



NATIONAL HIV COUNSELLING AND TESTING (HCT) POLICY GUIDELINES



National HIV Counselling and Testing Policy Guidelines

National Department of Health © 2010

Department of Health

Private Bag X828, Pretoria, 0001

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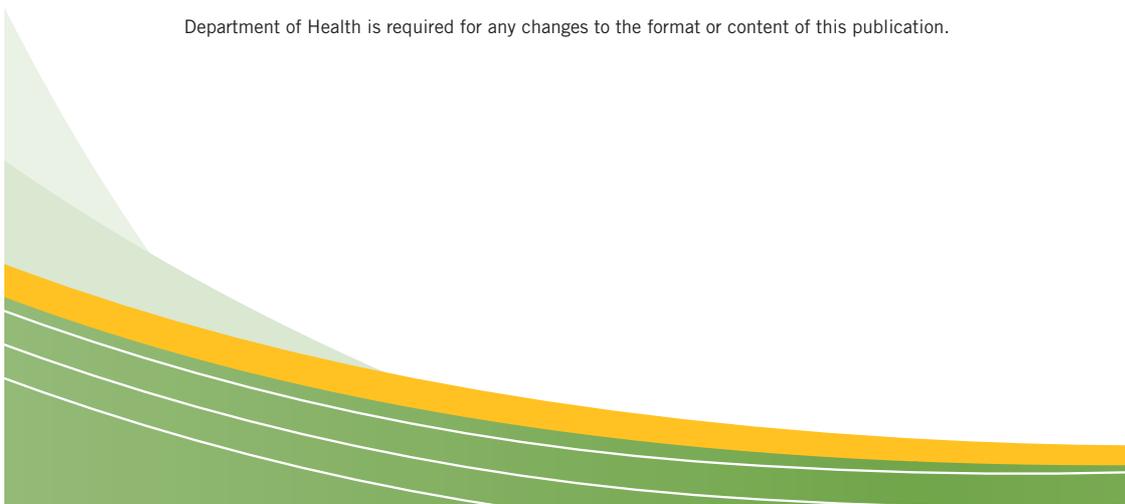
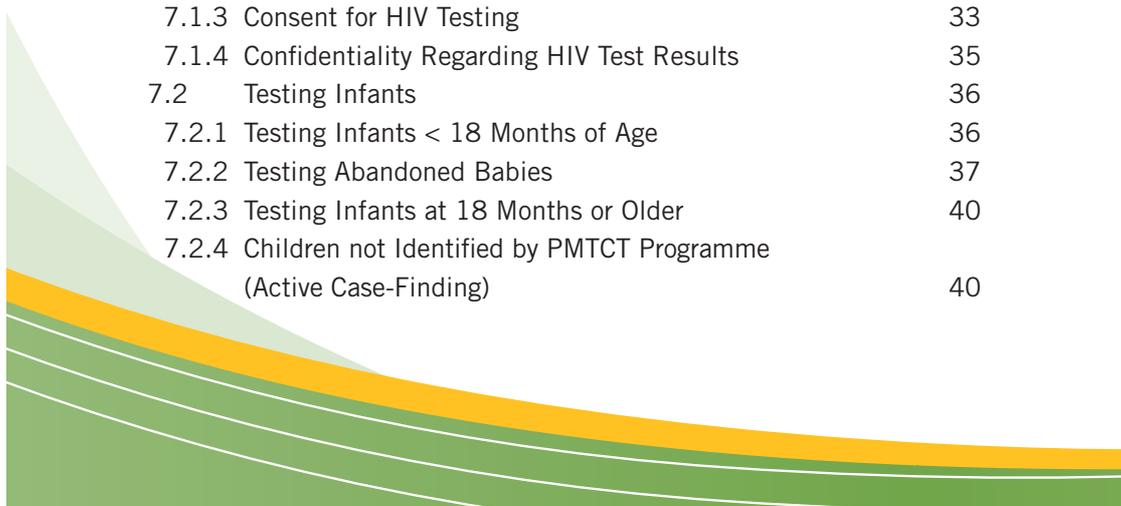


