HCT Principles, Approaches and Models

2.1 Guiding principles for HIV Counselling and Testing

The following principles should guide HCT services in Namibia. They should be observed by everyone offering HCT services whether in the public sector, non-governmental organizations (NGOs) or private sector.

2.1.1 Consent

When consenting individuals or couples for HCT counsellors should:

1. Ensure clients adequately understand the benefits, implications and consequences involved.
2. Recognize the right of clients to withdraw consent at any time, even after blood has been taken for HIV testing.
3. Recognize and promote the rights of those whose position to give valid consent to HIV testing is diminished for example due to age and/or mental impairment.

When consenting couples for HCT, counsellors should also ensure that both partners agree to:

1. Be counseled together and receive their test results together
2. Keep each other's test results private/confidential
3. Make decisions about disclosure to other persons together
4. Discuss HIV risk concerns together, and support one another

Consent is implicit in blood and organ donation and an HIV test is conducted each time a donation is made. All individuals and couples should be informed of the implications of blood tissue or an organ donation. Testing shall always be accompanied by consent (to donate and be tested), confidentiality and counselling and a plan made with the donor on how the results will be issued[1].

Declining an HIV test should not result in reduced quality or denial of services, coercive treatment or breach of confidentiality, nor should it affect a person's access to health services. Individuals or couples declining the test should be offered assistance to access HCT in the future. The patient's decision to decline the HIV test should be noted in their medical record so that, at subsequent visits to the health facility, a discussion of HCT can be reinitiated.

[1] The Blood Transfusion Service of Namibia Standard Operating Procedure

2.1.2 Counselling and disclosure of results should accompany every HIV test

Every HIV test should be accompanied by counselling that takes into account the language and level of understanding of the individual or couple (adult or child). The quality of counselling can vary widely and protocols have been developed to ensure a minimum quality is offered. Copies of the protocols for VCT, couples counselling and PITC are included in Appendices 4-6 respectively. Some clients may request HIV testing but decline counselling. These clients should be informed that every HIV test should include counselling.

All test results should be disclosed. It is not acceptable to withhold test results. Although patients can refuse to receive or accept results of any test or investigation, health care providers should make every reasonable attempt to ensure that patients receive and understand their test results in a confidential and empathetic manner. HIV test results should be disclosed in person only to the individual client or couple, unless the client is a minor (see section 8.3). Disclosure of the results to anyone else should only be done with the client's consent, which should be documented. Informing clients of their test result by telephone or other media is unacceptable. Disclosure of HIV status to children will depend on thorough assessment of the child's' level of understanding on HIV/AIDS issues and his/her level of maturity.

2.1.3 Confidentiality must be observed in all CT settings

Confidentiality should be discussed with all individuals and couples undergoing HCT and the few circumstances where this 'contract' may be broken should be clearly explained. Confidentiality may be broken if the HCT counsellor realizes that the client or another person may be put in danger; for example, **if a client has immediate plans to harm or kill themselves or another person**[2]. For HIV positive clients who are reluctant to disclose their results, the HCT counsellor can offer couples HCT for the client and their partner. Counsellors may also offer additional, on-going counselling to help the client inform the partner of their HIV-positive test result. The HCT counsellor may also assist individuals to disclose to their sexual partner(s) in the presence of the client, upon the client's request. Additionally, if couples HCT is not an option for the client, and the client fails to disclose after three documented counselling sessions or refuses to disclose at all, and the health care provider has sufficient concern that the partner is exposed to ongoing risk from unprotected sex, the counsellor should offer facilitation of disclosure.

Confidentiality also applies to client records. All clients' records, whether or not they involve HIV related information, should be managed in accordance with appropriate standards of confidentiality. All personnel with access to medical records should be trained in procedures to maintain confidentiality of HIV test results and should sign the code of conduct. Only staff with a direct role in the patient's management should have access to their records.

In clinical settings, shared confidentiality involves the client and health workers involved in their medical care (e.g. nurse, doctor, pharmacist, HCT counsellor). With patient consent and after explanation of the rationale (to improve access to care and treatment) HCT results should be recorded in the health passport after a test has been conducted for clinical reasons.

[2] Policy on Confidentiality, Disclosure and Partner Notification

In a couples HCT session, shared confidentiality refers to the fact that – since the couple may learn their HIV status together – both partners agree to keep one another's test results confidential, until they decide together to disclose to another person.

2.1.4 Correct test results must be given in all settings

All personnel who conduct HIV testing be trained and certified to do so. Tests should be conducted in accordance with the standard operating procedures[3]. All test results are recorded in the standardized HIV rapid testing logbook (see section 10.5 and Appendix 8) and all sites should take part in internal and external quality assurance (see section 10.11). Chapter 10 of these guidelines lays out the guidelines for HIV rapid testing.

2.1.5 Human rights should be respected

Voluntary testing remains at the heart of all HIV policies and programmes in Namibia, both to comply with human rights principles and to ensure sustained public health benefits. These guidelines encourage all Namibians to get tested either through their own initiative or because clinically indicated. In Namibia, all health care providers are bound by an ethical principle to do all that is necessary and available to provide the best possible care through the use of diagnostic tools and follow-up treatment. Therefore an HIV test must be offered when clinically indicated and treatment and follow-up provided as necessary and available. At the same time clients must be able to refuse tests. The human rights principles relevant to HCT include:

- The right to individual autonomy and dignity
- The right to informed consent before a medical procedure is carried out
- The right to information for making choices about one's health and well being.
- The right to education
- The right to privacy
- The right to non-discrimination, equal protection and equality before the law
- The right to marry and found a family
- The right to the highest attainable standard of physical and mental health

HCT sites should not provide mandatory testing for educational, employment or travel-related testing. However, these clients can be encouraged to learn their serostatus at the site, with the understanding that they will need to be tested again at a laboratory to receive written, certified results. Mandatory testing may be conducted by court order (e.g. for rapists)[4] and in this case a venous sample will be taken at the time of arrest and stored for testing if the rapist is convicted and discarded if acquitted. Results should be communicated to the appropriate authority and to the person tested following the post test protocols.

2.1.6 Professional and ethical codes of conduct should be followed

In all facilities where HCT is provided, service providers should act according to their professional and ethical codes of conduct. Breaches of these (for example breaches of confidentiality, arranging dates or

[3] Guidelines and Standard Operating Procedures for HIV rapid testing NIP, Oct 2008
[4] Combating of Rape Act 8, 2000

sexual encounters with clients, accepting money or other gifts from clients) will result in disciplinary action. In addition methods for redress for patients whose rights have been infringed must be put in place. Consideration should be given to the appointment of an independent mediator or patient advocate to whom breaches of testing and counselling protocols and codes of conduct can be reported for redress. HIV service providers who act professionally and ethically at all times and who keep all records for reference when needed should be provided with all the necessary protection against unwarranted claims by clients.

2.2 HCT Approaches in Namibia

There are three approaches to HCT in Namibia. The different locations and target audiences of the approaches are outlined in table 1 and the advantages and disadvantages in table 2.

2.2.1 Client-initiated Voluntary Counselling and Testing

Client-initiated Voluntary Counselling and Testing involves individuals, couples, or families actively seeking HCT in a setting that offers these services. For individuals, VCT emphasizes individual risk assessment by HCT counsellors, addressing issues such as individual risk behaviour, reason for wanting an HIV test and the development of individual risk reduction plans. This may be abbreviated for individuals who have been tested before. For couples and families, VCT may not include individual risk assessment, but rather the counsellor discusses the couple's risk concerns, and keeps the conversation focused on the present situation and the future. ***VCT may be delivered in a variety of models (see section 2.3 below) including stand-alone sites, sites co-located in health facilities, and through mobile and outreach services. Detailed recommendations for VCT may be found in Chapter 5 and the VCT protocol in Appendix 4.***

2.2.2 Provider-initiated testing and counselling (PITC)

This refers to HIV testing and counselling recommended by health care providers both in the public and the private sectors. This enables specific clinical decisions to be made that would not be possible without knowledge of the person's HIV status. PITC is delivered in health facilities and other settings alongside health services. A brief counselling or pre test education/information should always accompany testing even for diagnostic purposes and patients should never be forced to undergo testing against their will. Results must always be given to the patient along with post test counselling and appropriate referrals. PITC can also be provided to couples, and is generally accompanied by programmes for the Prevention of Mother-to-Child Transmission (PMTCT). Full guidance notes may be found in separate national guidance on PMTCT[5]. Details of the PITC process may be found in Chapter 6 and a protocol in Appendix 6.

2.2.3 Home-based HIV Counselling and Testing

Home-based HCT involves the offer and provision of HCT within the home. Home-based HCT is initiated by the HCT service provider, and members of the household have the right to decline testing. Home-based HCT occurs when HCT service providers visit homes. It may be delivered on a door-to-door basis, linked to other home-based services (such as bed net distribution or home-based care) or conducted in the homes of HIV positive index cases. Benefits of home-based HCT are maximized when sexual partners or couple

[4] National Guidelines for Antiretroviral Therapy, Third Edition, MOHSS July 2010

members are tested together, rather than as individuals, and when HCT is provided to children of HIV infected or deceased mothers.

Table 1: Locations and target audiences of different HCT approaches

Approach	Location	Target
VCT	Stand-alone sites: Sites in busy accessible areas in non-medical settings. NGOs, churches, commercial districts Primary health care centres	General public - all sexually active people; couples; young people; men people who don't visit health facilities
	Mobile and outreach: Remote rural areas Health facilities, community halls, school halls, youth facilities, tents and caravans	Workforce Vulnerable groups Prisoners Truckers Couples
PITC	Primary health care centres Hospital in patients STI, TB clinic, Out patients Antenatal care Doctors' offices, private hospitals	Adult patients Child patients Pregnant women and their partners Well adults Couples
Home-based	Person's home	Families, Couples, Children, Adults Families of index cases

2.3 HCT Service Delivery Models

2.3.1 Stand alone HCT

Stand-alone HCT centres are situated within the community and are specifically for the purpose of HCT. Although they do not provide general health services they are considered to be health facilities and are licensed accordingly (see chapter 4.1 below). They are also required to undergo a Site Readiness Assessment for this purpose (see Section 4.5 and Appendix 1). These sites may be operated by non-governmental organisations (NGOs) or other community-based organisations (CBOs).

2.3.2 HCT in health facilities

Health facilities already have a pre-existing licences but if they wish to add HIV rapid testing (RT) they are required to undergo a Site Readiness Assessment for this purpose (see Section 4.5 and Appendix 1).

Co-located HIV testing and counselling centres

In Namibia VCT sites are co-located on the grounds of a health facility such as a hospital or a health clinic. The sole function of these VCT sites is the provision of HCT services; other health services are generally not offered, though some related services such as family planning may be offered. The co-located VCT site may be a separate facility on the grounds of a functioning health facility, or it may be attached to the health facility such as a group of rooms in a specific ward.

Hospital or health clinic

HCT can be initiated from any service delivery point in all sections of a hospital or health facility for any person. An example of an HCT setting in the hospital or health clinic setting is the ANC, PMTCT, or HCT in the context of maternal and child health care (MCH). HCT may occur for pregnant women, infants and children in antenatal, maternity, or postnatal units. For children, HCT may also occur during routine immunizations or check-ups in the paediatric unit. HCT for TB patients may occur in the TB unit and for STI patients in the STI clinic. HCT may also take place as part of general outpatient or inpatient services.

Clinic for male circumcision

According to the WHO 2008, MC has been found to reduce HIV transmission in males by 60%. As such, programmes to encourage boys and men to get circumcised have been opened in a number of public health facilities in Namibia. Emphasis should also be put on ensuring that that the right messages of behaviour change, active STI screening and condom use are part of the prevention package that accompanies circumcision. HCT should always be offered as part of the package with male circumcision, preferably onsite as part of pre-MC counselling. HCT sites that wish to be considered as venues for MC should contact the MoHSS to determine the process.

2.3.3 HCT mobile services

Given the vast distances and rural populations of Namibia, mobile services are critical to providing HIV and other public health services. As long as the minimum requirements for HCT are met (trained HCT counsellors, certified to conduct rapid testing as outlined in these guidelines) and the setting is conducive to rapid testing (meeting the infrastructure requirements laid out in these guidelines) then HCT services can be provided in a fully mobile manner. The service may be provided from an adapted van, flat bed truck, train carriage or other similar vehicle. Mobile HCT may use either the VCT approach (as for example during the national testing day) or the PITC approach (as for example when HIV testing accompanies an existing health service or when wellness screening is conducted in businesses). The use of a mobile van needs prior written approval from the MoHSS through its licensing division as laid out in Chapter 4. Since mobile vans are considered health facilities by current Namibian law they must have a registered nurse as part of the programme in order to gain a licence.

2.3.4 HCT outreach services

Outreach HCT refers to services offered outside of a fixed site. Some examples include:

- Utilizing health facilities with spare rooms but no HCT provision
- Utilizing pre-existing community facilities such as a church, school, university, or market building
- Using tents as counselling rooms

Outreach HCT can be conducted at night to reach working populations, including taxi and truck drivers and sex workers who are more available for HCT at night. This is sometimes referred to as *Moonlight HCT.* Organisations conducting outreach HCT in Namibia must operate out of a base site that is licensed as a health facility (see section 4.1). It is the responsibility of the base site to ensure appropriate quality control measures are in place, and that the guidelines and policies in this document are adhered to in the outreach setting. The National Testing Day and other special events are considered to be part of outreach services (see section 11.3 for more details).

2.3.5 Home-based HCT

Home-based services refers to HCT delivered in a person's home or homestead. Counsellors and programmes must carry all necessary equipment with them and abide by the standards and quality assurance systems set out in these guidelines. Organisations conducting home-based HCT activities in Namibia must operate out of a base site that is licensed as a health facility (see section 4.1). It is the responsibility of the base site to ensure appropriate quality control measures are in place, and that the guidelines and policies put forth in this document are adhered to in the outreach setting. Additional counselling skills and training

may be required for counsellors working in home-based HCT programmes that address issues such as child testing (see chapter 8) and special circumstances that may be found in the home (see chapter 7). Programmes should give particular attention to community entry and involvement.

Table 2: Advantages and disadvantages of different HCT models

Model	Approach	Advantages	Disadvantages
Stand-alone	VCT	• High community accessibility • Staff dedicated and full-time • Strong linkages with providers of support services. • Anonymous and confidential testing • Serve as a platform for mobile and outreach services • Flexible hours including evenings and weekends • Promotional campaigns and incentives draw clients • Lay counsellors can spend sufficient time with couples, provide follow-up counselling for discordant couples	• Possible difficulties with long-term funding • High cost of human resources and infrastructure if underutilized Need to ensure good referral mechanism for follow-up care • Risk of staff burnout if no support • Need to have a high level of public awareness of the service, community mobilization, advertising
Health facility	PITC VCT	• Basic infrastructure already in place • Existing staff receive training in HCT • Close links with other medical services facilitate clinical referral • Potentially less expensive • Low stigmatization as people could be attending the facility for other reasons. • May be provided in private facilities • Diagnostic • Targeted • Can reach couples in ANC	• Staff must be given adequate space, time and training • It may be difficult to ensure privacy in a ward setting. • Requires meetings to ensure good liaison and referral • Limited space can affect expansion • May exclude men and youths • Inflexible hours may limit access • HCT services result in added work for existing staff • ANC services may need modification to be male-friendly
Mobile Outreach	VCT	• Improves access for hard to reach populations • Reduces stigma and discrimination • Attracts large numbers and is a very popular model • Rates of receiving HIV test results are increased • Promotes counselling and care at community levels • Potential to link with home-based care services and 'prevention with positives' interventions • Creates good community ownership • May enhance access to CT for men and their partners • Convenient for employees if HCT is at work places	• Strong support system and referral mechanism must exist at community level before services are initiated • Mobile teams from PHC services already overworked • Sites need to be inspected by NIP before starting • Privacy and comfort may be insufficient • Supervision and quality assurance (QA) must be well planned • Children may request HCT • Some areas inaccessible in rainy season • Concerns about confidentiality in work-place • Return visits may be necessary
Door-to-door	Home-based	• Convenient • Able to target household members, sexual partners and children of ART patients • Enhances family-based approach to HIV services • Highly acceptable to clients	• Comparatively expensive to run • MoHSS authorization required • Quality of HCT may be difficult to monitor • Strong support system and referral mechanism must exist • Counsel children and couples • Concerns about confidentiality • Transportation and security can be a challenge for HCT counsellors

Chapter 3: Roles and Responsibilities

3.1 National Level Roles and Responsibilities

In order to obtain coherent and functioning HCT services which follow an integrated approach the national, regional, district and facility levels all need to be addressed. This assumes well-defined roles and responsibilities in relation to HCT, the active involvement of all stakeholders and strong links to a national quality assurance system. The Namibia National Strategic Framework[1] clearly lays out the organizational structures in Namibia that contribute actively to HCT direction and implementation and the 'Plan for the National Multi-sectoral Monitoring and Evaluation for HIV/AIDS'[2] gives an organogram of their relationships to each other. These have therefore not been repeated here but a summary of the roles and responsibilities is provided in table 3.

[1] Namibia National Strategic Framework for HIV/AIDS 2010/11 – 2015/16
[2] Plan for the National Multi-sectoral Monitoring and Evaluation for HIV/AIDS, 2006

Table 3: HCT responsibilities at national level

Level	Body	Abbreviation	Responsible for
	National AIDS Committee	NAC	• Provides policy guidance and leadership for national multi-sectoral HIV/AIDS response
NATIONAL	National AIDS Executive Committee	NAEC	• Provides technical guidance and leadership in planning and implements of the multi-sectoral response
NATIONAL MoHSS	Directorate for Special Programmes	DSP	• Overall coordination and implementation of HCT • Facilitates employment of community HCT counsellors • Supervises the QA officers • Chairs the CT TWG • Maintains an active database of registered sites and certified providers
	Technical Advisory Committee for HIV Prevention	TAC	• Coordinates government and partners prevention programmes to increase collaboration and avoid duplication of efforts
	Namibia Institute of Pathology	NIP	• Sets standards and develops protocols for HIV testing • Acts as national reference laboratory, oversees external quality assurance (EQA)
	HCT Technical Working Group	HCT TWG	• Technical programme review by national experts • Ensures HCT programme is on track • Revises and updates standards and guidelines • Reviews the quality of HCT • Identifies support needs for sites • Advises on authorization of training institutions • Works with CMS on stock management • Rewards excellence (accreditation)
	Central Medical Stores	CMS	• Procurement of test kits, storage and distribution • Disposal of expired kits • Works with TWG on annual commodity requirements • Ensures efficient stock management • Reports to TWG quarterly
	Human Resource Management and General Services	HRM and general services	• Issues annual license to sites • Liaises closely with HCT TWG

3.2 Regional and District Level responsibilities

The multi-sectoral regional, district and constituency AIDS coordinating committees (RACOC, DACOC and CACOC) are composed of different stakeholders and are responsible for implementation and coordination of HIV/AIDS activities. Members of these committees are drawn from the public and private sector as well as civil society. These committees are expected to plan, implement, supervise and evaluate HCT activities at both district and regional levels. As part of the regional management team, the Regional Director of Health is responsible for the coordination of DSP activity in the region and plans the outreach and home-based HCT activities in the region. Organizations wishing to do outreach or home-based activities in a region should liaise with the Regional Director of Health. This is implemented by the chief or senior health programme administrator in charge of special programmes (HIV/TB/malaria). The regional monitoring and evaluation officer (data clerks) will collate HCT data alongside other regional health information (see chapter 12).

The regional quality assurance (QA) officers will work closely with and report directly to the chief (or senior) health programme administrator. The regional QA officers should accompany the regional health facility inspectors when registering or licensing sites. The regional QA officers are also responsible for overseeing the quality of testing, reviewing on-site HIV rapid testing logbooks and liaising closely with a named regional or national laboratory for technical support. They should be trained in this aspect by the Namibia Institute of Pathology and should be accompanied annually by a laboratory technologist.

Table 4: HCT responsibilities at regional and level

	Name	HCT responsibilities
REGIONAL	Regional, District and Constituency AIDS Coordinating Committees	• Multi-sectoral coordination • Implementation and coordination of HIV/AIDS activities • Community mobilization
REGIONAL MoHSS	Regional Director of Health	• Coordinates Directorate's activities in consultation with the management team to comply with the vision of the directorate, ensuring that the broader objectives of the Ministry are met.
	Chief (and/or senior) health programme administrator	• Coordination of district/regional HIV/AIDS/STI/TB and Malaria activities. • Provide technical support and training of staff for Special Disease Programmes
	Regional Health Facility Inspectors	• Inspect health facilities for licensing and re-licensing • Recommend deregistrationjj
	Regional Laboratory	• Oversee conducting of proficiency panels • Conduct laboratory supervision • Recertification of HCT providers in the region to conduct rapid tests
	Regional Quality Assurance Officers	• Assess, inspect and register new VCT sites in conjunction with health facility inspectors • Conduct supervision of counselling aspects • Review on-site HIV rapid testing logbook • Conduct observed practice • Create a culture and value system of quality improvement • Support poorly performing sites in good time to prevent deregistration
DISTRICT	Principal Medical Officer	• Co-ordinate integrated health care and medical services in all departments • Provide Technical Supervision and support to the medical officers and interns.