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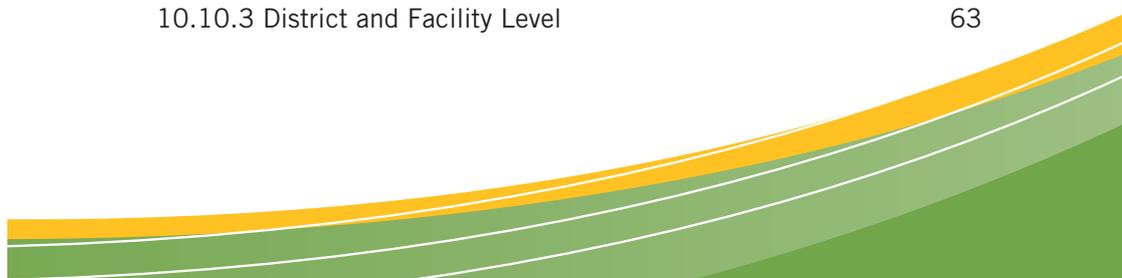
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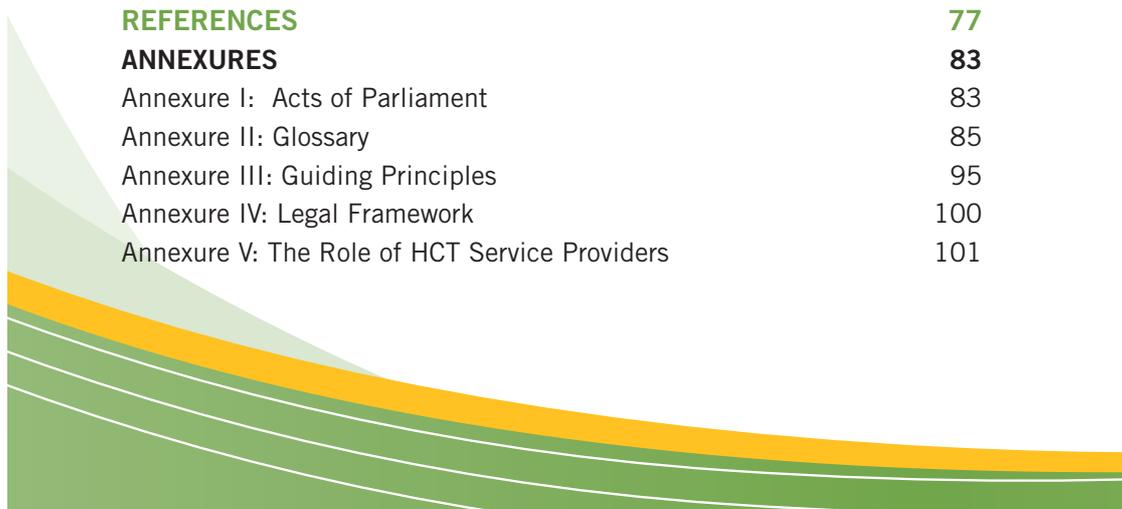
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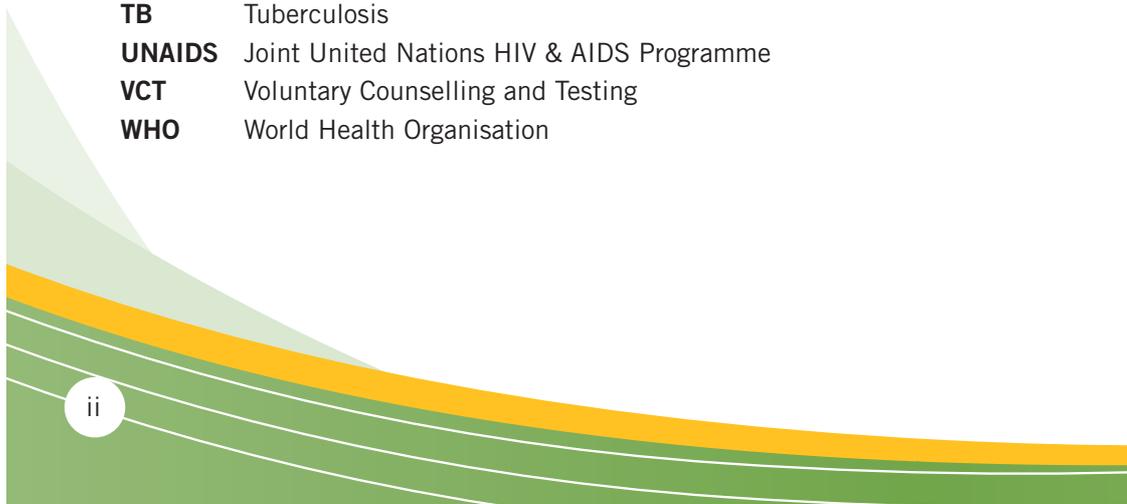
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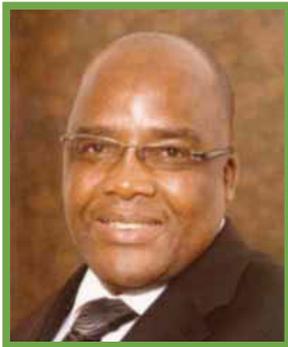
ACRONYMS

AFASS	Affordable, Feasible, Accessible, Safe and Sustainable
AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Clinic
BSS	Behavioural Surveillance Survey
CBO	Community-Based Organisation
CCMT	Comprehensive HIV and AIDS Care, Management and Treatment
CDC	Centers for Disease Control and Prevention
CHW	Community Health Worker
CICT	Client-Initiated Counselling and Testing
CT	Counselling and Testing
CXT	Cotrimoxazole
DHS	District Health System
DHIS	District Health Information System
DoH	Department of Health
EBF	Exclusive Breast Feeding
ELISA	Enzyme Linked Immunosorbent Assay
FBO	Faith-Based Organisation
FP	Family Planning
HBC	Home-Based Care
HCT	HIV Counselling and Testing

HIV	Human Immunodeficiency Virus
HWSETA	Health and Welfare Sector Training Authority
IMCI	Integrated Management of Childhood Illnesses
M&E	Monitoring and Evaluation
MDG	Millennium Development Goal
MSM	Men who have Sex with Men
MTCT	Mother-to-Child Transmission
NDoH	National Department of Health
NGO	Non-Governmental Organisation
NHIS/SA	National Health Information System of South Africa
NICD	National Institute for Communicable Diseases
NSP	National Strategic Plan for HIV & AIDS and STIs (2007-2011)
OI	Opportunistic Infection
PCR	Polymerase Chain Reaction
PHC	Primary Health Care
PHCC	Primary Health Care Clinic
PEP	Post-Exposure Prophylaxis
PICT	Provider-Initiated Counselling and Testing
PMTCT	Prevention of Mother-to-Child Transmission of HIV
QA	Quality Assurance
QC	Quality Control
RT	Routine Offer of Testing
SANAC	South African National AIDS Council
STI	Sexually Transmitted Infection
TB	Tuberculosis
UNAIDS	Joint United Nations HIV & AIDS Programme
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation



FOREWORD



Responding to HIV and AIDS is one of the most important tasks facing South Africa today. The South African government has made the fight against this disease one of its top priorities. In order to guide the national response, the National Department of Health updated previous commitments and developed the *National Strategic Plan for HIV & AIDS and STIs, 2007-2011 (NSP)*. The NSP outlines four key priority areas for the country:

- prevention;
- treatment, care and support;
- research, monitoring and surveillance; and
- human rights and access to justice.

Two primary goals inform these priority areas: to reduce the number of new infections by 50% by 2011, and to reduce the impact of HIV and AIDS on individuals, families, communities and society by expanding access to an appropriate package of treatment, care and support to 80% of all people diagnosed with HIV. Knowledge of HIV status is critical to these prevention and treatment goals. The implementation of the National HIV

Counselling and Testing (HCT) Programme within a legal and human rights framework is a key intervention towards the realisation of the goals of the NSP.

HCT is an entry point to a comprehensive continuum of care. Once an individual has been tested for HIV, prevention can be reinforced and referral made to the appropriate treatment, care and support services. HCT has become increasingly available in South African public health facilities in recent years, but despite this, uptake of counselling and testing remains low, and the National Department of Health is committed to supporting wide-scale social mobilisation to expand this service to all South Africans.