3.3 Facility level roles and responsibilities

VCT sites, whether located within health centres or hospitals or stand-alone, should be managed by the person in charge of the facility or department where the HCT services are provided. The person in charge should have planning and management skills, as well as skills in counselling and testing. They should apportion tasks appropriate to their team members to:

- Ensure the site is licensed and operating legally and that individuals are certified, annually for PITC and home-based HCT and every two years for VCT providers.
- Ensure quality of services by all staff through adherence to protocols and guidelines
- Ensure appropriate and effective referral mechanism is in place.
- Strive for centres/sites of excellence. Ensure that national HCT policies are well interpreted, integrated and implemented by all staff
- Feedback data to national level; report on HCT uptake success, barriers, and challenges
- Monitor day to day site activities
- Ensure proper stock management
- Provide adequate supervision
- Track referrals of HIV positive patients to enrollment in HIV care and treatment programmes
- Be able to conduct in room testing where appropriate

Individuals conducting PITC should:

- Ensure they are licensed to perform HIV rapid testing
- Ensure quality delivery of services by all staff through adherence to the protocols of PITC and in accordance with all quality assurance measures

Where a VCT site is co-located in a health facility, PITC and VCT service providers should work as a team.

Table 5: HCT responsibilities at facility and community level

Level	Person	Responsible for
FACILITY	Site managers	• Provide adequate supervision and support • Put programmes in place that can prevent stress and burnout for HCT counsellors • Ensure site is licensed • Fills out forms on stock availability • Monitor day to day activities and evaluate programme performance
	HCT service provider	• Conduct counselling and testing • Discuss HIV prevention and make appropriate referrals • Adhere to standard operating procedures • Fill out data forms • Attend support supervision and refresher trainings • Ensure use of data
	Data entry personnel	• Enter data • Compile reports
	Peer educators	• Mobilize for testing, conduct information giving sessions
COMMUNITY	Community leaders	• Link to mobile outreach services • Link to home-based care services • Raise awareness • Advocate for quality • Advocate for door-to-door programmes

Chapter 4: Operational Requirements

All sites are required to meet certain minimum standards in their infrastructure, their process and the outcome of their services. In certain circumstances additional things may be required to meet the particular needs of clients or the setting in which HCT is being delivered. These guidelines recognize that additional items may be useful but not widely available nor essential to the quality of HCT (such as a television in a waiting room) and therefore separate out the minimum expected standard required for sites to provide a quality HCT experience. The accompanying tools in Appendices 1-3 provide useful check lists for assessment of sites and cross reference the relevant subsections in these guidelines. Provided it meets the minimum requirements set out below HIV rapid testing may be in-room or in a separate lockable room, conducted in tents, people's homes or in other outreach locations.

In order for an HCT provider and/or HCT site to operate they should meet the agreed minimum requirements as set by these guidelines, whether testing is being conducted in the private or the public sector and regardless of setting.

4.1 Requirements for HCT service providers

Trained and certified individuals may conduct HIV counselling, HIV rapid testing or both. In Namibia most HCT counsellors are 'community HCT counsellors' (CCs), a term that describes the fact that they are drawn from the community. As an entry requirement for training, these individuals must have some experience in HIV and AIDS programmes and have a minimum of a grade ten certificate[1]. Health workers, social workers, teachers, NGO staff, youth and church leaders can also be trained as HCT counsellors. HCT service providers are encouraged to be voluntarily tested for HIV, both for their own personal risk-reduction planning and to understand clients' perspectives.

4.1.1 Certification in HIV counselling

HCT counsellors will be trained by qualified trainers practicing in institutions authorized by the MoHSS to certify individuals as HCT counsellors. These institutions must use the national HCT training curricula approved by the MoHSS and where appropriate provide additional training on child testing. They must be closely linked with HCT service delivery points for the requirement that students should have a periods of practical experience interspersed with theory. It is the responsibility of the individual health professional to ensure that they are registered with the Health Professional Council and that their certificates are presented for licensing exercises (see section 4.3 below). Currently community counsellors are not required to register with the Council but they are encouraged to keep abreast of any changes in registration status that may affect them in future.

[1] Guide for the Recruitment of Community Counsellors, MoHSS January 2007

4.1.2 Certification in HIV rapid testing

Where possible, it is desirable that rapid HIV testing be conducted by laboratory scientists and/or technicians. However, in order to support the expansion of HCT services in Namibia, health care workers and Community HCT counsellors who have been certified in conducting rapid tests are authorized to perform rapid HIV tests. Trainers authorized by the MoHSS will train these HCT counsellors to perform rapid HIV testing. Individuals who are new testers may only be certified as competent after they have completed the recognized RT training and conducted ten rapid tests with complete concordance on re-testing by the Namibia Institute of Pathology. These samples should be conducted immediately after the course is completed.

All individuals conducting rapid testing are responsible for ensuring that they take part in internal and external quality assurance measures as laid out in chapter 10 of these guidelines. This includes a proficiency panel to be conducted every two years by VCT service providers and annually by PITC and home-based testing service providers.

4.1.3 Recertification

Recertification should be annual for individuals conducting PITC and home-based testing. It should be every two years for those conducting VCT from a fixed or fully mobile site that already takes part in quarterly proficiency panels (see section 10.11). Individuals who have not practiced HCT for a period of more than 12 months are required to be recertified prior to seeing clients or patients. The requirements for recertification are:

- Attendance at a minimum of one refresher training a year
- Participation in burn out prevention programmes (see chapter 11) at least quarterly
- Proficiency panel conducted with concordance to reference lab.

Individuals who have not provided HCT services for a period of more than 24 months are required to be retrained from the beginning and issued a new certificate of competency.

4.2 Infrastructure requirements for sites

All sites are required to meet certain minimum standards in their infrastructure (Appendix 1).

4.2.1 Personnel

HCT should only be conducted by personnel trained and certified to do so (section 4.1).

For a site to be recognized and licensed as an official HCT site it must have adequate (at least two) trained and certified service providers, including at least one registered nurse. Additional personnel may be required in larger sites to fulfill the obligations demanded by data collection and reporting using the Health Information System (HIS) as laid out in Chapter 12 of these guidelines. Private Practioners acting as individual HCT service providers are not required to license their sites as HCT sites but follow the usual licensing requirements for private health facilities. They are however required to follow all standard operating procedures, including standard counselling protocols and national algorithms for testing.

4.2.2 Space and furniture

When counselling is conducted in rooms (as opposed to in homes or at the bedside) the rooms should have adequate space (min 200m^2) and include:

- three client chairs
- desk or table for writing notes and for keeping condoms
- penile and pelvic models
- good ventilation

Areas where rapid HIV testing is to be conducted (including in-room testing) must have:

- basin or bucket with a tap and bowl or other hand disinfectant in proximity
- adequate lighting for reading of test strips
- table, bench top or foldable testing area
- washable surface working area for easy cleaning

Stand-alone VCT sites should also consider:

- Reception area equipped with: desk and 3 chairs; lockable filing cabinet/s; condoms and information education and communication (IEC) materials on display; and, If possible, a computer for data entry.
- Waiting area equipped with a comfortable sitting facility with a display area for educational materials, including those that explain the HIV testing procedure; and, if possible, audio-visual equipment.
- Hygienic toilet facilities should be available where possible. Their absence should not prevent a site being licensed. .
- Wheelchair access should be available where possible, although its absence should not prevent a site being licensed.

4.2.3 Storage Facilities

All fixed sites are required to have storage facilities as bulleted below. Storage at a regional laboratory may be required for home-based HCT and for PITC providers. Specific attention should be paid to:

- Lockable cupboard for storage of test kits.
- Suitable mechanisms for storage of controls, reagents and kits at the required temperature. In many areas of the country kits are stable at room temperature throughout the year. A refrigerator or cooler hamper with thermometer may be required if serum samples are used for quality assurance.
- Lockable shelf or cabinet for storing of documents and patient records.
- Lockable storage space to store supplies other than reagent kits.

The managing organisation is responsible for the availability of appropriate storage, although this may be remote from the site where testing is conducted or may be portable (as in the case of bed-side, home-based and outreach HCT services).

4.2.4 Inventory and Stocks

The site supervisor should be assigned to look after the stock. The quantity and type of supplies will depend on the volume of clients expected. Additionally, if other medical procedures (e.g. TB or STI screening) are envisaged as part of the service, then supply lists will need to be appropriately modified. Critical supplies include:

- HIV test kits
- Needles and syringes, lancets, swabs, mentholated spirit, disinfectants, gloves
- Drugs for Post-exposure prophylaxis accessible 24 hours a day e.g. from a pharmacy
- Registers and HIV rapid testing logbooks for record keeping
- Condoms both male and female
- IEC materials

4.2.5 Safety, Infection Control and Occupational Health

All used materials must be disposed of appropriately in HCT sites. This requires:

- One waste container for general waste
- One waste container for biohazardous materials
- One sharps container for disposal of needles, lancets and other sharps

Every measure must be taken to reduce the risk of occupational transmission of blood-borne diseases. It is recommended that HCT counsellors receive hepatitis B immunization. All sites conducting RT should have basic first aid materials; a PEP protocol and 24 hour access to post exposure prophylaxis in case of occupational exposure through a needle stick injury. This may be through the district or other pharmacy. PEP must be available as soon as possible within 72 hours of exposure. National guidelines on procedures to be followed for PEP must be adhered to (and documented) at all times and counselling for adherence must accompany the administration of PEP. PEP for survivors of rape is covered in section 9.11 of these guidelines.

Site managers should also ensure periodic medical screening for all HCT counsellors as they may be exposed to other diseases in the course of their work. All areas used for counselling must be well ventilated, and HCT counsellors should receive routine preventive health screening, especially for TB. Those who are HIV positive should be provided access to preventive services such as TB preventive therapy, medication to prevent opportunistic infections, and ongoing medical and psychosocial support.

4.2.6 Client Handling

There is a need to ensure privacy during counselling and testing sessions regardless of the setting for HCT (stand-alone site, outpatient department, hospital ward, person's home etc). Assurances of confidentiality should be backed up by systems which ensure that confidentiality is maintained at all times in the handling of the patient and the reporting of test results. Attention should be paid to the privacy of the setting, the volume of client flow and the maintenance of optimum work flow.

4.3 Process requirements for sites

Having the necessary infrastructure in place is in itself not a guarantee that the delivery of HCT services will meet quality standards. To ensure that client needs are met a number of processes need to be followed.

4.3.1 Awareness of national policies and adherence to standard operating procedures

Counsellors must be aware of national policies and must adhere to protocols and standard operating procedures (SOPs). Every HCT site should ensure availability of all current HCT related policies, protocols and operating procedures for reference (see references section).

4.3.2 Client flow

Client flow in the facility should minimize waiting times (to no more than two hours), ensure confidentiality and ensure that clients and counsellors have sufficient time to conduct an appropriate HCT session.

4.3.3 Collection and submission of accurate data

HIV rapid testing logbooks and client registers need to be accurately completed on a daily basis. The registers and logbooks should remain at the site and be checked and signed by a site supervisor as well as reviewed quarterly by the regional QA officers. An important aspect of quality improvement is that much of the data stays at the facility level to be analyzed and used by the facility to improve the quality of service delivery. The registers and HIV rapid testing logbooks form the basis of data sent for monthly reporting (see chapter 12).

4.3.4 Site opening, staffing and stock outs

All HCT sites should be open during normal working hours with flexibility to open on weekends and after hours. In the event of weekend and after hours operation, arrangements should be made locally for staff to get compensatory time off. Site managers/supervisors need to ensure that there is adequate staffing, stock of kits, registers and HIV rapid testing logbooks, condoms and other consumables to be able to provide the service during operation hours.

4.3.5 Contribution of routine data to monitoring quality

Sites should take part in routine data analysis not only for the purposes of reporting but also to monitor quality in a systematic manner. In addition to meeting reporting requirements sites should analyse and use data for programming. For example HIV rapid testing logbooks may indicate that kits are due to expire before this has been noted by a stock take. Data analysis may indicate imbalances in male and female attendance rates, in counsellor workloads or in condom uptake that a site manager would need to identify as an area for quality improvement (see section 11.1).

4.3.6 Counsellor support systems

A number of systems together contribute to the support of counsellors. All systems may be seen as methods for assuring quality when a scale up of services is implemented. (see section 11.1). These include supervision,

burnout prevention (which may be seen as part of occupational health) and observed practice.

Weak, irregular supervision, that acts as a form of control rather than support is still a common problem in Namibia. Supervision often has an emphasis on quantity (number of visits) rather than quality, consequently much supervision has little impact on performance improvement. A key role of the Regional QA officers in Namibia is that they should act as supervisors and be equipped to support, mentor and coach HCT service providers at service delivery points, imparting knowledge and skills through continuing education. For HCT the counselling and laboratory components require specialized inputs. The regional QA officers should have specific training and expertise to enable them to conduct supervision in these areas. Good supervision will motivate counsellors and sustain quality but facilities need to build-in additional approaches to burnout-prevention.

"Burnout" has been described as a physical, emotional, psychological and spiritual phenomenon, characterized by progressive loss of idealism, energy and purpose experienced by people working in helping professions. Preventing burnout is critical for professional development, quality of counselling interactions, decreased staff turnover and sustainability of services. Strategies include the following:

- HCT counsellors should have clear roles and responsibilities,
- Mentors should be assigned to HCT counsellors so that a more experienced HCT counsellor acts as a mentor for a less experienced one.
- Regular counselling review meetings should be held on-site. These should be held at least once every two weeks and should be organized by the site managers/supervisors. During these meetings the HCT counsellors can discuss challenging cases, share experiences.
- Every HCT counsellor should attend at least three days of refresher training annually. These may be held at regional level. During these counsellors will be updated on new developments in HIV/AIDS and HCT.
- HCT counsellors may form peer support groups to support and assist each other in an informal environment where both social and work-related activities can be discussed.

With the consent of the client, a counsellor can request to be observed by an experienced counsellor whilst in session. This may be the designated mentor or regional QA officer. The value of observed practice is that it gives the counsellor instant feedback from a supportive senior counsellor or supervisor. Observed practice is done using an agreed checklist that follows the national protocols set out in these guidelines. The objective nature of the checklists help the counsellor to know whether they have conducted a client-centred session, have remembered the key components of the pre- and post-test counselling protocols and how well they dealt with the client's emotional reaction. Supervision by observation is intended as a continuation of the learning process and as such should be supportive rather than fault finding. Where rapid testing is conducted it serves as a useful tool to observe adherence to the standard operating procedures (SOP) for rapid testing. Observed practice can be adapted to all approaches and settings where HCT is conducted and for observing counselling sessions with couples as well as with individuals[2].

[2] Handbook for improving HIV testing and counselling services, WHO 2010 http://www.who.int/hiv/pub/vct/9789241500463/en/index.html

4.4 Proposed outcome measures for sites

The mere conducting of HCT is not an end in itself. Much depends on how the clients perceived the service and whether they act on the information they gained through knowledge of counselling and HIV status. In section 11.1 of these guidelines more detail is given on the relationship of outcome measures to quality assurance in HCT.

4.4.1 Measuring the system

Individual sites may not be able to measure coverage of testing in the community but they should be able to track uptake by those who have not been tested before and to follow up repeat testers. Furthermore HCT sites should measure and track the referrals that are made to MC services, treatment and care services for ART and HIV positive pregnant women who were successfully referred to PMTCT services, received the interventions and had a negative child. This tracking may be considered as contributing to quality indicators for HCT (see sections 11.1 and 12.2.1). A quality outcome of HCT is considered to be successful enrolment in care and treatment for those that test positive.

4.4.2 Getting clients' views

HCT services may be technically excellent but clients may dislike the way they are delivered because of inconvenient hours or locations, unfriendly staff, excessive costs or long waiting times. A number of methods should be used by sites to gain community perspectives and information from clients about the quality of the services they received. The responses can be used for quality improvement if a few simple questions are asked, a problem identified, and a solution developed and then re-evaluated. Common methods used are client exit interviews, suggestion boxes and involvement of the community in decisions about the services. The key issue at site level is not which method is used to gain client's views but that the information is collected and analysed in a systematic manner and solutions are developed at facility level.

4.4.3 Participation in quality assurance and improvement cycles

In addition to quality assurance of testing, a number of quality assurance measures can be adopted systematically by sites to monitor their performance. These include the regular analysis of routine data and the specific use of tools such as client exit interviews that are systematically administered and analysed at facility level. For example sites may wish to conduct 100 exit interviews every six months. For more details on quality assurance and improvement refer to section 11.1.

4.5 Site inspection and licensing

A three tier system ensures that the minimum standards set out in these guidelines are adhered to in all settings where HCT takes place and that excellence is rewarded. Standardized checklists for each tier may be found in the accompanying appendices. Together these build on and standardize the existing systems of site assessment by NIP and licensing by the Human Resource and General Services Division, Administration and Support subdivision, Hospitals and Health Facilities Registration. The regional QA officers will work collaboratively with the licensing division (see section 3.2 above) to inspect and support sites. Licensed HCT sites will be given a national HCT logo (see chapter 11) to indicate to the public that they have successfully obtained or retained their license. The three levels are described in 4.5.1, 4.5.2, and 4.5.3:

4.5.1 Site Readiness Assessment and Initial Licensing

A health facility license is a legal requirement for health facilities in Namibia[3]. All government health facilities are therefore already licensed. All NGO HCT facilities, include mobile HCT vans, should be licensed by MoHSS according to section 31 of the Hospitals and Health Facilities Act, 1994. For HCT sites planning to operate in already licensed health facilities a site readiness assessment visit is required before they can start to see clients, conduct rapid testing or be put on the national register of HCT sites. This assessment is based on whether the site meets all the ***infrastructure*** requirements set out above and uses a checklist (see Appendix 1). For sites planning to offer HCT that do not have an existing license the first visit is a combined visit by the licensing department and the DSP representatives in the region. While mobile vans will require a license, outreach services will operate under their base site license, negating the need for a registered nurse at every outreach location.

4.5.2 Annual Renewal of License

Renewal of license is also a legal requirement annually for health facilities in Namibia. These guidelines now propose a joint visit of the licensing department with the regional QA officers (as DSP representatives) at this stage. The licensing officers will conduct their usual visit and the DSP representative will confirm infrastructure has not changed and additionally focus on ***process*** measures (that standard operating procedures are being adhered to, waiting times are acceptable etc.) Sites should apply for renewal of licence three months in advance so that an appointment may be arranged and be prepared to present a copy of the previous licence to the assessors. A tool for this visit may be found in Appendix 2 at the end of these guidelines. Failure to comply with the provisions of these guidelines may result in the suspension, and/or withdrawal of the license.

4.5.3 Voluntary Accreditation

Is a voluntary process that rewards excellence. Potential 'role model' or demonstration sites may apply to the DSP in writing requesting an accreditation visit from a multidisciplinary team. Before requesting a visit, sites will have worked to ensure they meet all the standards outlined in these guidelines, have made appropriate adaptations for their circumstances and have data on ***outcome*** as well as the ***process and infrastructure*** standards as set out above. A sample tool for site accreditation may be found in Appendix 3 below and is more rigorous than that for annual relicensing as it represents all the features expected in an ideal site. Accreditation will last two years, negating the need for a DSP inspection the following year and will be rewarded by a star system (in a similar manner to that currently used in hotels).

4.6 Fees and cost sharing

Wherever possible (e.g. in public health facilities, mission hospital, mobile vans and NGOs) HCT should be available free at point of delivery. If an HCT site in the private sector charges a service fee, it should be posted clearly so that clients know in advance what it will be, and receipts should be given. NGOs wishing to practice in social marketing may charge a fee for HCT but the cost should be minimal and no clients should be denied HCT services for failing to pay the service fees.

[3] Hospitals and Health Facilities Act, 1994.

Table 6: A three step system for registration, licensing and accreditation of sites

- **Site Readiness Assessment and Initial licensing:** A health facility license is a legal requirement for health facilities in Namibia. All non government HCT facilities, including mobile HCT vans, should be licensed by the MoHSS For rapid testing sites we recommend that this initial license is issued on the basis of an assessment of whether the site meets all the infrastructure requirements. While mobile vans will require a license, outreach services will operate under their base site license, negating the need for a registered nurse at every outreach location.

- **Annual Renewal of License:** Renewal of license is also a legal requirement annually for health facilities in Namibia. These guidelines now propose a joint visit at this stage. During this stage the licensing officers will conduct their usual visit and the DSP representative will confirm infrastructure has not changed and additionally focus on process outcomes (that standard operating procedures are being adhered to, waiting times are acceptable etc.)

- **Voluntary Accreditation** is a voluntary process that rewards excellence. Potential 'role model sites' may apply to the DSP in writing requesting an accreditation visit from a multidisciplinary team. The checklist administered will be more rigorous and represent all the features expected in an ideal site.

Chapter 5: Voluntary Counselling and Testing for Individuals, Couples and Groups

VCT is a client-initiated approach to HCT. The counselling combines information given with a client-centered confidential dialogue aimed at enabling the client to know their HIV status and make informed personal decisions about HIV testing and their health. The VCT intervention is "client-focused" to the extent that the HCT counsellor focuses on the client's unique issues and circumstances related to HIV risk. The emphasis is on the initiation of small incremental behaviour change steps to reduce risk. Therefore, VCT is an intervention that builds on small incremental successes. When VCT is provided to two or more persons who intend to or currently do have a sexual relationship together, it is called couples HCT.