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

The *HIV Counselling and Testing Policy Guidelines* seeks to help HCT service providers provide caring, good quality, uniform and equitable HCT services in the country. In addition, guidelines for the implementation of a comprehensive national HIV counselling and testing programme are provided. Scaling up HIV testing through the routine offer of voluntary testing directed at all users of health (and non-health) facilities and to all age groups forms the foundation of this programme. The document highlights the importance of ethical and legal considerations, outlines the approach to HIV testing in children and pregnant women, and emphasises adherence to National Quality Assurance Standards on rapid HIV testing.

Government recognises that prevention remains the cornerstone of all our efforts in the response to HIV and AIDS and that testing provides access

to the continuum of prevention, treatment, care and support. We therefore continue to urge each and every one to do their part towards developing an HIV-free generation.

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

Minister of Health

Dr A. Motsoaledi

A handwritten signature in black ink, appearing to read 'A. Motsoaledi', with a long horizontal stroke extending to the right.



ACKNOWLEDGEMENTS

The development of the *HIV Counselling and Testing Policy Guidelines* would not have been possible without the assistance from countless people and organisations. Our thanks go to all who took the time and effort to assist in the development of this document, be it through drafting sections or reading and commenting on the draft.

DR. YOGAN PILLAY

ACTING DIRECTOR GENERAL: HEALTH





SECTION 1: INTRODUCTION

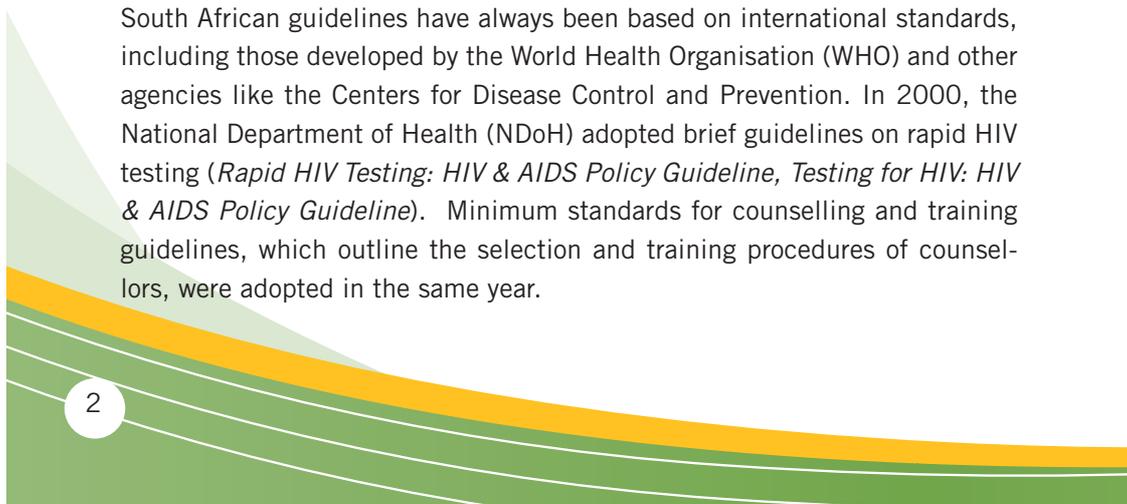
South Africa has a generalised, hyperendemic HIV epidemic with prevalence exceeding 18%. HIV prevalence among pregnant women is estimated at 29.3% (*National HIV and Syphilis Prevalence Survey, 2008*). The country has an estimated 5.7 million people living with HIV (UNAIDS, 2008). Within the infected population, 90 000 are babies born with HIV, and 85% of infections occur through heterosexual sex in the general population.

The *National Strategic Plan for HIV and AIDS and STIs, 2007-2011 (NSP)* is a concerted and coordinated response to the epidemic in South Africa. The NSP's two primary goals are to reduce the incidence of new HIV infections in South Africa by half, and to ensure that at least 80% of those who are already HIV-positive have access to treatment by 2011. Knowledge of HIV status is central to both these goals. Specifically, key strategies in the NSP are to increase access to and uptake of voluntary counselling and testing (VCT), and to increase the geographic coverage of VCT services in medical and non-medical settings by 2011. In addition, the plan seeks to increase the proportion of people (15-49 years) who access VCT services from 25% to 70%.

HIV Counselling and Testing (HCT) has become increasingly available in South Africa in recent years. More than 4500 public health facilities are offering provider-initiated testing and counselling (PICT) also known as routine HIV testing (RT) and client-initiated counselling and testing (CICT) also known as VCT. HCT is also offered through mobile services, as well as non-medical sites. The National Department of Health's HCT programme supports approximately 8000 lay counsellors with stipends; they provide HIV counselling at medical and non-medical sites.

With increasing availability of HCT in many public health facilities in South Africa, uptake of counselling and testing is also increasing. The proportion of people who have ever had an HIV test and are aware of their status has increased from 21% in 2002, to 30% in 2005, and to 50% in 2008 (Shisana and Simbayi, 2002; Pettifor *et al.*, 2004; HSRC, 2008). Moreover, in 2002 only one in five South Africans who were aware of the services had actually utilised them (Kalichman & Simbayi, 2003). In order to achieve the goals of the NSP, HCT services in facilities must be improved and scaled up through PICT. In addition, HCT services provided through mobile and community-based models by non-governmental and faith- and community-based organizations (NGOs, FBOs, CBOs) must be expanded. Greater collaboration with the private sector is essential; all implementing groups must work in partnership with the South African government to achieve the NSP's goals.

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



In order to provide continued guidance for VCT implementation, the NDoH developed guidelines, *The South African National Voluntary Counselling and Testing (VCT): HIV Prevention and Care Strategy*, in 2003. These guidelines catered for both the public and private sectors and addressed issues around counselling and testing in the context of HIV and AIDS prevention and care interventions. Furthermore, they provided an approach for the implementation of VCT services in health and non-health facilities and built on the experiences accumulated during the previous three years (from 2000-2003) utilising documented practices from South Africa and other countries.





SECTION 2: RATIONALE FOR THE HCT POLICY GUIDELINES

The implementation of the National HCT Programme has been guided mainly by programme-oriented recommendations. Rapid HIV testing as a screening and diagnostic test is regarded as one of the key interventions in the national response to HIV and AIDS. Point-of-care HIV tests through VCT are now widely available in the public and non-governmental sectors, and this has led to the adoption of numerous different approaches. Consequently, the NDoH is charged with the responsibility and challenge of ensuring that the necessary policy documents are in place and that point-of-care HIV testing is carried out in the most sensitive and caring way with specific attention to issues of human rights, quality and access.

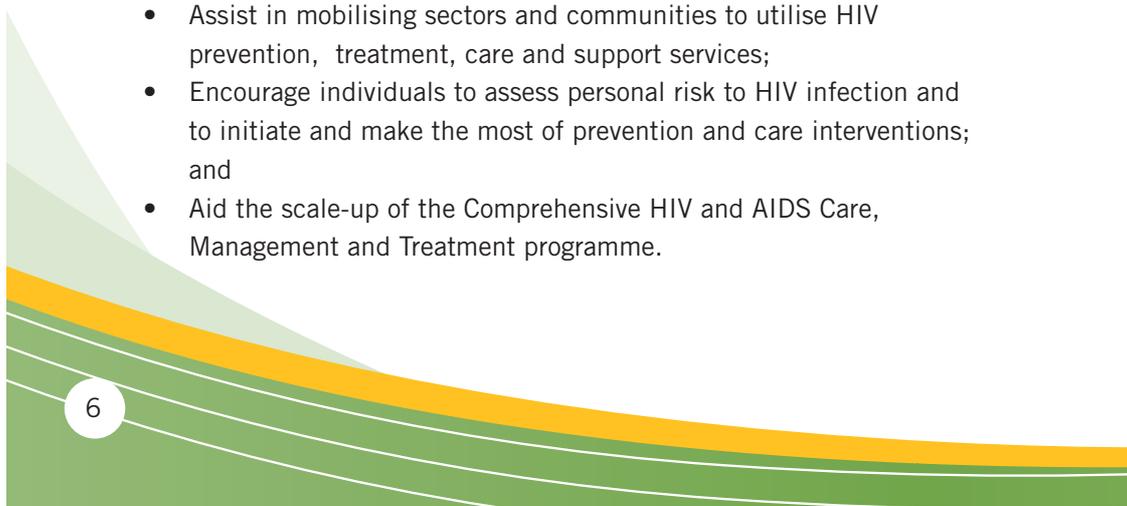
This policy guideline seeks to address this gap. It flows from and builds on *The South African National Voluntary Counselling and Testing (VCT) HIV Prevention and Care Strategy 2003*, and draws from international practices on HIV counselling and testing. In addition, the policy guideline seeks to provide a framework for all the HCT models that have been implemented in the country.