The VCT protocol may be found in Appendix 4. Each component has a goal and specific tasks and builds on the previous one. The protocol is accompanied by a series of questions (available as cue cards[1]) that direct the HCT counsellor-client discussion. The HCT counsellor should select questions relevant to the client.

Clients can be registered by code (anonymous unique identifiers) or by name (confidential).

5.1 Recommendations for individual VCT in Namibia

5.1.1 Pre test Counselling

Pre-test counselling assesses clients readiness to test and provides an opportunity for clients to explore their risk for HIV and learn about appropriate prevention strategies. The major components of the pre test counselling session are:

- Basic facts on HIV and AIDS where these are not known
- Discussion of benefits and potential difficulties
- Explanation of HIV rapid test process and meaning of HIV test results
- Exploration of personal HIV risk behaviour and options for reducing risk
- Assess client's readiness for HIV testing and coping strategies for a positive result.
- Exploration of support system and discussion of disclosure mechanism
- Obtaining consent for HIV testing

In addition for information for women who are planning to become pregnant should include:

- The risks of transmitting HIV to the infant

- Measures that can be taken to reduce mother-to-child transmission, including antiretroviral prophylaxis and infant feeding counselling
- The benefits to infants of early diagnosis of HIV.

Oftentimes clients who present for VCT will have thought through their decision and will have sought appropriate information about HIV and AIDS. Because of this, as well as the anxiety associated with the desire to know one's status, the pre-test counselling session should be tailored to the individual and can be very brief, omitting the review of basic HIV knowledge, whilst still ensuring that the client is ready to test and that consent has been obtained. Sometimes clients may attend VCT services to learn about HIV but do not want to receive HIV testing. Others may decide after pre-test counselling that they do not want to be tested or that they want to go away and think about testing. The service provider should accept the decision not to be tested, and encourage the client to come back for further counselling, with or without being tested.

5.1.2 Consent for HIV testing in VCT

Every HIV test should include either verbal or written informed consent. The standard in most VCT settings is verbal consent as the service is client-initiated and the act of coming for services implies consent already. Details of the consent procedure and the guiding principles may be found in chapter 12 section 2.1.1.

5.1.3 Post test counselling

All clients undergoing HIV testing must be counselled when their test results are given, regardless of the test result. Ideally, post-test counselling should be provided by the same HCT counsellor or health care provider who provided pre-test counselling. Couples should be encouraged to receive results together. The VCT protocol in Appendix 4 and the Couples protocol in Appendix 5 outlines the format of post test counselling depending on the results.

The focus of post-test counselling is to provide psychosocial support to cope with the emotional impact of the test result, facilitate access to treatment, care and prevention services, prevention of transmission and disclosure to sexual partners. It should also indicate whether there is a need for re-testing (see section 10.7) All individuals tested alone (both HIV-negative and HIV-positive) should be encouraged to return for HCT together with their partners. Counsellors should encourage and offer referral for counselling and testing of children.

Post-test counselling for pregnant women whose test result is HIV-negative should recommend partner testing or couples HCT and a re-test in the third trimester of pregnancy.

Post test counselling for pregnant women whose test result is HIV-positive should address partner testing or couples HCT as part of the package of PMTCT messages.

5.2 Recommendations for Couple HIV Counselling and Testing in Namibia

Routine HCT data from the MoHSS indicate that the uptake of HCT among couples is low. An estimated 3% of women in antental clinics test with their partners and even stand-alone VCT sites that target couples were only reporting 8% of HCT sessions being conducted with couples in 2009. Strategies to improve the uptake of HCT among couples are urgently needed in Namibia.

5.2.1 What is Couples HCT?

Couple counselling is recognized as an important and effective intervention in which pre-sexual or established sexual partners are counselled and provided with HIV test results as a couple. This encourages the couple to start planning for their future and discuss a realistic risk reduction plan that they can implement together. Details of the couples counselling protocol may be found in Appendix 5. Accompanying training materials clarify the expectations of the counsellors, who are not intended or trained to be marriage guidance counsellors. Same sex partners (homosexual) should be counseled according to the couples protocol, cognizant of the increased risk of HIV transmission in men who have sex with men (MSM) and the additional prevention counselling needs. Counsellors and health care providers should remain objective and nonjudgmental with clients regarding their personal sexual preferences and behaviours. A client-centered approach should be encouraged in which a safe environment for the client is created where they can openly discuss their sexual behaviours. Clients with multiple concurrent partners should be counseled on the risks he/she is putting to him/herself and the other partners and encouraged to refer the partners for HCT as well as to reduce the number of partners and to prevent contracting and/or spreading HIV through use of correct and consistent use of condoms.

In situations where the couples refuse to receive services together, they can be counselled as individuals, receive results separately, and then encouraged to disclose results to each other. If this happens this should not be considered as Couples HCT for programmatic as well as monitoring and evaluation (M&E) purposes.

5.2.2 Pre-test counselling for couples

Prior to receiving Couples HCT, the counsellor should establish that both parties have come voluntarily, and that they are both willing to openly discuss their risk issues and concerns, and support one another. If the HCT counsellor is concerned that one member of the couple has been coerced, or there is on-going intimate partner violence, he/she should encourage the couple to return when they are both ready for couples HCT (appropriate referral to services for IPV should be made where available and consent is obtained). Furthermore, couples receiving HCT agree to the principle of shared confidentiality, meaning that neither partner can disclose the other's test result outside the couple relationship unless it is mutually agreed upon. The counsellor should also assess the couple's readiness for testing and willingness to receive their results together. Couples should be encouraged to openly disclose their results to other relevant persons, such as their children, the family, the doctor or nurse, and they should explore the implications of doing this.

5.2.3 Consent for couples

When VCT is provided to couples, the counsellor should ensure that both partners consent to be counseled and tested together, and to receive their results together. They also agree to keep each other's test results private/confidential, to make decisions about disclosure to other persons together, and to discuss HIV risk concerns together and support one another. Details of the consent procedure and the guiding principles may be found in section 2.1.1 above.

5.2.4 Post test counselling for different outcomes in a couple

Results in couples may be concordant (where both partners have the same result) or discordant (where they do not). Post test counselling for concordant negative couples should focus on risk reduction and referral, including for additional couples counselling and for male circumcision where appropriate. Post test counselling for concordant positive and discordant couples should focus on coping and support, care and treatment options, family planning and PMTCT, disclosure and risk reduction. Relevant and accurate information about HIV/AIDS should be given and the couple helped to make informed decisions regarding their health, family planning, childbearing and safer sex. For discordant couples it should be made clear that it is a relatively common occurrence that does not necessarily indicate one partner has been unfaithful. The counselling session should include discussion of the role of consistent condom use in preventing HIV transmission to the uninfected member of the couple. Male circumcision should also be encouraged for the HIV negative males in discordant couples. Depending on the specific circumstances of a discordant couple there may be need to discuss retesting after three months and annually thereafter (see section 10.7). For example, if there has been a burst condom or they had unprotected sex.

5.3 Recommendations for Group HIV Counselling and Testing in Namibia

Group information sessions, with skilled facilitation can be used to prompt discussions on HCT prior to individual sessions by the service provider. These act to impart information, thus reducing the time spent in the individual sessions. Group education may also be a good time to discuss the benefits of couple HCT. While pre-test information giving is encouraged in a group context counselling is not. Trying to provide the full HCT package to groups of individuals poses too many challenges to counsellors. It is difficult for them to ensure confidentiality, to conduct client-centered counselling and to ensure that individual client needs are met. The exception to this is when counsellors conduct HCT in home-based settings (see chapter 7) where household groups may be counselled and tested together in their own homes at their request.

5.3.1 Group pre-test education sessions

Giving HIV information to a group can be a time saving way of passing information about HIV/AIDs that maximises opportunities while people are waiting for services (such as during health talks). It is also used when sites experience very high rates of client flow such as during National Testing Days. This may be done face to face or through video or other means.

5.3.2 Families that come for testing

Occasionally family groups present to VCT sites and this may require counsellors to have additional skills in counselling and testing children. More information may be found in Chapter 8 on consent, guardianship and disclosure for children. The impact of the knowledge of status on the family as well as its individual members needs to be assessed in pre-test counselling alongside the potential advantages of a family approach. See also chapter 7 on home-based HCT.

5.3.3 Peer groups that come for testing

School, workplace and institutional testing venues find themselves presented with peer groups. While group pre-test information is useful individual or couple counselling should be the norm. When assessing a client's

readiness to test counsellors should take into account whether the individual is under pressure from peers to test. They should also be aware of the risk of inadvertent disclosure to a waiting group for example through spending longer with positive than negative clients.

5.4 Referral and Linkages

HIV test results must be communicated with an explanation of services available and necessary to ensure the health of the patient. Community-based HIV prevention, treatment, care and support services are especially important resources. It is important for VCT sites to establish and maintain collaborative mechanisms with these services. At a minimum, referral should include providing the client with information about whom to contact as well as where, when and how to contact them. Counsellors should be familiar with the services to which they refer their clients. This is particularly important for mobile, outreach and home-based HCT services. Client referral works best if the service provider makes contact in the presence of the client (for example by telephone) and schedules an appointment. Some counsellors may physically escort clients to a referral point. Staff within the referral network need to routinely inform each other of changes in personnel or processes which could impact upon the referral of clients.

5.4.1 Community linkages

VCT site teams should map out all possible linkages in the community as a tool in planning partnerships and clinical collaborations. Community-based linkages include networking with church leaders, traditional healers, traditional leaders, youth leaders, partners of PMTCT clients, peer educators, community home-based care groups, AIDS Committees, community based organizations, faith based organizations, nutrition support organizations and men's groups. Support groups for people living with HIV and AIDS and those that specifically work with discordant couples , are also extremely important referral points. These support groups should develop close links with VCT sites, and make plans for cross referrals. Additionally this means that PLWHIV will be involved in the planning and implementation of VCT services. Some VCT sites may wish to establish post test clubs. These clubs comprise of clients who have undergone counselling and testing regardless of their HIV status. They are a forum to promote behaviour change as well as to increase knowledge and demand for HCT.

5.4.2 Follow-up counselling, care and support

When possible, follow up counselling should be provided to both HIV negative and HIV positive VCT clients. This is especially important for HIV-sero-discordant couples (where one partner is HIV-positive and one HIV-negative). Follow-up counselling can empower the HIV negative clients to continue with their risk reduction strategies and receive re-testing as necessary. It can also encourage uncircumcised men to consider voluntary MC. Some HIV negative individuals who are at risk may need to return for retesting (see section 10.6). Those who are HIV positive will be offered support for disclosure to their partners, or may receive couples HCT. HIV positive clients and patients will also receive support to reinforce their positive prevention strategies to enable them to live positively. These clients should be referred for appropriate services such as treatment for opportunistic infections and sexually transmitted infection (STI) as well as TB management, PMTCT, sexual reproductive health services such as family planning, nutrition and psychosocial support. VCT counsellors may also offer adherence counselling. Clients that need on-going support should be referred to therapeutic counsellors and or a programme for 'prevention with positives'.

5.4.3 Referral from mobile, outreach and home-based VCT

Mobile and outreach VCT organisers need to make plans for eventual referral right from the outset. As they plan the programme they need to establish what the existing referral network is, create a referral directory and visit individual sites. A planned date for return visits by the counsellors to the same area will allow for follow up counselling, re-testing after the window period and in some cases tracking of referrals (see chapter 7 on home-based testing).

Chapter 6: Provider Initiated HIV Testing and Counselling

Provider Initiated HIV Testing and Counselling (PITC), refers to HCT recommended by health care providers to persons attending health care facilities as a standard component of medical care. In particular, in high HIV prevalence settings like Namibia, PITC provides an opportunity to detect HIV infected individuals who may present for other health care related purposes. PITC should be integral to clinical management and care in all health facilities. It is recommended that PITC be conducted in-room by the health care provider that initiated the discussion (doctor or nurse).

6.1 Settings for PITC in Namibia

HCT should be recommended by health care providers as part of the normal standard of care provided to the patient, regardless of whether or not the patient shows signs and symptoms of underlying HIV. It should be recommended in medical and surgical services, public and private facilities and inpatient and outpatient settings. The PITC approach is suitable for adults (individuals and couples) and children. Priority settings for PITC in Namibia are outlined in 6.1.1 – 6.1.5

6.1.1 Medical wards and other clinical settings

Hospital medical wards and other clinical settings may have a high concentration of patients with HIV who would benefit from diagnosis, treatment and care. At a minimum, HCT should be prioritized and recommended to all patients admitted to hospitals and other inpatient facilities. PITC should also take place in outpatient settings.

6.1.2 Tuberculosis clinics

TB is the most common serious infectious complication associated with HIV infection in Namibia. HCT should be offered routinely as part of the standard of care for all TB patients. Similarly, TB screening using the standard questionnaire[1] should be offered to every client counseled for HIV. Where possible partners of TB patients and suspects should be counselled and tested for HIV.

6.1.3 Antenatal, childbirth and postpartum health services

HCT should be recommended to all women of unknown HIV status during antenatal care and in labour wards. If an HIV test has not previously been performed, HCT should also be recommended during postpartum. This

[1] National Guidelines for the Management of Tuberculosis, 2nd Edition 2006

should be done at booking and repeated for HIV negative women in the third trimester. It is recommended that all male partners attend ANC with their female partners, in order to receive HCT together with their partners at the first ANC visit. If men cannot attend on the first ANC visit, they should be encouraged to attend as soon as possible, so as to maximize the prevention benefits of HCT, and prevent infection to female partners and their babies. Family planning may also be integrated into couples HCT services in ANC, childbirth, and postpartum health services.

6.1.4 STI Services

HCT should be recommended to all patients presenting with STIs at their first presentation for treatment, 3 months after any identified exposure and annually if they are re-infected. STI patients should also be offered couples HCT with their partners.

6.1.5 Male Circumcision (MC) services

HCT should be offered as a standard practice to all men seeking male circumcision as a means of preventing HIV infection. Conversely, men seeking HCT should be educated about the benefits of MC on HIV prevention. Men should be referred for male circumcision services as appropriate. Men receiving MC should be offered the opportunity to receive HCT together with their partners, to maximize the prevention benefits of HCT.

6.2 Recommendations for PITC in Namibia

The PITC protocols for Namibia may be found in appendix 6. Two flow charts are included: one for in-patient and one for out-patient settings since these vary.

6.2.1 Pre-test counselling for PITC

The pre-test discussion in PITC is shorter and focuses on information giving, the diagnostic need for testing and the rationale.

6.2.2 Consent for PITC

PITC is neither mandatory nor compulsory. It incorporates the informed right of the client to decline the recommendation of an HIV test. The norm for PITC is verbal consent (see section 2.1.1) but the provider should indicate in the health passport that the consent has been discussed. This is particularly important in the context of child testing.

6.2.3 Performance of rapid testing by health care workers

In-room testing by trained and certified health care workers, (see section 4.1) is preferable as it enables the provider to initiate HCT and immediately perform the test in the consulting room or ward. Some providers may prefer to send samples to the laboratory where this option is available. Where HCT counsellors are located within a health facility and providers feel that a more in depth pre-test assessment is required they may continue to refer clients to onsite HCT facilities where there are HCT counsellors specializing in this area.

6.2.4 *Post-test counselling for PITC*

Post test counselling for negative patients is very brief in PITC and focuses on the need for partner testing and basic prevention messages. Positive patients are given appropriate treatment for their presenting conditions and referred for on-going care and treatment. The post test counselling session resembles that in VCT and details may be found in the protocol (appendix 6). After discussion with the patient about the benefits of this approach, PITC service providers should record the result in the health passport

6.2.5 *Counselling partners and couples in PITC*

Patients who receive PITC services should be encouraged to re-attend with their partners. This is particularly important with STI patients and with pregnant women. Couples HCT can equally be offered in this setting. The couple's protocol in Appendix 5 may be used.

6.3 Recommendations for PMTCT in Namibia

The full details of the PMTCT (Prevention of Mother-to-child transmission of HIV) protocol may be found in the National Guidelines for Antiretroviral Therapy[2] and the points outlined in 6.3.1 – 6.3.5 should also be noted:

6.3.1 *HIV counselling and testing in antenatal care*

In Namibia HIV counselling and testing in PMTCT settings is routinely offered in the first trimester of pregnancy and again later in pregnancy if HIV status is unknown. 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 to ensure that acute HIV infection is not missed. Correct knowledge of status is the cornerstone of all interventions to reduce mother to child transmission (MTCT) of HIV. HIV testing and counselling should be initiated by the health care provider (provider initiated).

6.3.2 *HIV counselling and testing partners of pregnant women*

All pregnant women should be asked to attend with their partners for testing. Strategies to increase rates of partner testing (for example invitation letters and incentives such as being seen first in the queue) should be actively considered by programmes.

6.3.3 *HIV counselling and testing in labour wards*

Health care facilities with provisions for labour wards should ensure availability of HIV testing and counselling services. The MoHSS recommends performance of rapid HIV testing during labour, if the woman's HIV status is unknown. The rapid test used is an HIV antibody test that gives a result within 20-40 minutes. A positive result allows for safer delivery practices to be adopted, and for appropriate antiretroviral drugs to be administered during labour and delivery and to the infant.

[2] National Guidelines for Antiretroviral Therapy, Third Edition, MOHSS July 2010

6.3.4 HIV testing and counselling during the post natal period

Women who have not been tested for HIV in pregnancy or in labour, should be offered HIV counselling and rapid HIV testing in the immediate post partum period. Within 72 hours after delivery, there is still a window of opportunity to offer PMTCT interventions that include antiretroviral (ARV) prophylaxis to the infant. Additionally, the mother can benefit from counselling on safe infant feeding options.

6.3.5 Follow up for the HIV exposed infant

Infants of HIV positive mothers should be put on co-trimoxazole preventive therapy until their HIV status is known. Once diagnosed HIV positive infants should be commenced on ART as soon as possible. Procedures for early infant diagnosis are outlined in the full in the latest National Guidelines for Antiretroviral therapy and summarized in section 10.11.

Table 7: Provider-initiated HIV counselling and testing (PITC): Summary

HCT should be recommended by the health care providers as part of the normal standard of care provided to the patient, regardless of whether or not the patient shows signs and symptoms of underlying HIV. It should be recommended in medical and surgical services, public and private facilities, inpatient and outpatient settings. The following should be considered priorities for PITC in Namibia:

1. **Medical Wards:**
   Hospital medical wards usually have a high concentration of patients with HIV who would benefit from diagnosis, treatment and care. HCT should be recommended to all patients admitted to hospitals and other inpatient facilities.

2. **Tuberculosis clinics:**
   TB is the most common serious infectious complication associated with HIV infection in Namibia.

3. **Antenatal and MCH and Family Planning services:**
   HCT should be recommended to all women of unknown HIV status at booking, in the third trimester and post partum.

4. **STI Services:**
   HIV testing and counselling should be recommended to all patients presenting with STIs at their first presentation for treatment, 3 months after any identified exposure and annually if they have recurrent STIs.

5. **Male Circumcision:**
   HCT should be recommended to all men seeking circumcision as a means of preventing HIV infection. Conversely, men seeking HCT should be educated about the benefits of MC on HIV prevention.

Chapter 7: Home Based HCT

Home-based HCT is when HCT is carried out in people's homes by trained HCT counsellors. It is a popular and highly acceptable approach to HCT in many sub-Saharan African countries. Home-based HCT is a family-focused approach that is relatively new to Namibia and the guidelines below are intended to guide programmes getting started.

7.1 Models of home-based HCT

There are a number of different models for home-based HCT.

7.1.1 Door –to-door (D2D)

The main purpose of home-based HCT in Namibia is to bring HCT services to households in densely populated areas of high HIV prevalence.

7.1.2 Index patient

As Namibia has a high HIV and TB prevalence, home-based HCT may also be expanded to target family members of known HIV positive patients and/or TB cases. The consent of the 'index' patient needs to be obtained before home visits are made.

7.1.3 Part of existing home-based care services

Home-based HCT may be conducted as part of a home-based care program. While the advantages of this approach are that it facilitates linkages and referrals it may require additional training, extended roles and in some cases is hard to sustain without significant external funding.

7.2 Requirements at national level

Home-based HCT may be incorporated as a programmatic strategy by organisations and agencies with sufficient capacity, appropriately trained staff, and high quality control standards.

7.2.1 How are organisations authorised to conduct home-based HCT?

Organisations wishing to do home-based HCT must obtain written authorization from the MoHSS. In order to obtain this authorisation they must demonstrate how they plan to meet the standards set out in these guidelines. Additionally they must show evidence that:

1. Personnel levels are adequate:

a. There will be a minimum of 4 certified and experienced counsellors trained according to the MoHSS curriculum in counselling and the approved HIV rapid testing curriculum.

b. A minimum of one team leader/senior counsellor who is available on the site or area where the counselling is being conducted. For larger programmes there should be one team leader/senior counsellor for every 10 counsellors.

c. One community mobilizer

2. Infrastructural requirements met (see Section 4.2 A written plan of intent is sufficient at the outset.

3. Laboratory supervision mechanisms are in place. A named laboratory technologist with expertise in HIV rapid tests who will be responsible for consultation and technical support supervision as well as on-site support and ensuring providers take part in External Quality Assurance.

7.2.2 Who can conduct home-based HCT?

Individual home-based HCT service providers must be certified in rapid testing and should be trained in counselling according to the MoHSS 12 week curriculum or equivalent. Additional training for conducting home-based HCT is highly recommended. Home-based HCT tends to be more complex than traditional VCT/PITC and includes the need to counsel a range of clients – couples, children, adolescents with potential need to negotiate gender dynamics and other challenging domestic circumstances. Rapid testing occurs under less than favorable conditions and additional experience will benefit the counsellors.

7.3 Programme Planning

Since home-based HCT may be conducted in a place far from an HCT facility or from organisation head quarters careful pre-implementation planning is required to ensure a successful programme.

7.3.1 Choice of location and timing of rotations

Organisations authorised to conduct home-based testing must liaise with the Regional Management Team and District Coordinating Committee (DCC) when selecting geographical areas for service provision so as to avoid overlap with other home-based, mobile, or outreach HCT activities and to fit in with the regional strategy for health. Recipients of home-based HCT should be linked with follow-up HIV prevention, care, treatment, and support services (see section 7.7) and for this reason a geographical location should be chosen that has at least one accessible ART delivery point.

Community sensitisation is required as a first step in home-based HCT (see section 7.4). An initial detailed mapping exercise, where the location and inhabitants of individual households are mapped can help in planning. Mapping allows for Home-based HCT services to be provided in a systematic manner. This is particularly important in the door-to-door model and when high coverage rates of households in a given area are required. The differences between rural and urban settings should be taken into account when planning. For example, the counsellors in urban areas may be allocated a particular street to ensure maximum coverage. Before moving to another place a recap is done, where people who had been missed are offered an opportunity to test. This happens from street to street or from village to village and reports are done before moving on.

Home-based HCT requires return visits. After the first visit to a household the counsellors may be asked to return. A return visit is often necessary to meet members not available on the particular day of the first visit (for example if they are at work or away from the house). Other people may have requested a return visit while they make a decision about testing, await the return of the head of household or when they are at the end of the window period. For this reason counsellors may require additional visits to selected households. Some programmes have at least one weekend day when they visit homes so that they are able to find families together in the home. Additionally, return visits allow for follow up and tracking of referrals and counsellors can assess if individuals have been able to attend the referral point in the interval.

7.3.2 Logistics, supplies and waste disposal

Careful planning can make the difference between a successful programme and chaos. In home-based HCT the supplies of kits, consumables and reagents should be the same as for any HCT settings as set out in section 4.2. Attention needs to be paid that test kits do not exceed stated temperature recommendations during storage and transport. As with any HCT, the testing area must be clean, washable and flat and placed in a well ventilated area. In addition to the usual supplies required for testing the following may also be required:

a. Cool boxes
b. Thermometers (to check the temperature in the cool box at the hottest time of day)
c. Torches for counsellors
d. Plastic sheets that can be spread out on a flat surface or alternative testing surface such as a plastic cutting board
e. Portable sharps disposal containers
f. Portable biohazard waste containers.
g. Rain gear
h. Timer or watch
i. Soap/hand sanitizer and paper towels
j. Backpack
k. Water bottle
l. Mobile phone
m. HCT job aids / counselling cue cards
n. Home-based HCT protocols

7.3.3 Security and transport

Rural and urban areas pose quite different challenges in HCT in Namibia. In both settings it is advisable for counsellors to work in pairs (as far as possible this should be one male and one female counselor). Counsellors should have at least one mobile phone in each pair. In rural areas counsellors may find themselves walking in the heat between homesteads in a particular area. They should be prepared for carrying equipment and that they may encounter animals, including snakes. They may find they need extra drinking water. Counsellors and supervisors should plan for services to finish before dark and for secure means of transport to where they will be spending the night. In urban and more densely populated areas counsellor safety and comfort still need to be considered in planning. Counsellors are also vulnerable to sexual abuse and allegations against

them. These are additional reasons to recommend that they work in pairs. Finally working in pairs will help counsellors to strategize and problem solve when facing challenging counselling issues, home environments, or other difficult situations.

7.4 Community and home-entry protocols

The support of the gatekeepers and opinion leaders in the community is critical to the success of any home-based HCT programme. Organizations, through the community mobilizers, need to contact community elders, religious leaders and traditional chiefs well in advance of any programme starting in their area. A supportive community leader can make the difference between no one accepting testing and almost everyone accepting it. Finding leaders that will champion home-based HCT can make a strong impact and help boost the uptake of services. Use of community theatre, performances or community events can also help to promote the service.

As part of testing counsellors also need to enter homes and it is critical that they do this in keeping with community norms. In most communities, providers enter the home or compound using the main gate, follow the demarcated route to the house, knock on the house door and wait to be welcomed. The service providers need to introduce themselves and the Home-based HCT package. In some settings the community mobilizers may accompany the Home Based HCT service providers to the household and introduce them.

7.5 Recommendations for home-based HCT

It is recommended that the household receive information about HCT as a group. This may include couples, polygamous groups, children and disabled family members. Counsellors should familiarize themselves with the appropriate sections of these guidelines (couples: chapter 5; child testing: chapter 8; special circumstances: chapter 9). It is not always clear who qualifies as a family and a broad view defined as 'those who eat from the same pot' might include extended family members and neighbors. The program should clearly define who should be tested – some programs may decide to offer testing to anyone who is present at the home when the counselor arrives. Other programs choose to only test individuals who have resided in that home for a certain number of months. A decision at program level will help counselors to efficiently determine whom to test when entering homes.

7.5.1 Pre-test

In addition to the pre-test counselling normally conducted the counsellor should explain the purpose of the home based Home-based HCT program and the benefits of knowing HIV status as a family or couple. They should reassure the household of confidentiality taking into account additional aspects posed by the shared confidentiality in family groups, couples and multiple concurrent partnerships. This should include an explanation that confidentiality will not be broken unless they perceive the client to be a danger to themselves or others. When discussing disclosure the household and counsellor may together make a joint plan for how this will be done (for disclosure to children see chapter 8). When discussing risk reduction it is important for counsellors to use their discretion with condom demonstration since this may not be pertinent to all household sessions or household members.

7.5.2 Consent

The same consent procedures apply for HCT in the home setting as in any other. Counsellors should be aware that some members may be uncomfortable giving consent to testing in the absence of the head of household and should arrange another time. All the HIV tests done at the households must be done with the client's knowledge and consent and all the clients tested and counselled are free to give their consent or decline the test.

i. The consent should be verbal and documented in the client's notes (see section 2.1).
ii. For adults who are unable to consent due to acute confusion or mental conditions the family members should be advised to take them to a clinical setting for PITC.
iii. People who are visibly intoxicated from alcohol or other substances are not able to give consent for HCT. They should be asked if they wish a return visit.
iv. For children the guidelines in chapter 8 apply.

7.5.3 Testing

The same conditions and algorithm apply to testing as in all HCT settings (see chapter 10). Particular attention should be paid to adequate lighting and to appropriate waste disposal. Test kits that use oral fluid instead of whole blood or serum may be most appropriate as these do not require sharps disposal and are easily transported.

7.5.4 Post test counselling

Individual adults are given their results individually. Access to HIV test results shall only be available to members of the household who have agreed to test and receive the results together as a family or couples. In cases where couples are counselled and tested together consent for disclosure to the partner is given during contracting. Disclosure to a third party (such as to their children) can only be done after obtaining a written consent of the couple. All individuals, couples and parents/guardians living with children must be counselled after their test results are given, regardless of the test result. The content of post test counselling follows the VCT protocols for HIV negative and positive results. Confidential referral to appropriate services should be made (see section 7.7).

7.6 Recommendations for data collection in home-based HCT

The routine HCT data register should be used in home-based HCT. Additional data should be collected for planning purposes. This should include the street address or a description of the location (locator information), the named referral points and if and when a return visit is planned. It should capture family and group testing. Individual household members and whole households who decline testing should also be recorded to enable future visits if requested and the coverage rates to be calculated.

Since the data include locator information the issue of data security is key. Programmes must plan for how counsellors will safely move around with data, and how and where it will be stored securely in the field.

7.7 Referral

Referral is a very important part of home-based HCT and all sites for referrals that include treatment, prevention, care and support services should be mapped out. Services should have capacity to absorb new clients/patients generated by the home-based HCT. Organisations conducting home-based HCT as well as individual counsellors should familiarize themselves with the referral system and visit the referral sites before making referrals. This will enable them to find out more about the available services, meet the carers and develop a list of referral points. Home-based HCT should only be conducted in areas where referral to an ART clinic is possible. Counsellors in home-based HCT services have a unique opportunity to revisit households and this can enable them to assess and track referrals.

7.8 Quality Assurance of Home-based HCT

Home-based HCT programmes should have quality assured testing. EQA for testing should be done on an individual provider basis using proficiency panels as for PITC providers (see sections 4.1.2 and 10.11). Each provider must conduct one panel annually to remain registered. Quality assurance measures should also be designed for counselling. Observed practice, client interviews and counsellor self assessment may be used for quality assurance.

7.9 Special circumstances

7.9.1 Alcohol

Individuals who are drunk are not fit to give informed consent and should therefore not be offered home-based HCT. Counsellors should explain this and if possible make an appointment to see them at another time (see section 7.5.2). Counsellors should be aware that drunk household members could become combative, particularly when discussing sexual risk behaviour.

7.9.2 Violence

Counsellors may come across violence in the home and are responsible for ensuring their own safety and that of their clients. If counsellors feel that they are at risk they should leave and contact their supervisor about the next steps. Counsellors should evaluate the risk of intimate partner violence or domestic violence before testing and not test if they feel the test results could worsen the situation for an individual, couple or family. With consent appropriate referral to organisations dealing with violence, including gender-based violence, should be made. In certain circumstances, where the counsellor feels an individual may be a risk to others they may need to break confidentiality as regards the violence in the home. This is already a routine part of 'contracting' with the clients as outlined in section 7.5.1.

Table 8: Home based testing: Summary

- Home-based HCT is new to Namibia and initial programmes will target densely populated areas with high prevalence.
- Home-based HCT tends to be more complex than traditional VCT/PITC and includes the need to counsel a range of clients – couples, children and adolescents with a potential need to negotiate gender dynamics and other challenging domestic circumstances.
- HIV rapid testing in the home setting follows national algorithms and External Quality Assurance systems.
- Community mobilization, the support of community leaders and community entry processes are critical to the success of home-based testing programmes.
- Home-based HCT involves a family centered approach.
- The logistics, location and return visits for home-based HCT need careful planning.
- Counsellors should work in pairs.

Chapter 8: HCT for Children

According to international conventions[1] to which Namibia is a signatory, as well as the Children Status Act of 2006, "the best interests of the child shall be a primary consideration" in all actions concerning children. This includes decision-making about medical care.

In Namibia, anyone who is aged 16 years or above is considered able to give full informed consent for HCT. For children below the age of 16 a parent or legal guardian's consent is required for testing unless the child is considered to be a mature minor. The HCT counsellor should assess the minor's maturity to receive HCT services. Young people under 16 years of age who are pregnant, parents, or engaged in behaviour that puts them at risk or have a STI should be considered **"mature minors"** who can give consent for HCT. In some cases the counsellor may feel that a minor is mature but they do not meet the criteria listed above. Alternatively the minor may meet the criteria but the counsellor has concerns about their ability to cope with the results. In these cases the HCT counsellor should discuss the case with their supervisor or a more senior counsellor before making a decision.

Consent for testing should be carefully documented with children. This may be written consent or documented verbal consent. This latter should include the date, names of person(s) consenting and name and signature of counsellor/health care worker written in the health passport or health records).

- For infants under 18 months: The guardian/parent consents for the child.
- For younger children aged 18 months to ten years: The parent/guardian consents. However, the child may be allowed to participate in the counselling session.
- For older children from ten to sixteen years: The parent/guardian consents and ideally the child assents. The parent/guardian should be involved in the counselling and testing session even if the child assents.
- For mature minors the minor gives verbal consent and the counsellor documents that they have assessed them to be a mature minor. The parent/guardian is usually not involved in the counselling session unless the minor specifically requests this.

8.1. VCT

Deliberate efforts to attract adolescents and youth to VCT sites should be expanded in Namibia. Since young people might be reluctant to attend HCT services where adults are also receiving the same services, the number and coverage of "youth-friendly" services should be strengthened and scaled up. Specially trained youth HCT counsellors and peer educators should work with this age group when possible, and offer flexible hours and modalities of service. HCT counsellors providing services to adolescents and youth should receive additional training on the unique issues related to HCT among this group.

[1] UN Convention on the Rights of the Child; African Charter on the Rights and Welfare of the Child

As a result of these youth-friendly policies a number of mature minors will present for testing, and provided they meet the criteria outlined above should receive appropriate HCT.

If a child is brought to a VCT site for testing by their parent(s) or guardian, the HCT counsellor should meet with them to determine the reasons for testing. The welfare and health of the child must be the primary concern when considering testing a child for HIV. If the HCT counsellor feels that testing is not in the best interest of the child (for example would mean that they were not able to be adopted into a family) then the HCT counsellor reserves the right to refuse testing. HIV-exposed infants under 9 months should be referred for HIV DNA PCR (section 10.12). Children between 9 and 18 months may receive antibody testing in the first instance and if this is negative and the child is no longer breastfed a negative result can be given out. Children over 18 months may receive antibody testing at VCT. Counselling should accompany testing and the counsellor should assess if testing is in the child's best interest. The counsellors should be conversant with the national algorithm for testing infants and children so they are able to explain it clearly[18]. If HCT goes ahead then counselling should be provided to both the child and the parent or guardian as appropriate. Children showing signs and symptoms of HIV infection should be referred for HIV testing at the nearest care and treatment centre, communicable disease clinic or ART clinic where they will be able to receive appropriate medical care.

8.2. Provider Initiated Testing and Counseling

The early initiation of ART in children results in greatly improved child survival. These guidelines recommend that HIV counselling and testing services be offered to all HIV exposed infants (including those whose mother's status is unknown) and all children and adolescents seeking health care in Namibia so that those who are HIV positive may be identified early and have timely access to treatment. This also applies to children admitted as inpatients as well as those attending outpatient departments, clinics and other health facilities.

8.2.1 Consent when testing children in PITC

As minors, children below the age of 16 years cannot legally provide informed consent (see the exception of mature minors above). This falls to their parents or legal guardians. Health care providers should document in the health passport that consent has been obtained. Where there is no parent or legal guardian available to provide informed consent, health care providers should seek informed consent from an individual (sometimes known as a "substitute decision-maker") who has authority under the law to make a decision based on the best interest of the child. If there is a clinical need for testing this may be the doctor in charge of the child's medical care.

HIV exposed babies from PMTCT programmes will be routinely offered HIV testing and consent should be obtained from the parents or guardians. All unwell children who have been hospitalised or treated in out-patients should also receive HCT with the consent of their parents or guardians.

8.2.2 Refusal of consent when testing children in PITC

Mandatory testing should be avoided, however it may be a violation of the rights of the child if the caregiver's refusal to permit testing results in life-saving interventions being denied. In Namibia there are legal procedures for over-riding an unreasonable parental decision[2]. Health care workers need to understand both what is in the best interests of the child and when it is their duty to provide testing for children. Health care workers

[2] Section 20 (6)-(7) of the Children's Act

should also be sensitive to the fact that recommending testing for an infant or young child often implicitly tests that child's mother and that parents may refuse to allow testing based on this or other reasons. Often both parents need to be supported in making the decision to test their children.

8.2.3 HIV tests kits used for children in PITC

A summary of this may be found in section 10.12 of these guidelines and more detail may be found in the National Guidelines for Antiretroviral Therapy[3].

8.3. Communicating HIV results to children

Children who are aware of their HIV infection have better psychological health and due to the improved adherence to antiretroviral medicines, a benefit to their physical health. Disclosure of HIV results to children is a process rather than a one-time event and is ideally done in the context of care and treatment by people that the child already has a relationship with. How this disclosure is done needs to take into account the age and the level of development of the child. Training on HIV disclosure should be provided to all service providers interacting with the family, particularly those tasked with this responsibility in any specific clinic. HCT counsellors should determine with the parents/guardian in advance whether the results will be disclosed to the child and, if so, how it will be done. The parents/guardians are the ones who will face the consequences of disclosure of HIV status to a child at home and in the community and should therefore be comfortable with and supported in their decision to disclose. If there is no parent/guardian involved, the HCT counsellor determines the child's readiness to receive results and arranges for the child to have a support person preferably a community health worker within that area present.

The result of HIV testing is the property of the child tested and shall not be disclosed to third parties other than parents/guardians unless clearly in the best interest of the child. Service providers should ensure that the parents or legal guardians are intimately involved with all issues pertaining to the child's illness including the disclosure process. Parents or legal guardians of HIV positive children should be counselled about HIV so that they develop better understanding of the child's circumstances and emotional needs.

Since HIV may be acquired vertically the identification of an infected child has implications for their family. HCT should be recommended to parents and siblings of HIV-infected children, where possible and appropriate, in the form of couples or family HCT.

8.4. Special considerations

8.4.1 Orphans and vulnerable children

Orphans and vulnerable children need special attention in programs to prevent HIV as their situations may put them at high risk. Specialized training should be provided to HCT counsellors on counselling this category of children to address the multitude of psychosocial needs that they might have. In some special cases, such as child adoption, a HCT counsellor may refuse a testing request when they feel it is not in the best interests of the child.

[3] National Guidelines for Antiretroviral Therapy, Third Edition, MOHSS July 2010, p43

8.4.2 Children who have been sexually abused

Children who have been sexually abused and put at risk of HIV infection shall receive HCT and help to access appropriate services. Children presenting within 72 hours of an alleged rape should be offered post-exposure prophylaxis according to the standard PEP protocol with age appropriate doses of antiretrovirals[4]. They should be referred with their parents or guardians to the judiciary (Women and Child Protection Unit), social, counselling and other medical support services as appropriate. Tests that detect acute HIV infection (for example fourth generation rapid tests (section 10.3) may provide a useful addition to HCT services in the management of rape. More details on HIV counselling and testing after rape may be found in section 9.11 below.

8.4.3 Child-headed households

While children who are the heads of households are themselves considered mature minors (and may therefore consent for testing) they may not consent on behalf of other children in their care. In the absence of a living parent, custodial or legal guardian consent for testing reverts to the health care worker or the State and testing should only be conducted if it is in the best interest of the child and/or clinically indicated.

8.4.4 Primary caregivers who are not parents or legal guardians

For some children their primary caregiver is not a parent or legal guardian but often members of the parents' extended family and may bring children for testing. Where children require testing for clinical reasons the decision should be made and documented by the health care worker in the best interest of the child as outlined above and the results disclosed to the custodial guardian. Where children are brought for testing at VCT sites by a custodial guardian, the counsellor should assess the best interest of the child, the guardian's motives for testing and the proposed disclosure plan. They may need to seek the advice of a senior more experienced counsellor or their supervisor and should inform the custodial guardian that they will be doing this.

Table 9: HIV testing in children: Summary
• Early testing, diagnosis and treatment in HIV infected infants and children reduces morbidity and mortality.
• Testing children is more straightforward than many healthcare workers fear.
• Healthcare providers should not hesitate to initiate child HIV testing and counseling.
• These guidelines set out who is responsible for testing children and clarify age-appropriate consent and disclosure procedures. They account for the special circumstances of children without parents or guardians.
• Antibody testing is not diagnostic for children under the age of 18 months. Virological confirmation is recommended for antibody positive infants in this age group.
• Age-appropriate algorithms should be available at all testing centres, supported by well-defined standard operating procedures for laboratory testing.
• Paediatric focused HIV counselling and disclosure training and job aides will be required for healthcare workers.

[4] National Guidelines for Antiretroviral Therapy, Third Edition, MOHSS July 2010, p64

Chapter 9: Special Populations And Circumstances

These guidelines lay out the basic standards for HCT in Namibia that apply in all settings and approaches where HCT is conducted, regardless of the population or circumstance. However, occasionally populations are deemed to be at particular risk of HIV or particularly vulnerable. Some of these are outlined in this chapter so that programme managers who work with these special populations or individuals seeking guidance in a particular circumstance have somewhere to turn to.

The chapter assumes that the VCT approach (see chapter 5) is the approach that is being used, with the exception of section 9.10 (medical emergencies/seriously ill and unconscious patients) which uses a PITC approach and 9.11 (HCT for survivors of rape) that may be either VCT or PITC.

Reaching vulnerable populations requires flexible approaches that are responsive to the local circumstances and for this reason mobile and outreach services as well as extended opening hours are all approaches that have been successfully used.

9.1 HCT in prisons

HIV transmission is known to occur in prison populations in Namibia. There is little data available on HIV prevalence rates on entering prison and even less on HIV incidence (new cases due to transmission in prison). Unofficial estimates indicate HIV prevalence is high prisoners in Namibia. It is therefore recommended that HCT is made available to the whole prison community to prevent further spread of HIV among prisoners, the officers and their respective families.

9.1.1 Policy on HCT in prisons

Namibia does not have a mandatory testing policy for prisoners and no prisoner should be forced or coerced into having an HIV test. However, HCT should be routinely offered to prisoners on entry to the prison and prior to release. Systematic collection of HCT data will also act to inform prevention programmes. A minimum package of services for prison populations should include education, counselling and testing, condom information, access to care and treatment, other prevention interventions and ongoing support for prisoners living with HIV, with adequate discharge counselling. The rights of prisoners are the same as for any individual requesting to be tested, with the exception of convicted rapists where a judge has ordered HIV testing to be done. The specific rights of prisoners to access information and counselling as well as special care where needed are outlined in the Namibian HIV/AIDS Charter of Rights.[1]

[1] Namibian HIV/AIDS Charter of Rights, Nov 2004

9.1.2 Challenges for HCT in prisons

Currently condoms are not allowed in Namibian prisons but information about condoms is encouraged. Counsellors working in prisons are advised to keep abreast of any changes to this situation and to advocate for safe sex wherever possible.

Prison HCT sites should ensure the safety of counsellors during HCT sessions. For example this could include panic buttons or glass windows on counselling room doors. As the length of individuals' inmates sentence varies so does access to HIV prevention, care and support. Those with short sentences may see opportunity for life style changes on re-integration into the community and prevention messages in prison should focus on these as well as the current setting. Long term serving prisoners are more likely to benefit from ART adherence counselling and closely monitored treatment but lack psychosocial and partner support.

9.1.3 Post-exposure prophylaxis in prisons

Where available, post exposure prophylaxis following sexual exposure or abuse in prisons should be administered according to the national protocol and as summarized in section 9.11 below. This may require transfer to hospital of clinic providing PEP services and should be done within 72 hours of the reported exposure. In situations of repeated exposure and requests for PEP by a long term serving prisoner then counsellors should seek the advice of a clinician.

9.2 HCT for men who have sex with men

The role of sex between men in sub Saharan Africa has only recently gained recognition as a potential target for HIV prevention. MSM have a much higher HIV prevalence than the general population in Namibia, as in the rest of Africa. Men frequently have concurrent partnerships with women and the HIV epidemic in MSM is closely related to that in the general population. Many MSM would not self-identify as such. Understanding MSM behaviour and providing HCT counsellors with skills to more effectively provide HIV risk reduction are key public health targets.

HCT counsellors and clinicians face challenges due to social stigma surrounding MSM behaviour, may lack skills in working with MSM and may find it hard to put aside their own values and attitudes when seeing clients. Current counselling training and service provision through VCT approaches have focused almost exclusively on heterosexual HIV transmission. New approaches as well as additional training for HCT counsellors dealing with MSM on a more regular basis are required. In order to maximize the prevention opportunities of HIV counselling and testing MSM should be offered couples HCT (see section 5.2.1).

HCT services should be offered unconditionally to MSM if they confidentially disclose their sexual orientation to providers. While sodomy is considered a common law crime in Namibia, there is no law against homosexuality or against coming for HCT with a same sex partner. However, fear of disclosure may be a significant factor discouraging, MSM from presenting for HCT as individuals or as couples.

The following should be considered when setting up MSM-friendly services:

- Creating safe spaces where men can talk openly and receive STI care and counselling.
- Targeting sexual partners through exploring sexual networks
- Securing the participation of members of the MSM and implementing peer education

- Conducting outreach and education at centres/meeting places where MSM go.
- Raising HIV and HCT awareness among MSM using internet dating sites
- Provide free or affordable HCT and STI services.
- Provide lubricant for use with latex condoms, or provide alternative condoms and lubricant for anal sex such as the 'female' condom.
- Additional training on values and attitudes towards MSM may be required. Counselling sessions may need to be modified from the traditional HCT protocol to ensure that:
- Sessions assist MSM to assess the possible contribution to sexual risk of:
- substance use behaviours (e.g. alcohol and drugs).
- personal vulnerabilities (e.g. internalized stigma, depression, forced sex, economic hardship).
- social vulnerabilities (e.g. discrimination, commercial sex environments, geographic distance from home).
- Sessions address sexual health (such as risk practices, condom use and STIs); personal beliefs (enhancing self-esteem and empowerment) and structural factors (e.g. criminalization of homosexual sex; poor access to STI services).
- Risk reduction counselling takes into account knowledge of practices and ensures that counsellors are comfortable discussing sex between men.

9.3 HCT services for male and female sex workers

Because of high HIV prevalence rates among both male and female sex workers, HCT counsellors should include addressing risk reduction issues, promoting and distributing condoms and disseminating information about HIV/AIDS to sex workers. The following should be considered:

- Integrate HCT into activities/centres (e.g., rehabilitation centres) where sex workers go for income-generating activities (small-scale projects that provide alternative income).

- Establish user-friendly HCT services targeting sex workers, their clients, shebeen and brothel owners, or managers. More accessible services might be required to be open in the evenings ('moonlight VCT') and/or provided through outreach VCT.

- Involve sex workers, their clients, health officials, law enforcement officers, community leaders, the media and the community in the process of establishing HCT services.

- Provide free or affordable HCT and STI services.

- Integrate HCT services into other health services attended by sex workers e.g., STI, FP services.

- Implement peer education e.g through the use of retired sex workers to promote peer counselling and benefits of HCT; involve them in the leadership of the HCT program and in the community.

- Implement mobilization and educational campaigns to promote HCT among sex workers.

- Encourage couples testing with the long-term partners of sex workers.

9.4 HCT services for refugees and displaced persons

Refugees are vulnerable to HIV infection due to economic and social insecurity. Most refugees and asylum seekers do not have access to HCT and do not know their HIV status. The main risk factors for HIV transmission among refugees include sexual abuse, rape, coercion in the form of exchanging sex for food, and prostitution. The following should be considered:

- Provide outreach/mobile HCT services to refugee populations.
- Address cultural issues by providing culturally specific education videos about sexuality, relationships, HIV/AIDS and other STIs produced in the refugees' local language.
- Promote partner reduction and free condom distribution and simultaneously create rapport and promote HCT services.
- Referral for post rape care as indicated in section 9.11.

9.5 HCT for Mobile Populations

Mobile populations such as truck drivers, fishermen and migrant workers are at risk of HIV infection and therefore counselling and testing services as well as other prevention programs should be made available to them at convenient locations such as truck stops, harbours and workplaces.

9.6 HCT for military or uniformed persons

Uniformed personnel in Namibia such as the military or police, represent mobile high risk populations. Counselling and testing services should be provided for these groups. The following should be considered:

- Establishment of counselling and testing services in all military and police health facilities that provide services to uniformed personnel and their partners.
- Provision of Outreach/mobile HCT services where static services are unavailable.
- Integrating MC with HCT where possible.
- HCT promotion among uniformed personnel.
- Availability of effective referral to care and support.
- Partner/spouse referral

9.7 HCT for people with disabilities

- HCT services shall be wheelchair accessible wherever possible.
- HCT service shall accommodate the special needs of people with visual impairments by adopting appropriate media of communication.

- Since sign language is a separate language, HCT services shall be provided for the deaf either through an interpreter, through training of HCT service providers in Namibian sign language or through the training of deaf HCT service providers in rapid testing.

9.8 HCT for people with learning difficulties

People with learning difficulties require special care when providing counselling and testing services, particularly regarding communication of the results.

The welfare of people who are seriously mentally challenged should be the primary concern of the HCT counsellor when HCT is requested. The HCT counsellor reserves the right to refuse testing if he or she feels that the testing is not in the best interest of the client. HCT, however, can be provided in the company of a legal guardian if considered to be in the best interests of the client.

9.9 HCT, drugs and alcohol

HCT services must not be provided to clients who are intoxicated with alcohol or other drugs because they cannot give informed consent. Counsellors should explain this to the client and a return appointment should be offered. Some clients may drink some alcohol before HCT deliberately to calm their nerves; it is the counsellors' responsibility to determine if the client is able to provide informed consent and can handle the results. Counsellors should be aware of the signs of acute intoxication that include smelling alcohol, staggering walk and slurred speech.

Both alcohol and drugs increase risk taking behaviours and have been associated with increased rates of HIV transmission, both in heterosexuals and MSM. Drinking alcohol is a common social behaviour and may be used to overcome natural inhibitions when meeting people. Alcohol use precedes a large proportion of unprotected sexual encounters with casual partners. Counsellors should therefore be specifically aware of the impact of alcohol and able to assess problem drinking and its potential to undermine risk reduction planning. Training for a Brief Motivational Intervention (BMI) can help counsellors learn practical counselling skills to assist clients in decreasing alcohol and drug intake over time.

9.10 HCT for Medical emergencies/seriously ill and unconscious patients

Critically ill or unconscious patients may not be able to provide informed consent to HCT. In such circumstances, and in line with international practice, the patient's clinician should act according to the best interest of the patient. This decision should be discussed with the most senior clinician available and should be clearly documented in the patients' records along with a brief explanation of the clinical indication. Circumstances where testing may be justified in the best interests of patients are those where the differential diagnosis and subsequent life-saving management would be altered by an HIV positive result. For example: unconscious or confused patients with meningitis or other neurological complaints and severe respiratory distress requiring ventilation. As soon as such a patient is able to understand, s/he should be counselled and receive the results of the test that was done, whether positive or negative.

If a patient is unconscious in intensive care with a non-HIV related complaint (e.g. following trauma) and are the source of a needle stick injury HIV testing should not be conducted in the interests of the health care provider alone. Rather the health care provider should take PEP in the normal manner, making the assumption that the donor of the needle sticks is HIV positive. They should continue the PEP until such a time as the patient is awake and able to consent to HIV testing (and the results are negative) or for 4 weeks, whichever comes first.

9.11 HCT for survivors of rape

A number of additional counselling and testing challenges are posed in dealing with the survivors of rape. All survivors of rape[2] should be offered HCT. Survivors who test HIV negative and have presented within 72 hours should be offered post-exposure prophylaxis (PEP) in accordance with the Namibian National Guidelines for Antiretroviral Therapy. Those who test positive should be referred for treatment and care.

The counselling needs of survivors may be beyond the skill set of the HCT counsellor and where available a referral to a more experienced counsellor should be made. HCT counsellors should be cognisant of necessary variations to the standard HCT protocols (chapters 5 and 6) as laid out below. The counselling of children who have been sexually abused presents further challenges as outlined in section 8.4.2 above. Due to the number of additional challenges posed, counsellors and their supervisors should make every effort to prevent burnout. Only if counsellors are in turn supported, supervised and counselled will they be able to continue to provide the valuable support and testing services to rape survivors.

9.11.1 Contracting for counselling in post rape

The counsellor will need to clarify right at the beginning of the session if the client has had or is still appropriate for PEP and make appropriate and immediate referral if this is the case. They will need to explain the need for shared confidentiality of the results and that the results will be issued as a written certificate. This is needed as referral for other services and legal redress may require documented and dated results. Counsellors should advise survivors that they may need several counselling sessions and that this may necessitate referral to a more experienced counsellor.

9.11.2 Pre-test counselling

During pre-test counselling with rape survivors counsellors will need to give additional time for the exploration of client's feelings, their story and their fears as well as doing a specific risk assessment (was it vaginal or anal rape, were there multiple perpetrators, etc). Information should be given to clients about post exposure prophylaxis (PEP) availability and practical aspects of taking ARVs. Additional attention should be given to information and referral for STI prophylaxis and treatment, emergency contraception and or referral for termination if appropriate.[3] Clients may also wish to have further legal information and referral to the criminal justice system and other services (Women and Child Protection Unit).

When discussing the HIV test counsellors should prepare clients through the risk assessment and explain the implications of the test results in the context of rape. Clients on PEP may experience a longer window period as antibodies take more time to develop (in the rare event of seroconversion). The need for a three month follow up period needs to be explained clearly. Counsellors should also pay additional attention to clients' plans for disclosure as this is no longer a disclosure of HIV testing alone.

[2] Combating of Rape Act (Act No 8, 2000)
[3] Abortion and Sterilization Act (Act No. 2, 1975).

9.11.3 Testing survivors of rape

Fourth generation test kits should be used where available to detect early seroconversion wherever possible. Written certificates should be issued with the results of HIV testing to facilitate follow up care and legal action. In most cases this will require referral to a nearby laboratory.

9.11.4 Post test counselling for survivors of rape

Counsellors should explore client's readiness, give results, allow client to process results, and establish clients' understanding of the results. A summary is given below that may assist counsellors in post test counselling for HIV negative and HIV positive rape survivors.

If negative	If positive
Discuss window period Risk reduction practices PEP adherence Disclosure of rape+ results Referrals (medical, legal support) Follow up counselling Next visit (after 1 week. ensure sessions coincide with medical appointments)	Acknowledge clients fears and feelings Discuss results vs assault Discontinuation of PEP Risk reduction practices Disclosure of rape + results Plan of action Referrals-HIV care, legal support Ongoing counselling Next visit

9.11.5 Comprehensive management

It is strongly suggested that PEP be administered in the context of a comprehensive support programme for survivors of rape that includes STI prophylaxis, pregnancy testing and emergency contraception, and hepatitis B and tetanus vaccination where appropriate. Medical-legal assessments and completion of registers may also be required. The details are laid out in the National Guidelines for Antiretroviral therapy[4].

[4] [4] National Guidelines for Antiretroviral Therapy, Third Edition, MOHSS July 2010, p64

Chapter 10: HIV Rapid Testing

In order to provide guidance for the scale up of HCT this chapter focuses on HIV rapid testing. While HCT services may use longer laboratory based tests, their use is governed by existing manuals and guidelines and they are performed in laboratory settings. Many HCT services however use only HIV rapid tests and these may be performed by a variety of service providers. This chapter is not a 'how-to' manual for conducting rapid testing. Details of this may be found in the Guidelines and Standard Operating Procedures for Rapid HIV Testing in Namibia[1] and in the product inserts of the rapid test kits. Rather this manual sets out agreed standards for rapid testing and how quality of HIV testing services can be assured.

10.1 The National Reference Laboratory

The MoHSS has the power to award the status of National Reference Laboratory by an Act of Parliament and since 1999 this function has been the mandate of the Namibia Institute of Pathology. It provides a number of services in relation to HIV rapid testing and these include: certification, test kit evaluation, and internal and external quality assurance systems. Together these have an impact on the quality of HIV testing services nationally and on the rate and nature of scale-up. Throughout this document the term NIP is used rather than National Reference Laboratory.

10.2 Conducting rapid testing

While rapid tests have excellent performance criteria, they are simple to use and may be performed by non-laboratory personnel it is not enough to rely on this alone. Certain minimum criteria must be met when conducting rapid testing. HIV rapid testing may be conducted in any setting (for example a laboratory, a counselling room, private doctor's rooms, a bedside, a mobile van, a tent or a home) where these conditions are met. Below is a list of the minimum criteria which should be met.

10.2.1 Eligibility for conducting rapid testing

All HIV rapid testing for HCT should be done by individuals who have successfully completed a MoHSS accredited training in testing procedures under the supervision of the NIP as laid out in section 4.1.2 (certification in rapid testing) and 4.1.3 (recertification in rapid testing).

10.2.2 Minimum infrastructure requirements must be met

The recommended requirements for conducting HIV testing (furnishings, storage, safety, etc) may be found in section 4.2 of these guidelines. All HIV rapid test sites should be registered and licensed under the Hospitals and Health Facilities Act No. 36 of 1994 as outlined in Chapter 4.

[1] Guidelines and Standard Operating Procedures for Rapid HIV Testing, NIP, October 2008

10.2.3 Adherence to Standard Operating Procedures

Each time an HIV rapid test is performed it should be done in accordance with the standard operating procedures and appropriate safety precautions taken.

10.2.4 Supervision of rapid testing

Regular supportive supervision by regional QA officers should be provided to all staff performing HIV rapid tests. The site supervisor and counsellors are required to check on and record temperature, storage, stock expiry dates and the on-site standardised HIV rapid testing logbooks (section 10.5). The HIV rapid testing logbooks should be assessed for completeness, compliance with national algorithms and rates of discordance. Visits should happen at least quarterly and should be accompanied by a laboratory technologist annually or more frequently if there are identified problems that have not been solved.

10.3 Recommended rapid HIV tests

A number of different rapid tests are available for detection of HIV antibodies and (in the case of fourth generation tests) of p24 antigen. It is recommended that rapid test kits used for HCT are rapid with simple procedures, use whole-blood or oral fluid, do not require electricity to run, and require refrigeration only in hot climatic conditions. The rapid tests kits used in Namibia are recommended by the World Health Organization (WHO) and have been evaluated by the NIP before local use. Approved kits must have excellent performance characteristics and a documented sensitivity and specificity of over 99% in local evaluations. A list of nationally approved kits is available from the NIP and should be updated annually with new tests. The majority of recommended tests are rapid HIV antibody tests that work using an Enzyme Linked Immunosorbent Assay (ELISA) mechanism. Antibody only tests are adequate for most HCT encounters. However, as long as they are on the list of nationally approved kits, fourth generation rapid tests (that detect HIV antigen as well as HIV antibody), combined tests (for example tests that detect HIV and syphilis) and other new tests may also be used.

10.4 Testing algorithms

A testing strategy or algorithm describes the number and order of tests that need to be performed. The choice of strategy depends on local prevalence rates, as these impact the positive predictive value of the test, and will influence the choice of test kits since the first test conducted should always be highly sensitive and the second highly specific.

All HIV testing facilities in Namibia, whether public or private, must adhere to a parallel testing algorithm. A parallel testing algorithm is when a whole blood sample is tested with two different HIV test kits simultaneously ('in parallel') and the results given if both tests indicate the same result. Parallel testing algorithms are used in Namibia as the high HIV prevalence rates in the country make this a cost effective and time-saving choice. Details of the test kits and order as well as flow charts may be found in the Guidelines and Standard Operating Procedures as well as on the WHO web-based resources.

10.5 A standardized HIV rapid testing logbook

A standardized HIV rapid testing logbook should be maintained daily at each site where HIV rapid testing takes place. This should include columns for the date, name or code, sex and age as well as details of lot numbers, expiry dates and who conducted testing. The columns should follow the national algorithm with data on two rapid tests and the final result entered. A copy may be found in the appendices (Appendix 7). A logbook is an essential component of stock control, monthly reporting and quality assurance. It allows laboratory and site supervisors to assess at a glance the performance of individual providers and sites. They can also track the numbers of discordant results and whether the correct algorithms and procedures are being performed. HIV rapid testing logbooks should remain at the site where testing is performed (such as inside the VCT room, in the laboratory or in the designated testing area in the TB room, etc.). Home-based HCT counsellors should complete a single logbook for each team at the daily meeting and this should be kept secure by the supervisor while in the field.

10.6 Discordant results

If one test is reactive and another is non-reactive (meaning the results are "discordant") there are a number of possible explanations and all discordant results should have a specimen sent to a laboratory. The following are possible explanations:

- The discordant result could be the result of a kit or operator error and immediate retesting with new kits is recommended.

- The patient could be in the very early stages of HIV infection. This should be clear from the history and pre-test counselling. In that case they should be offered fourth generation testing if available (see 10.3) and/or advised to return for retesting in two weeks. Since these patients may be in the 'window period' they should be given advice on condom use to prevent the onward transmission of HIV in this period.

- The discordant results may be due to the fact that no test is 100% sensitive or specific. If this is the case the result will remain discordant on the return visit and a sample should be sent to the reference laboratory. Discordance is resolved by further testing according to the SOPs for rapid HIV testing[2].

10.7 Recommendations for re-testing

Retesting is recommended in circumstances outlined in 10.7.1-10.7.5:

10.7.1 Patients and clients with discordant results

As outlined in section 10.6, all persons with discordant test results (where one rapid test gives a reactive result and one a non-reactive result) should be offered immediate retesting and if still discordant, retesting at two weeks. The client or patient should be advised that they cannot know if they are negative or positive at this stage and may be seroconverting. They should be issued condoms and advice on their consistent use. If the results are still discordant at two weeks a third test should be done to resolve discordance according to the SOPs for HIV rapid testing.

[2] Guidelines and Standard Operating Procedures for HIV rapid testing, NIP version 2008

10.7.2 High risk negative individuals and discordant couples

Clients who test HIV negative but who may have been recently exposed to HIV infection should be encouraged to return for a repeat test in 4 weeks from the date of exposure. HIV-negative persons should be advised that if they have a specific incident of known or suspected HIV exposure in the future then they should return for an HIV test following that exposure. Additionally, persons with ongoing high risk behaviours, those with a known HIV-positive partner, and persons with a partner of unknown HIV status should be tested for HIV at least annually and provided with appropriate risk reduction counselling.

10.7.3 Persons attending health facilities

Persons should be told that if they receive health-related services from other facilities, they may be advised to receive another HIV test and counselling in those settings in the future. This should be done to ensure correct documentation of HIV status. For pregnant women who have previously tested HIV negative at an antenatal care clinic, HIV testing should be recommended with each new pregnancy. Patients with an STI should be re-tested and counselled with each new STI diagnosis. Any patient presenting with an HIV related illness should be retested even if there is a previously documented HIV negative result in the health passport.

10.7.4 Pregnant women testing HIV negative in their first or second trimesters

In order to prevent mother-to-child transmission (MTCT) of HIV, pregnant women should be tested *as early as possible* in each pregnancy. Women who test HIV negative in their first or second trimester of pregnancy should be **recommended to return for another HIV test in their third trimester** of pregnancy, preferably between the 28th and 36th weeks.[3] In the event that a woman does not return for testing during her third trimester, it is recommended that she be tested at labour or, if that is not possible, immediately after delivery. Pregnant women should be re-tested in each new pregnancy.

10.7.5 Persons taking PEP

Baseline HCT should always be offered to persons who have experienced sexual violence or an occupational exposure. This should be included as part of (PEP). If PEP is not available, persons with a possible HIV exposure who test HIV negative at the first HIV testing encounter following the incident (i.e. sexual violence/ rape or occupational exposure) or who have an indeterminate HIV status warrant re-testing after four weeks to ensure that they are truly HIV negative as a result of that exposure. In persons receiving PEP, the production of HIV antibodies may be affected and, in some cases, the time to development of a full antibody profile may also be affected. Re-testing should be offered at three months following the incident.

[3] WHO. *Testing and counselling for prevention of mother-to-child transmission of HIV support tools*. Geneva, WHO, 2006. Available at: http://www.who.int/hiv/pub/vct/tc/en/index.html.

Table 10: Recommendations for retesting: Summary
[a] Patients and clients with discordant results (where one HIV test is reactive and the other non-reactive).
[a] High risk negative individuals
[a] Discordant couples (where on partner tests HIV positive and one partner tests HIV negative)
[a] Persons attending health facilities with STIs
[a] Pregnant women testing HIV negative in their first or second trimesters
[a] Persons taking PEP

10.8 Test kit logistics

10.8.1 Procurement and distribution of test kits

Test kits for use in MoHSS facilities will be procured by the Central Medical Stores (CMS) through a single procurement system. Where possible parallel procurement systems should be avoided and NGOs, FBOs and other sites offering HCT services should also try to utilize the (CMS). Private practitioners are obligated to procure only those tests approved for use in Namibia by the NIP.

10.8.2 Stock management and storage of test kits

Generally, test kits and related supplies should be stored in the pharmacy of a health facility. The facility pharmacist should store bulk supplies and will work with HCT supervisors to order sufficient supplies of all necessary items during routine six weekly ordering. In non-health facilities (i.e., stand-alone or mobile sites), a designated staff member should be in charge of ensuring that test kits are stored properly and used before their expiry date. Adequate attention should be paid to the maintenance of sufficient buffer stock without wastage of expired kits.

For proper storage of test kits see the (SOPs). Test kits have been selected that are able to be stored at room temperature (0-30 degrees Centigrade). However, if local climactic conditions routinely exceed 30 degrees, provision for a refrigerator and the cost of running it should be included in the project budget. Because rapid test kits have a relatively short-shelf life (12 months), facilities should take caution when ordering test kits. They should not order more kits than will be used within a 3-4 month period. Test kits are packaged in material that helps maximize their shelf life, e.g foil packs, which protect from light and somewhat from heat. Consequently, the fewest number of packages should be opened at one time. Facilities should strive to minimize the number of open packages.

10.9 Handling of contaminated waste

Sharps, such as lancets and needles, must be placed in specially designed sharps disposal containers/boxes. Used test kits and blood-contaminated materials should be placed in a bio-hazard bag while household waste should be disposed of in normal waste containers. CMS currently issues red bio-hazard bags. All containers, including sharps disposal containers, must be incinerated or disposed of according to standard health facility practices. Given the additional cost of incineration, facilities should carefully separate waste at the point of origin. See the MoHSS policy on waste management.

10.10 Post-exposure prophylaxis

Health care workers and HCT counsellors should ensure that the risk for occupational exposure is minimized. PEP should be administered according to the national guidelines on PEP[4] and it is recommended that the following measures be taken:

- Infection control committees should be put in place to cover all health facilities.
- Increased attention for the correct handling of sharps and all infected materials (for example, never recapping or bending needles, disposal of all sharps in solid containers, etc.
- Staff should be fully informed about the measures to be taken after a needle stick injury. Each health facility should establish and disseminate clear procedures to ensure adequate management after occupational exposure.
- For each accident, the supervisors should investigate the circumstances and report the findings and proposed corrective measures to the infection control committee.
- ARV drugs for PEP should be made available to HIV negative health care workers who have had an occupational exposure on a 24-hour basis according to the Namibia Guidelines for ARV Therapy.
- Where possible health care workers should be vaccinated for Hepatitis B, PEP should also be provided for all health care workers following sharp injuries or exposure to infected materials. The risk of transmission of Hepatitis B from an occupational exposure is significantly greater than the risk for transmission of HIV.

10.11 Quality assurance

The availability of HIV test kits with excellent performance characteristics does not automatically guarantee reliable test results. Errors can occur at any of the many steps involved during specimen collection, the testing procedure, interpretation of results and reporting. Measures to assure the quality of HIV testing are vital, since the consequences of either a false positive or a false negative result are great. Quality assurance (QA) is defined as the overall programme that ensures that the final HIV test results reported are correct. QA entails both internal and external:

10.11.1 Internal QA

Types of controls

1. Control built into the test device	This control develops as a red line in the control area of the test device to indicate that the test result is valid. It generally provides information about adequacy of quantity of specimen and whether the device is working properly.
2. Proficiency testing	Known positive and negative controls are used to evaluate the accuracy of the test and to check if the person doing the test performs it correctly.

[4] National Guidelines for Antiretroviral Therapy, Third Edition, MOHSS July 2010, p61

One known positive and one known negative control should be done (for the first two tests in the algorithm) weekly at each site and each time that:

1. A new operator (a trained staff member who has not been doing testing for a while, or a newly trained operator) starts at a site.

2. HIV rapid test kits with a new lot number are opened.

3. Rapid test kits are exposed to temperatures that are above or below the range needed for stability as defined by the manufacturer, e.g. above 27 °C.

10.11.2 External Quality Assurance

External quality assurance (EQA) involves a combination of re-testing and proficiency testing. In the former, samples are sent from the site to a reference laboratory for re-testing. In the latter, samples are sent from the reference laboratory to the site for proficiency testing. In both cases concordance between the results at the two testing sites is looked for. Feedback should be given to the sites in writing.

(i) Re-testing:

Blood samples should be sent from the sites to the reference laboratory for re-testing. Five percent (5%) of all blood samples must be sent to the NIP for re-testing in the following circumstances:

- The first 3 months that a site is open;
- Sites with an identified problem; and
- All sites from a designated region of the month (with each region having one specified month a year where they submit 5% of all samples).

(ii) Proficiency Testing:

Samples sent from the reference laboratory to the sites may be sent as liquid panels or as dried tube specimens. They should be sent quarterly to all facilities providing VCT. These should be blinded and operators should perform them on a rotational basis. Supervisors should assign the testing of EQA proficiency panel samples alternating the testers, based on a register of individuals certified to conduct HIV rapid testing at the site. All PITC and home-based HCT counsellors should conduct at least one panel annually for their certificate to remain valid. For VCT counsellors this requirement is reduced to once every two years, provided that the site as a whole is participating in quarterly panel testing. In PITC sites with several operators this will require more panels and close coordination of this process through the regional and district laboratory staff. All facilities failing the re-testing or proficiency tests need to receive additional technical support. A panel is classified as PASS if it meets all the requirements or FAIL if results are incomplete, any results are incorrect, or for incomplete submission forms, use of incorrect testing algorithm or deviation from standardized procedures.

- *Site assessment, observed practice and HIV rapid testing logbook review:* Quarterly assessments will be conducted by the regional QA officers (see section 10.2.4 and chapter 3). QA officers will each have a designated laboratory technologist at regional or national level to call upon for trouble shooting. In addition they will be accompanied annually to the site visit by the laboratory technologist. They will together review the logbooks and systematically review HIV rapid testing procedures and site operations using a standardized checklist[5].

In the event of continued non compliance by any HIV rapid test site to take successful corrective action when recommendations have been made, the NIP will be required to inform the Permanent Secretary of the MoHSS regarding the failing site. At that time, appropriate further recommendations will be made by the NIP in line with the requirements of the Hospitals and Health Facilities Act and the NIP should then be authorized to enforce closure of the site. Such a site would remain closed until all NIP recommendations have been fully and successfully met. The site and all the testers would require re-certification by the NIP.

Table 11: The Quality Assurance system for HIV rapid testing: Summary

- [a] Standardized HIV rapid testing logbooks should be used at all sites.
- [a] Internal QA should be conducted weekly.
- [a] External QA through re-testing will be done by the NIP on 5% of blood samples sent from sites in the first 3 months after opening, from sites with an identified problem and all sites from the designated region of the month (with each region having one specified month a year where they submit 5% of all samples).
- [a] External QA through proficiency testing will be done quarterly at VCT sites and annually by each individual PITC and home-based HCT counselor.
- [a] Site assessments will provide systematic review of HIV rapid testing procedures and site operations using a standardized checklist.

10.12 Testing Children

10.12.1 Early infant diagnosis of HIV using diagnostic DNA PCR testing[6]

As a result of the programme for the prevention of mother-to-child transmission (PMTCT), a large number of HIV-exposed infants are being identified who require HIV diagnosis and follow-up care. It is important to identify young infants with HIV infection early and to refer them for ART because of the high mortality from untreated HIV/AIDS in children. It is also important to promptly identify young infants who are not HIV-infected in order to reassure their parent(s), discharge them from costly follow-up, and measure the overall effectiveness of the PMTCT programme. The polymerase chain reaction (PCR) test can reliably and accurately detect HIV DNA on a dried blood spot (DBS) specimen at an early age. This test detects the genetic material of HIV instead of anti-HIV antibodies, and therefore is not affected by the transplacental transfer of maternal anti-HIV antibodies, unlike the standard HIV serological tests. If the PCR test is positive, then it means that the child is truly HIV-infected and should start antiretrovirals. If the PCR test is negative and there has been no breastfeeding for the previous 2 months, then it means that the child is truly HIV-negative. The algorithm for diagnostic DNA PCR testing is summarized in the PMTC chapter of the National Guidelines for Antiretroviral Therapy referenced below[25].

[5] HIV Rapid Testing Site Assessment Form, NIP, 2008
[6] National Guidelines for Antiretroviral Therapy, Third Edition, MOHSS July 2010 p 44

10.12.2 Children between 9 and 17 months in HIV-exposed infants or with symptoms of HIV

The algorithm for HIV diagnosis in these circumstances is outlined on page 45 of the National Guidelines for Antiretroviral Therapy referenced below[25]. Use of this approach may reduce the need for early infant diagnosis using PCR, thereby saving money.

10.12.3 Children over 18 months:

HIV antibody tests are used to diagnose HIV infection in children 18 months or older; a positive test confirms that the child is HIV-infected. A negative HIV test result in a breastfeeding infant or child may not be conclusive; another test should be conducted at two months after complete cessation of breastfeeding.

10.13 Integrated Approaches to Point of Care testing

New rapid testing technologies for other STIs and conditions (syphilis, Hepatitis B, malaria and anaemia) are increasingly available and should be integrated into the HIV, RT, EQA systems and HIV rapid testing logbooks if they become routine practice in antental or STI clinics.

Chapter 11: Scaling Up Quality Hct Services

11.1 Quality assurance and quality improvement for HCT scale up

The fundamental elements of a comprehensive approach to quality HCT in Namibia are:

- Adherence to these guidelines, providing the basis for minimum standards for the components of HCT services in Namibia (testing, counselling, data management, logistics and health systems and referrals).

- A coherent, systematic and coordinated approach towards quality assurance with clearly defined roles and responsibilities for quality at each level of the system.

- A focus on quality improvement

11.1.1 What is quality assurance?

Quality assurance is a way of monitoring and evaluating the quality of services provided in accordance with established national guidelines, policies and standards. Approaches for assessing the testing aspects of HCT are covered in section 10.11. Approaches for assessing the counselling aspects of HCT services include mystery client surveys, client exit interviews to measure client satisfaction, HCT counsellor self-assessment, regular training, supportive supervision, stress management sessions and operations research. These approaches must be used regularly to assess and monitor the quality of counselling provided at each facility and are also described in sections 4.3 and 4.4.

11.1.2 What is quality improvement?

Quality Improvement (QI) is an approach for the study and improvement of the processes of providing services. HCT QI team members should be encouraged to work together to understand client needs and expectations, analyze how the processes and systems work, and to develop, test and implement solutions to improve performance. The most important step is for the QI team at facility level is to have a picture of HCT quality through the routine monitoring of HCT services. Teams should be guided by a stepwise approach:

Step 1: Identifying, prioritizing and defining the problem
Step 2: Analyze and try to understand what is causing the problem
Step 3: Develop solutions to overcome the problem
Step 4: Deciding on and implementing the solution

11.1.3 What are the key quality indicators for HCT in Namibia?

Quality indicators enable supervisors and HCT providers to demonstrate compliance with these guidelines. The suggested quality indicators in Namibia are:

1. Number of individuals receiving correct results
2. Number of HIV positive individuals enrolled in care and treatment centres.

These indicators can be used in routine monitoring at facility level as part of a quality improvement programme. When facilities perform poorly against selected quality indicators, this will signify where quality improvement efforts should focus.

11.1.4 What is the role of the QA officers

The primary role of the Regional QA officers is to assure and improve the quality of HCT in Namibia. They have a number of roles and responsibilities for HCT summarized in table 4 of chapter 3. Through regular (at least quarterly) visits to sites they should support and supervise sites in all aspects of both testing and counselling and should be experienced and knowledgeable about both. They should also play a role in ensuring the quality of data collection and in the use of and training in quality improvement approaches.

11.2 Integrated Communication Strategies for HCT scale up

The scale up of HCT should be accompanied by a communications strategy that involves professional promotion of the services. The increased promotion will in turn increase demand for access to services and so the two go hand in hand.

11.2.1 The HCT logo

The DSP is responsible for the development and roll out of a national HCT brand that can be linked to registration and licensing. Registered VCT sites should apply to the MoHSS DSP for a logo that they can display on a signboard. Training institutions may use the logo for certificates and individual PITC, mobile and home-based HCT providers may be issued with branded lapel pins to indicate that they are certified according to national standards.

11.2.2 Community Participation and Mobilization

The full participation and support of the community is needed for the establishment of an enabling environment to implement HCT. To achieve this, there is a need for community education, including public campaigns. It is essential that communities are aware of the importance of HCT in the fight against HIV and AIDS. Therefore, existing and new strategies on creating community awareness and mobilization should be intensified and implemented. Information specific to the HCT approaches, including PITC, should be made available to create awareness that HCT will be part of "standard of care" in all health facilities. Community preparedness and social mobilization should be seen as an integral part of the process of scaling up access to PITC, in an effort to normalize HCT in the country. Community endorsement and acceptance of PITC services can make knowing one's HIV status normative and through this, go a long way in combating stigma. PLWHA, CBOs, women and youth groups, as well as community and political leaders within communities

should be involved in the formulation, implementation and monitoring of such campaigns. Public HIV testing efforts by influential people and role models in the society have resulted in the increased normalization of the importance of knowing one's status. Some have disclosed their HIV positive status, and shared their encouraging experiences regarding positive living. This initiative should continue in assisting the country to address stigma and discrimination so as to normalize HCT in the country.

11.2.3 Couples CT Promotion

A pro-active communications strategy should be developed that fosters positive relationship values, dispels fears of counsellors probing into individuals sexual histories during counselling and defines a 'couple' in the health context.

11.2.4 Male involvement

Namibia is a patriarchal society where the role of males in the decision-making process is important, especially for married women. The government will continue to step up efforts to inform and educate men so that they understand and support such programmes as PMTCT for the benefit of the family. Special programmes targeting men as partners and as individuals should be put in place to encourage them to get tested and take an active part in reducing the spread of HIV through behaviour change. Efforts should be made to target men in traditionally male settings including border posts, mines, some sports and certain workplaces.

11.3 The National Testing Day and other special events

Special HCT promotional events such as National and Regional Testing Day events and other campaigns also play an important role in the scale up of HCT services since not all individuals seek or feel comfortable seeking HCT from the routine services. In Namibia, the National Testing Days (NTDs) have proven socially acceptable and popular since 2008. Based on the high public demand experienced to date, a multi-day NTD model should be considered for future national testing events. Events should follow the template established since 2008, with services offered nationwide through a network of temporary testing sites and routine testing facilities. HCT services provided during the NTD should meet all the requirements for counselling and testing in outreach settings and at VCT sites as laid out in these guidelines. Where possible, sites participating in an NTD should be expected to operate an extended working day. Depending on the level of demand, this may include staying open late.

11.3.1 Coordination and Planning

Responsibility for the coordination of NTD events lies with the Multi-sectoral National NTD Steering Committee within the MoHSS. This committee should meet every two weeks (or more often when necessary) starting at least three months prior to the NTD. Its members should be divided into subcommittees including, but not limited to:

i. Resource mobilization – responsible for liaising with donors, including the private (commercial and NGO) sector, to mobilize direct or in-kind contributions (e.g., SMS services, ATN advertising).

ii. Service provision – responsible for human resources; operational issues (e.g., facility management) and design of referral cards.

iii. Test kits and logistics – responsible for procurement and distribution of test kits, condoms and other supplies (including sharps boxes and the safe disposal of waste).

iv. Publicity and campaigns – responsible for national mass media and community-based social mobilization.

Regional planning is the responsibility of the Regional NTD Steering Committees. Responsibilities include, but are not limited to:

i. Briefing and planning meetings with stakeholders such as traditional chiefs and political and religious leaders.

ii. Providing timely and accurate information on the numbers of sites and human resources (testers, counsellors, logisticians, administrators) available for the NTD. This regional committee may also need to ensure the availability of auxiliary testers and counsellors; requests for these should be conveyed to national level as early as possible. Back-up testers may be required at sites to relieve existing testers for periods during the day.

iii. Engagement with the private sector locally to promote the event and support demand creation.

iv. Organizing entertainment for clients while they wait for testing (optional).

Local planning at sites should also be done.

i. Centres handling multiple outreach delivery points should also have a command centre/coordinating room where all coordination and communication takes place. This avoids staff wasting time locating each other to discuss logistical issues that arise during the day. These coordinating centres should also establish central telephone contact numbers and identify initial points of contact through whom specific requests can be channelled and triaged to relevant technical or administrative staff.

ii. Crowd control and client management strategies should be developed locally, early in the planning process. Managing clients' expectations on the day of the NTD, and ensuring the efficient movement of clients through the counselling and testing process may reduce the number of clients discouraged by long wait times.

11.3.2 Stocks and supplies for special events

Given the lead time it may take from the manufacture of test kits and condoms to receipt and distribution within Namibia, facilities should include special events as part of annual planning and reporting to MoHSS in order that CMS can order sufficient stock to last throughout the year. Stocks should be distributed in advance based on daily target figures. Logistics and stock planning should be an integral part of the planning process for each event. National and site-specific targets should be set based on information from the

logistics and procurement sub-committee. NTD planning committees should seek to avoid relying too heavily on buffer stocks to meet demand, although additional buffer stocks should be available in each region for rapid mobilization if required.

11.3.3 Promotion of National Testing Day

Special events should be promoted in order to demystify HCT and encourage the previously untested members of the general population to get to learn their HIV status. Demand creation and raising public awareness through mass media campaigns should commence at least one month before the NTD. Promotional methods may include electronic and print media campaigns, mobile phone text messaging services and reminders posted on automated bank machine screens. Follow-up messaging to inform the public about the success of the NTD event should also be considered.

11.3.4 Protocol adaptations

Adaptations to the routine protocols may be required for the NTD. Pre-test group education sessions for up to 10 clients at a time are recommended, although consent, testing and post-test counselling are still conducted with individuals or couples. Testing follows the national algorithms but organiser should consider the use of oral fluid testing in the NTD as these require fewer infection control mechanisms.

11.3.5 Identification of referral sites

As with any outreach or mobile event referral points should be identified and visited early with a referral directory developed.

11.3.6 Data collection for National Testing Day

The standard HCT registers should be used during NTD. Some modifications are required to enable programmatic information on campaign success and other issues to be collected.

Table 12: National Testing Day: Summary

- Responsibility for the coordination of NTD events lies with the MoHSS-led Multi-sectoral National NTD Steering Committee. This should start meeting at least three months before the NTD.
- Services should be offered nationwide through a network of temporary testing sites and routine testing facilities.
- Logistics and stock planning should be an integral part of the planning process for each event.
- Promotional methods should be innovative and start at least one month before the NTD.
- The standard HCT protocol may require adaption to include more than usual group pre-test counselling.
- The standard HCT registers should be used during NTD. Some modifications are required to enable programmatic information on campaign success and other issues to be collected.

Chapter 12: Monitoring, Evaluation and Data Management

12.1 Monitoring and evaluation

Monitoring and evaluation (M&E) are important elements required for measuring the commitment on HIV/AIDS in addressing the global, regional and country level response. Whereas monitoring involves the regular, routine assessment of ongoing activities, evaluation is episodic and examines large scale impact and achievements to answer specific management and epidemiologic questions that will guide future actions, planning, and decision making regarding HCT. Both monitoring and evaluation are critical components of Namibia's *National HIV/AIDS Monitoring and Evaluation Plan.* The response is measured by the achievement of concrete and time-bound targets such as in scaling up universal access to HCT. A Monitoring and Evaluation system should be developed within the framework of existing M&E systems and with the full participation of a broad range of stakeholders in order to ensure a comprehensive approach to reporting in line with national strategic frameworks goals and targets. The DSP will develop a national M&E plan that includes indicators for HCT, their data sources and methods of determination. In addition all HCT service providers should be actively engaged in M&E processes, and are encouraged to utilize their own programme level data to improve and strengthen their operations.

12.1.1 Monitoring Routine Data on individual clients and uptake by couples

The HCT client data (see section 12.2) should be used to monitor and evaluate HCT services at each site, in each district and region, and at national level. Special studies may be required for specific issues, but in general the emphasis should be on using the HCT database as much as possible to maximize the use of this system for programming purposes. This database should contain information on a minimal number of routine indicators (individuals tested, couples counselled together, HCT approach, etc.), as outlined in 12.1.3.

12.1.2 Monitoring routine data on licensed HCT sites

The DSP will maintain a live database of fixed and fully mobile sites that have passed a *Site Readiness Assessment* visit (see chapter 4) and were issued an initial annual license. Using updates from the regional QA officers the database will record the site's current status and date issued:

1. Initial licensing
2. Removal of license (temporary/permanent)

3. Annual relicensing
4. Accreditation (rewarding excellence)

The database can identify when each fixed or fully mobile site is due for its next external assessment. In this way the DSP will have a complete picture of the current status of all HCT sites across the country. Sites conducting outreach or home-based HCT from a base point must ensure that all service providers are certified (see section 12.1.3 below and section 4.1.1 above) and that individual client data are submitted to DSP as outlined in section 12.2 below.

12.1.3 Monitoring routine data on individual service providers

The regional QA officers, on behalf of the DSP, will maintain a live database of individual service providers in their regions that are certified to conduct HCT (see chapter 4). This will include information on certification for counselling and on certification for rapid testing from the recognized training institutions. Using updates from the refresher trainings and the annual individual proficiency testing, the database will record the individual's current status and date issued:

1. Certification in counselling
2. Certification in rapid testing
3. Able to conduct in-room testing
4. Date of last annual proficiency panel

The database can identify when each individual is due for its next external assessment. In this way the DSP will have a complete picture of the current status of all HCT service providers across the country.

12.2 Data Management

Data management is essential for the effective management and improvement of HCT services. Some of the points guiding management of HCT data in Namibia are outlined in 12.2.1-12.2.9. They are designed to follow the existing Health Information Systems (HIS).

12.2.1 Data collection

All HCT service providers will use a standardized HCT register as a data collection tool (see Appendix 8) and data will be recorded using a standardized coding system. 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. See Figure 8. Referral systems should track data of individuals and couples referred to prevention, care, treatment and support.

12.2.2 Data flow

Data will be generated at the Point of Service (POS) (See Figure 8-Data Flow Chart), where the Daily HIV Counselling and Testing registers are filled. All HCT facilities are expected to follow the data collection methodology below. The following system should be used from POS to the National Level:

1. Each client's profile is entered in an HCT register

2. Within 3 working days after the month, a tear off duplicate of all clients entered in the register will be sent to the district level for entry into the electronic data base.

3. The District HIS person will send or transmit via e-mail attachment this aggregate Monthly data-set of all HCT POS facilities in that District to the Regional HIS office within 7 working day of the new month.

4. The responsible Regional person will send or transmit via e-mail attachment this aggregate Monthly data-set to the National HIS/Response M&E (RM&E) office and the HCT Unit office within 7 working days of the new month.

5. National level/RM&E will do the data analysis, produce a quarterly report and disseminate the report to all the relevant stakeholders including the implementing sites.

12.2.3 Data collection instruments

A standardized data collection instrument (see Appendix 8) will be used at all HCT sites, including government and mission hospitals and health centres, NGOs, PLWHA organizations, and private and commercial sites offering HCT. This instrument includes ten core HCT data elements/variables that aim to collect key demographic, behavioural, and other information from each client. These core data elements are: Site, type of counselling (individual or couple), sex, age, reason for visit, did the client receive pre-test counselling, did the client receive post-test counselling and HIV results for each test performed, partner HIV status, and was the client referred to available services. In addition, the month/year of the report are included in the data set. When using the HCT register, counsellors should inform the client about shared confidentiality and that names are not recorded electronically (see section 2.1).

12.2.4 Data recording

The counsellor/individual who provides the service should fill out the HCT client register before the client leaves the counselling room. The counsellor should ensure that filling out the register truly reflects the content of the session without interfering with establishing rapport with the client or delivering an effective counselling session.

12.2.5 Coding system

A standardized system will be used to assign codes to data elements/. Every HCT site should keep a copy available for reference.

12.2.6 Record keeping

For ease of data entry and integrity, the original of the monthly data collection register should stay at the site for a period that is in line with the archiving system of the facility and MoHSS. A standard filing system for HCT records should be developed and followed. Information from HCT service delivery points should be treated with the same level of confidentiality that all medical records are given. Only authorized officers should be permitted to handle client-level data. All efforts must be maintained to keep HCT records confidential and stored in a secure room.

12.2.7 Data Quality Assurance

To ensure that there is credibility of the data that is reported, every quarter the District, Regional and National level HIS officers will select visit some sites for data verification. A data verification tool will be developed in order to maintain validity and reliability.

12.2.8 Data analysis and Feedback

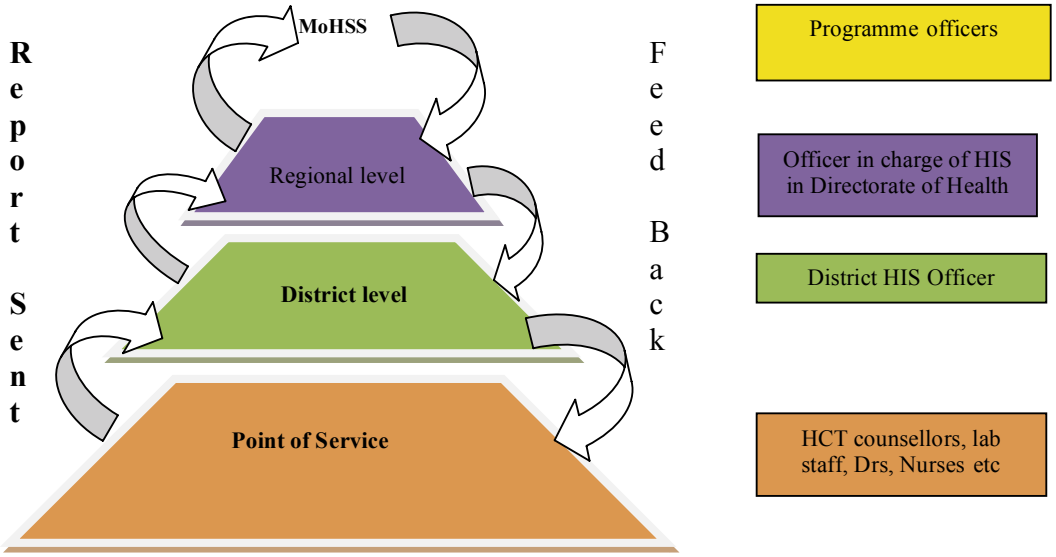
HCT data will used for understanding the epidemic and will be utilized for decision making and improving HCT services. A user-friendly software program should be developed and installed at all District, Regional and National level Offices for entering, managing, and analyzing data. A key product at each level will be automated data summary reports that will be shared with all levels including the implementing sites: District HIS Officers should share these reports with all HCT sites in their District; Regional Directorates should share their reports with all Districts within their Region; and the National Level (DSP) should share reports that are generated with all HIS Offices, national AIDS committees, and all necessary stakeholders including relevant AIDS control units in various ministries (See Figure 8). The report outputs will be aligned with national HCT input, output and outcome indicators.

Routine reports should be distributed on a quarterly basis with ad hoc reports as necessary. A user manual will be created to be used by counsellors, and other clinic/lab staff to assist them in completing registers and monthly summary forms. Another manual will be developed for data clerks and HIS officers. Both manuals will define the variables, how to record results, and how the data will be used.

12.2.9 Documentation and Publication of HCT data

The Ministry of Health and Social Services encourages documentation of data, best practices, lessons learnt and also the publication of such experiences. Any articles or publications based on HCT data must be submitted to the DSP for clearance before publication. This includes abstracts for national and international conferences. When appropriate, other national clearing mechanisms, such as national HCT and AIDS committees, should also be engaged.

Figure 8: Data Flow chart for HCT



Useful Resources

Namibian Resources

Namibia National Policy on HIV/AIDS (March 2007) Overarching document that also makes reference to legal frameworks and human rights
Namibia National Strategic Framework for HIV/AIDS 2010 – 2015 The framework provides strategic policy, planning and implementation guidance and leadership for the national HIV and AIDS multi-sectoral response. Has strategy for HIV counselling and testing, aiming to increase coverage rates of individuals ever tested for HIV to 90% in women, 70% in men and 50% in children by 2015.
Namibia National Guidelines for the Management of Tuberculosis. MoHSS/DSP. 2nd Edition (March 2006). Gives clinical guidance on the diagnosis and management of tuberculosis and includes reference to HIV counselling and testing in TB patients.
Ministry of Health and Social Services. National Guidelines for Antiretroviral Therapy, MoHSS/DSP. Third Edition (July 2010) Gives clinical guidance on antiretroviral therapy for adults and children. Includes comprehensive sections on prevention of mother to child transmission, early infant diagnosis and post rape care, including post exposure prophylaxis.
World Health Organization Resources
WHO Guidance on provider-initiated HIV testing and counselling in health facilities (June 2007) Sets out guidelines for health care workers on recommending and conducting HIV counselling and testing in health care settings. Available from: http://www.who.int/hiv/pub/vct/pitc/en/index.html
WHO Delivering HIV test results and messages for re-testing and counselling in adults (June 2010) explains when retesting should and should not be recommended for HIV negative individuals. Available from http://www.who.int/hiv/pub/vct/hiv_re_testing/en/index.html
A Handbook for Improving HIV Testing and Counselling services (Nov 2010) sets out the basic building blocks for HCT quality and gives next steps to facilities, districts, regions and national level for getting started. It provided basic tools for adaptation. It is available from http://www.who.int/hiv/pub/vct/9789241500463/en/index.html
WHO Policy requirements for HIV testing and counselling of infants and young children in health facilities, (2010) Discusses the areas that need national policy adapted to the local context and legal frameworks. Not country specific. Available from: http://www.who.int/hiv/pub/paediatric/testing_counselling/en/index.html
WHO Recommendations on the diagnosis of HIV infection in infants and children (2010) Lays out technical aspects of HIV testing in infants and children. Explains the need for virological confirmation in infants. Available from: http://www.who.int/hiv/pub/paediatric/diagnosis/en/index.html

APPENDICES

Appendix I

Site Readiness Assessment for Initial Licensing of HIV Counselling and Testing sites

Name of Facility:	**District:** **Region:**	**Date of Visit:**		
HCT approach	PITC / VCT / Home-based			
HCT site	Health facility / stand alone / mobile / outreach / home based			
Assessors: 1. **2.**	**Managing Agency**			
Site opening hours	Mon-Fri	Sat	Sun	Holidays

Staff Profile**:** (attach copies of certificates)				
Names	**Designation**	**Full time**	**RT certificate**	**Counselling certificate**
		Y / N	Y / N	Y / N
		Y / N	Y / N	Y / N
		Y / N	Y / N	Y / N
		Y / N	Y / N	Y / N
		Y / N	Y / N	Y / N

Infrastructure requirements for initial license:

Section Ref	Question	Yes	No	N/A	
4.2.1	**Personnel**				
	a	Are there adequate staff at the site at all opening times?			
	b	Are staff conducting HCT counselling certified in MOHSS curriculum?			
	c	Are staff performing HIV rapid testing trained according to MoHSS RT approved curriculum?			
	d	Is there a programme for recertification of individuals (annual for PITC, HBCT and every two years for VCT service providers)?			
4.2.2	**Space and Furniture Requirements**				
	a	Is adequate private room / space available?			
	b	Good ventilation			
	c	Bench space for the performance of HIV testing			
	d	Wash basin in proximity of testing space			
	e	Protective cover on working area, easy to clean and disinfect.			
4.2.3	**Storage facilities**				
	a	Is the kit storage area kept under lock and key?			
	b	Storage of kits within temperature range			
	c	Temperature controlled storage of specimens for proficiency testing			
	d	Lockable cabinet for storing documents			
4.2.4	**Inventory and Stocks**				
	a	System in place for obtaining supplies? Forecasting etc.			
	b	Is the site supervisor assigned to look after the stock?			
	c	Stock control measures in place and written policy present?			
	d	Are there adequate stocks of condoms at site today?			
4.2.5	**Safety and Infection Control**				
	a	Waste container for general waste			
	b	Waste container for bio hazardous waste			
	c	Containers for sharps disposal			
	d	Does the R.T. site have a post exposure protocol?			
4.2.6	**Client Handling**				
	a	Does this site provide privacy for counseling and testing?			
	b	Is client handling and reporting of tests done confidentially			
	c	Is the site suitable for various volumes of client flow? Can optimum workflow be maintained?			

General Comments:

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DATE OF ASSESSMENT	NAME OF NIP SITE ASSESSOR	SIGNATURE OF ASSESSOR

Send original form to QA Office, NIP Head office, Windhoek.

For Office Use

Date Received: _____ Signature: _____

SITE ASSESSMENT EVALUATION

Appendix II

HCT Annual Renewal of Site Licensing

Name of Facility:	**District:** **Region:**	**Date of Visit:** dd/mm/year		
HCT approach	PITC / VCT / Home-based			
HCT delivery model	Health facility / stand alone / mobile / outreach / home based			
Assessors: 1. **2.**	**Managing Agency**			
Site opening hours	Mon-Fri	Sat	Sun	Holidays

Staff Profile**:** (attach copies of certificates)				
Names	**Designation**	**Full time**	**RT certificate**	**Counselling certificate**
		Y / N	Y / N	Y / N
		Y / N	Y / N	Y / N
		Y / N	Y / N	Y / N
		Y / N	Y / N	Y / N
		Y / N	Y / N	Y / N

Infrastructure requirements for annual renewal of license:

Section Ref	Question	Yes	No	N/A	
4.2.1	**Personnel**				
	a	Are there adequate staff at the site at all opening times?			
	b	Are staff conducting HCT counselling certified in MOHSS curriculum?			
	c	Are staff performing HIV rapid testing trained according to MoHSS RT approved curriculum?			
	d	Is there a programme for recertification of individuals (annual for PITC, HBCT and every two years for VCT service providers)?			
4.2.2	**Space and Furniture Requirements**				
	a	Is adequate private room / space available?			
	b	Good ventilation			
	c	Bench space for the performance of HIV testing			
	d	Wash basin in proximity of testing space			
	e	Protective cover on working area, easy to clean and disinfect.			
4.2.3	**Storage facilities**				
	a	Is the kit storage area kept under lock and key?			
	b	Storage of kits within temperature range			
	c	Temperature controlled storage of specimens for proficiency testing			
	d	Lockable cabinet for storing documents			
4.2.4	**Inventory and Stocks**				
	a	System in place for obtaining supplies? Forecasting etc.			
	b	Is the site supervisor assigned to look after the stock?			
	c	Stock control measures in place and written policy present?			
	d	Are there adequate stocks of condoms at site today?			
4.2.5	**Safety and Infection Control**				
	a	Waste container for general waste			
	b	Waste container for bio hazardous waste			
	c	Containers for sharps disposal			
	d	Does the R.T. site have a post exposure protocol?			
4.2.6	**Client Handling**				
	a	Does this site provide privacy for counseling and testing?			
	b	Is client handling and reporting of tests done confidentially			
	c	Is the site suitable for various volumes of client flow? Can optimum workflow be maintained?			

Process requirements for annual renewal of license:

Section Ref	Question	Yes	No	N/A	
4.3.1	**Awareness of national policies and adherence to SOPs**				
	a	National HCT guidelines easily accessible			
	b	HCT protocols (VCT, PITC or HBCT) available and on display			
	c	Standard Operating Procedures for HIV rapid testing on display in testing area			
	d	Safety guidelines available and on display, including advice on needle stick injuries			
	e	Gloves available & used when collecting blood samples			
		Correct testing algorithm used?			
		Correct algorithm followed for discrepant results?			
4.3.2	**Client Flow**				
	a	Door tags used for privacy			
	b	Clients wait less than two hours on day of visit			
4.3.3	**Collection and submission of accurate data**				
	a	Client register maintained daily			
	b	Standard HIV rapid test logbook available and used daily			
	c	Monthly reports submitted within 7 working days			
	d	Analyzed data available at site for programming			
4.3.4	**Site opening, staffing and stock outs**				
	a	Site opening times clearly displayed			
	b	Uninterrupted and adequate supply of test kits over the last year			
	c	Availability of an updated stock register			
	d	Availability of a staff duty roster			
4.3.5	**Quality assurance**				
	a	Availability of a counselor supervision schedule			
		Availability of files with counselor supervision information			
		Client opinions sought in a systematic manner and used for QI			
		Gaps identified during supervision are used for QI			
		100% concordance with PT panels achieved in last six months			

General Comments:

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DATE OF ASSESSMENT	NAME OF MoHSS SITE ASSESSOR	SIGNATURE OF ASSESSOR

Send original form to QA Office, MOHSS Head office, Windhoek.

For Office Use

Date Received: _____ Signature: _____

SITE ASSESSMENT EVALUATION

Appendix III

Accreditation of HIV Counselling and Testing sites – Rewarding Excellence

Name of Facility:	**District:** **Region:**		**Date of Visit:** dd/mm/year	
HCT approach	PITC / VCT / Home-based			
HCT delivery model	Health facility / stand alone / mobile / outreach / home based			
Assessors: 1. **2.**	**Managing Agency**			
Site opening hours	Mon-Fri	Sat	Sun	Holidays

Staff Profile**:** (attach copies of certificates)										
Names	**Designation**	**Full time**	**RT certificate**	**Counselling certificate**						
		Y / N	Y / N	Y / N						
		Y / N	Y / N	Y / N						
		Y / N	Y / N	Y / N						
		Y / N	Y / N	Y / N						
		Y / N	Y / N	Y / N						

Section Ref		**Question**	**Yes**	**No**	**N/A**
4.2.1	**Personnel**				
	a	Are there adequate staff at the site at all opening times?			
	b	Are staff conducting HCT counselling certified in MOHSS curriculum?			
	c	Are staff performing HIV rapid testing trained according to MoHSS RT approved curriculum?			
	d	Is there a programme for recertification of individuals (annual for PITC, HBCT and every two years for VCT service providers)?			
	e	Is there a training register for all HCT staff.			
	f	Value of counselling work is recognised by other facility staff?			
	g	HCT staff attitude, motivation, job satisfaction and professional improvement is assessed and monitored over time (annual appraisal)?			
4.2.2	**Space, equipment and furniture Requirements**				
	a	Is adequate private room / space available?			
	b	Good ventilation			
	c	Bench space for the performance of HIV testing			
	d	Wash basin in proximity of testing space			
	e	Protective cover on working area, easy to clean and disinfect.			
	f	Facility registered to provide VCT services (registration certificate on display)?			
	g	Room/s adequately equipped with 3 chairs, 1 table and separate testing area?			
	h	Penile model available and on display?			
	i	Lockable cupboard for storing client records available ?			
	j	Room/s and waiting area well maintained and clean?			
	k	Accessible clean toilets with hand washing facilities?			
4.2.3	**Storage facilities**				
	a	Is the kit storage area kept under lock and key?			
	b	Storage of kits within temperature range			
	c	Temperature controlled storage of specimens for proficiency testing			
	d	Lockable cabinet for storing documents			
4.2.4	**Inventory and Stocks**				
	a	System in place for obtaining supplies? Forecasting etc.			
	b	Is the site supervisor assigned to look after the stock?			
	c	Stock control measures in place and written policy present?			
	d	Are there adequate stocks of condoms at site today?			
4.2.5	**Safety and Infection Control**				
	a	Waste container for general waste			
	b	Waste container for bio hazardous waste			

	c	Containers for sharps disposal			
	d	Does the R.T. site have a post exposure protocol?			
	e	Pit, incinerator or contractual arrangement in place for disposal of contaminated waste			
	f	Protective clothing available and used for testing (gown and gloves)?			
	g	Running water available in testing room?			
4.2.6	**Client Handling**				
	a	Does this site provide privacy for counseling and testing?			
	b	Is client handling and reporting of tests done confidentially			
	c	Is the site suitable for various volumes of client flow? Can optimum workflow be maintained?			
	d	Informed consent before testing client for HIV			
	e	Client satisfaction assessed?			
	f	Mechanisms for client feedback in place (suggestion box, community meetings etc)?			

Section Ref	**Question**	**Yes**	**No**	**N/A**		
4.3.1	**Awareness of national policies and adherence to SOPs**					
	a	National HCT guidelines available & easily accessible				
	b	HCT protocols (VCT, PITC or HBCT) available and on display				
	c	Standard Operating Procedures for HIV rapid testing on display in testing area				
	d	Safety guidelines available and on display, including advice on needle stick injuries				
	e	Gloves available & used when collecting blood samples				
	f	Correct testing algorithm used?				
	g		Correct algorithm followed for discrepant results?			
	h		HCT offered to all clients irrespective of ability to pay			
4.3.2	**Client Flow**			Yes	No	N/A
	a		Opening hours prominently displayed			
	b		Door tags used for privacy			
	c		Clients wait less than two hours on day of visit			
4.3.3	**Collection and submission of accurate data**					
	a		Client register maintained daily			
	b		Standard HIV rapid test logbook available and used daily			
	c		Monthly reports submitted within 7 working days			
	d		Analyzed data available at site for programming			
4.3.4	**Site opening, staffing and stock outs**					
	a		Uninterrupted and adequate supply of test kits over the last year			
	b		Availability of an updated stock register			
	c		Availability of a staff duty roster			
	d		Rapid HIV test kits within expiry dates?			
	e		Kits stored at an appropriate temperature (fridge required if above 30 degrees)?			

4.3.5	**Quality assurance**		Yes	No	N/A
	a	Availability of a counselor supervision schedule			
	b	Availability of files with counselor supervision information			
	c	Client opinions sought in a systematic manner			
		QA tools used for systematically monitoring quality of service provision (client exit interviews, counsellor self assessment or observed practice)?			
	d	Gaps identified during supervision are acted on (check record)			
	e	Regular HCT counsellor meetings conducted (monthly)			
	f	Regular QI site meetings conducted (monthly)			
	g	100% concordance with EQA testing (re-testing and proficiency testing) over last 12 months			
5.4	**Referral system**				
	a	Traceable referral system in place and functional			
	b	Referral directory/list available			
	c	Designated referral site for care and support?			
	d	Post-test support available (e.g. PTC, PLWHA support group, discordant couples support group)			

	Records and Information System	**Yes**	**No**	**N/A**			
4.2.4	a	Uninterrupted and adequate supply of HCT registers and logbooks					
12.1	b	HCT client register available and used?					
10.5	c	Laboratory log book available and used?					
5.1	d	System for anonymous client coding in place and functioning?					
12.2	e	Easily retrievable copies of submitted monthly reports available?					
10.11	f	Written EQA feedback/reports from the laboratory available?					
4.2.4	g	Stock register available and up to date?					
4.2.5	h	Accident/incident book available and used?					
11.2	**IEC Materials**				**Yes**	**No**	**N/A**
	a	Availability of signboards, labels and directions for HCT room/s?					
	b	Opening hours prominently displayed?					
	c	Door tags used for privacy (please enter/counselling in progress)?					
	d	Uninterrupted and adequate supply of HCT leaflets and posters?					
	e	HCT leaflets on display and available for clients?					
	f	Content of leaflet is clear and easy to understand?					
	g	HCT posters prominently displayed?					
	h	Content of posters clear and easy to understand?					
	i	Adequate supply of condoms freely available and on display?					
4.6	**Financial Management**				**Yes**	**No**	**N/A**
	a	Fee charges prominently displayed?					

	b	Records of accounts available?			
	c	Clear policy and measures in place for clients unable to pay?			
11.1	**Continuous Quality Improvement**				
	a	Client opinions sought in a systematic manner and used for QI			
	b	Gaps identified during supervision are used for QI			
	c	Regular monitoring and analysis of HCT data conducted (summary sheets, graphs)?			
	d	Facility QI teams formed and meet quarterly			
	Performance (Are the following indicators calculated on a quarterly basis?)				
	a	Average number of clients/counsellor/day (<8 clients)			
	b	% Counselled clients who take HIV test			
	c	% Clients coming back for follow-up counselling			
	d	% Test results indeterminate			
	e	Timely submission of monthly reports			
	f	% Clients given condoms			
	g	Breakdown of clients by age, sex and test result			
	Society		**Yes**	**No**	**N/A**
	a	Public image and cultural acceptability of service is assessed at regular intervals and considered?			

General Comments:

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DATE OF ASSESSMENT	NAME OF ASSESSOR	SIGNATURE OF ASSESSOR

Send original form to HCT - QA Office, Head office, Windhoek.

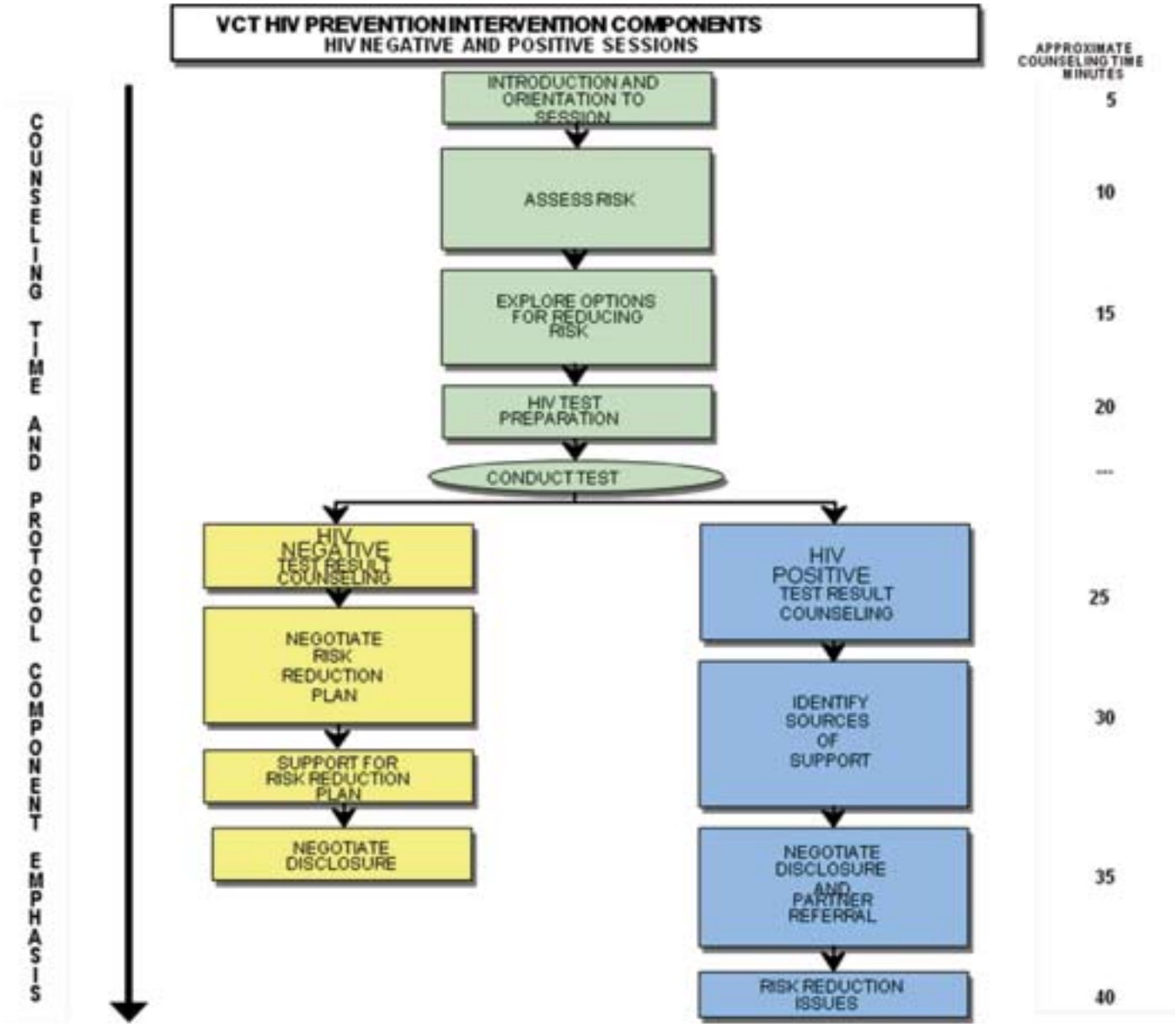
For Office Use

Date Received: _____ Signature: _____

National Accreditation Tool

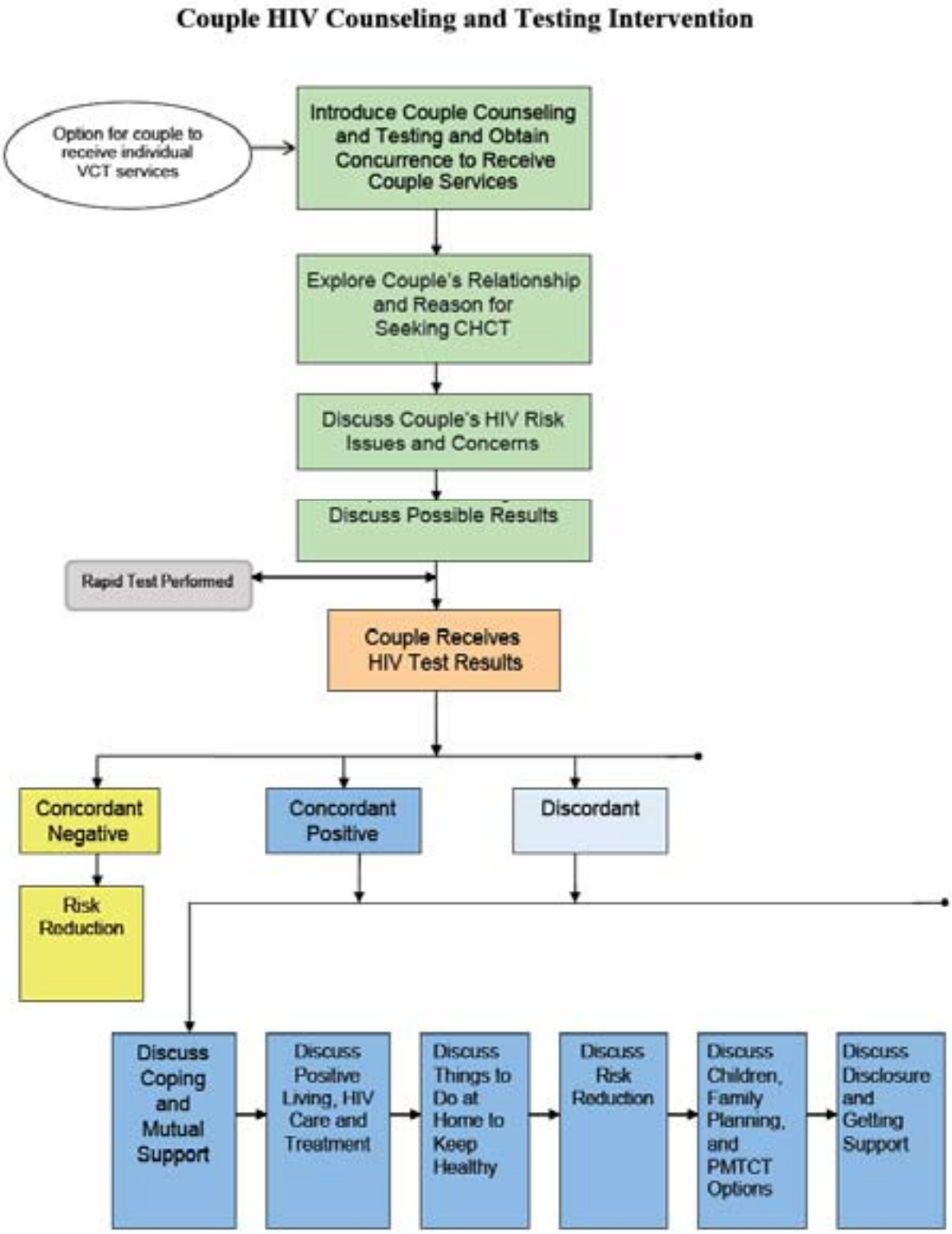
Appendix IV

VCT protocol



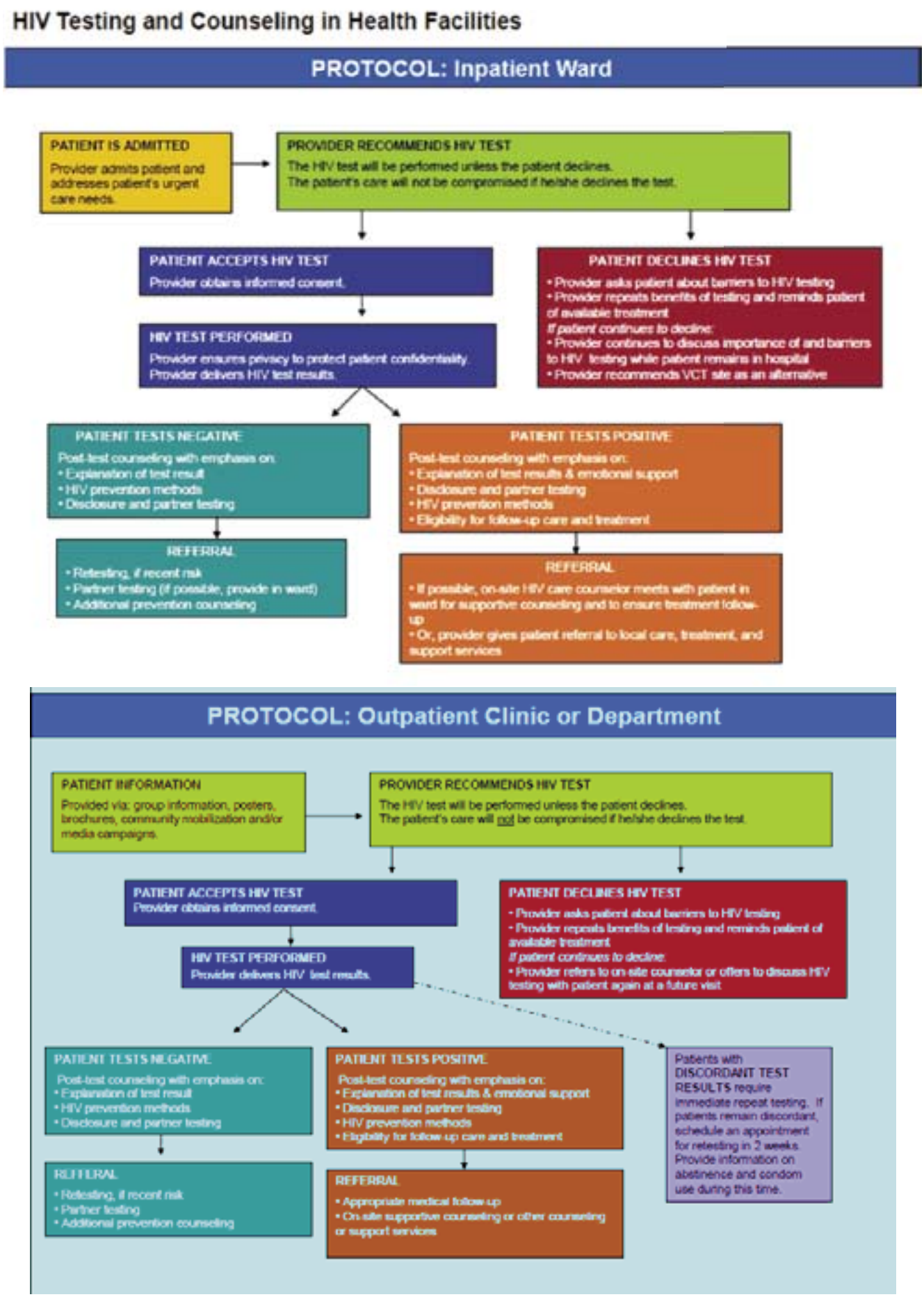
Appendix V

Couples protocol



Appendix VI

PITC protocols



Appendix VII

Standardized HIV Rapid Test Logbook Namibia

RT LOGBOOK Namibia29092011.xls

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Serial No.	**Client or Specimen ID**	**Age (Yrs)**	**Sex**	**Date Tested**	**TEST 1** Kit Name _____ Lot No. _____ Exp.Date_____	**TEST 2** Kit Name _____ Lot No. _____ Exp.Date_____	**TEST 3** Kit Name _____ Lot No. _____ Exp.Date_____	**FINAL RESULTS**	**Operator Name / Initials**	**Sent for Further QA Testing**	**Date Sent**	**Final QA Results**	**Date Received**	**Comments**
1			M F		R NR INV	R NR INV	R NR INV	**P N INV**		☐		P N I		
2			M F		R NR INV	R NR INV	R NR INV	**P N INV**		☐		P N I		
3			M F		R NR INV	R NR INV	R NR INV	**P N INV**		☐		P N I		
4			M F		R NR INV	R NR INV	R NR INV	**P N INV**		☐		P N I		
5			M F		R NR INV	R NR INV	R NR INV	**P N INV**		☐		P N I		
6			M F		R NR INV	R NR INV	R NR INV	**P N INV**		☐		P N I		
7			M F		R NR INV	R NR INV	R NR INV	**P N INV**		☐		P N I		
8			M F		R NR INV	R NR INV	R NR INV	**P N INV**		☐		P N I		
9			M F		R NR INV	R NR INV	R NR INV	**P N INV**		☐		P N I		
10			M F		R NR INV	R NR INV	R NR INV	**P N INV**		☐		P N I		
11			M F		R NR INV	R NR INV	R NR INV	**P N INV**		☐		P N I		
12			M F		R NR INV	R NR INV	R NR INV	**P N INV**		☐		P N I		
13			M F		R NR INV	R NR INV	R NR INV	**P N INV**		☐		P N I		
14			M F		R NR INV	R NR INV	R NR INV	**P N INV**		☐		P N I		
15			M F		R NR INV	R NR INV	R NR INV	**P N INV**		☐		P N I		
16			M F		R NR INV	R NR INV	R NR INV	**P N INV**		☐		P N I		
17			M F		R NR INV	R NR INV	R NR INV	**P N INV**		☐		P N I		
18			M F		R NR INV	R NR INV	R NR INV	**P N INV**		☐		P N I		
19			M F		R NR INV	R NR INV	R NR INV	**P N INV**		☐		P N I		
20			M F		R NR INV	R NR INV	R NR INV	**P N INV**		☐		P N I		

PAGE TOTAL

Total Tested						
Total Reactive/Positive						
Total Non-Reactive/Negative						
Total Invalid (or Indeterminate)						

R = Reactive, NR = nonreactive, and INV = Invalid

P = Positve, N = Negative and I = Indeterminate

(Rev. 06/09)

Ministry of Health and Social Services

COUNSELING AND TESTING REGISTER

NAME OF FACILITY:..... MONTH:..... YEAR:.....

----------IDENTIFICATION ----------				----------DEMOGRAPHIC----------								---------- COUNSELING AND TESTING ----------							----------TODAY'S RESULTS ----------							---------- OFFICE ADMINISTRATION ----------						- REMARKS -
Date of Visit (dd/mm/yy)	Client Code	PartnerCode	Additional PartnerCode	Surname / Given Name	Sex 1=F 2=M	If Male,Circumcised and if yes, Where 1=Yes 2=No	If Male,Circumcised and if yes, Where (Use Codes)	Date of Birth (dd/mm/yy)	Age	Marital Status (Use Codes)	Highest Level of Education 1=None 2=Primary 3=Secondary 4=Tertiary	Previously Tested for HIV 1=Yes 2=No	If Tested before, When(dd/mm/yy)	Previous Test Result 1=HIV+ 2=HIV-	If Tested before, Where (Specify other) (Use Codes)	Attended Group Education 1=Yes 2=No	Pre-Test Counselled 1=Yes 2=No	Reason for Testing today (Use Codes)	Post-Test Counselled 1=Yes 2=No	Type of Post-Test Counseling (Use Codes)	Received Results 1=Yes 2=No	If Yes, Date Results Received (dd/mm/yy	Test Results 1=HIV+ 2=HIV- 3=Unknown	Partner Status 1=HIV+ 2=HIV- 3=Unknown	Couple Status (Use Codes)	Referred to (Specify other) (Use Codes)	Counselor Name & Signature	Nurse Name & Signature		Supervisor Name & Signature		Date of Testing (dd/mm/yy)		
1																														1
2																														2
3																														3
4																														4
5																														5
6																														6
7																														7
8																														8
9																														9
10																														10
11																														11
12																														12
13																														13
14																														14
15																														15

Type of Facility
1=Public Health Facility
2=Traditional
3=Self
4=Private Health Facility

Marital Status
1=Child
2=Never Maried
3=Maried
4=Living with Partner
5=Divorced/Separated
6=Widow/Widower

If Tested before, Where
1=This Site
2=New Start Centre
3=Other Public Health Facility
4=Private Health Facility
5=Blood Donation Service
6=Military VCT
7=Private Medical Practitioner
8=Outreach
9=Other (Specify)

Reason for Testing
1=Self refer
2=Provider initiated

Type of Post Test Counseling
1=Individual
2=Partner
3=Parent/Guardian with Child

Referred to
1=PMTCT
2=ARV Clinic
3=Psychosocial Support
4=TB Screen
5=STI
6=Other (Specify)

Test Result
1=Concordant
2=Serodiscordant

1. NB: If "Age" is less than 1 year,indicate with an asterisk(*) before number!
2. Codes are 10 digits numbers, i.e Facility code(3),Delivery Point (TB, STI, etc)(1),Surname & Initial (2),Sequential Number(4)