It is aligned with the principles outlined in the *National Operational Plan for the Comprehensive HIV and AIDS Management, Treatment, Care and Support of 2003* (The Comprehensive Plan). The plan takes the current legal framework into account, and considers recently released policy guidelines such as those on prevention of mother-to-child HIV transmission (PMTCT) (NDoH, 2010), the *Accelerated PMTCT Plan and Management of Paediatric HIV* (NDoH, 2009), and recommendations of the Integrated Management of Childhood Illnesses (IMCI) strategy (2009). In short, the document seeks to provide the necessary policy framework that will help implementation of HCT, and ultimately, lead to the attainment of the goals of the NSP.

Institutional challenges to health systems such as inequity, poor access, and the constraints of human, infrastructural and financial resources (*WHO Task Shifting Global Recommendations and Guidelines*) will need to be addressed. Social mobilisation around HIV testing should be intensified in order to encourage and to increase the uptake of testing. Ultimately, HCT, PMTCT, and other HIV and AIDS services should be integrated in the primary health-care programme through the district health system. Quality assurance is a critical element of the *HCT Policy Guidelines*.

A good quality, standardised, uniform, equitable, affordable and sustainable HCT programme supported by a firm human rights base is required. The implementation of this policy should:

- Lead to increased public awareness of HIV and AIDS;
- Assist in mobilising sectors and communities to utilise HIV prevention, treatment, care and support services;
- Encourage individuals to assess personal risk to HIV infection and to initiate and make the most of prevention and care interventions; and
- Aid the scale-up of the Comprehensive HIV and AIDS Care, Management and Treatment programme.



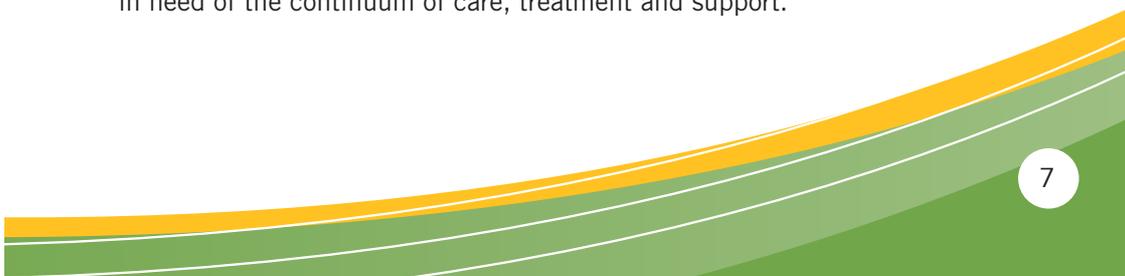
SECTION 3: AIMS AND OBJECTIVES OF HIV COUNSELLING AND TESTING

3.1 Vision

An enabling environment for HIV counselling and testing, where the majority of people in South Africa are knowledgeable about their HIV status, and able to act on this knowledge to ensure an HIV-free generations.

3.2 Mission

To develop a sustainable, coordinated and integrated National HCT Programme in partnership with other stakeholders to expand access to and increase uptake of HCT services with the aim of appropriate referral for those in need of the continuum of care, treatment and support.



3.3 Aims

The *HCT Policy Guidelines* aim to:

- Provide a national framework and guidance for the provision of HIV counselling and testing services in the public and private sectors in South Africa; and
- Provide a framework for conducting HIV counselling and testing among adults and children.

The National HCT Programme aims to provide universal access to good quality, effective HIV counselling and testing and referral services to all the people in South Africa.

3.4 Objectives

The objectives of the *HCT Policy Guidelines* are to:

- Provide core requirements and guidance to ensure the delivery of standardised, high quality and ethical HIV counselling and testing services;
- Outline different types of HIV counselling and testing approaches for different circumstances and target groups;
- Ensure compliance with a legal and human rights approach to HIV counselling and testing;
- Expand access to HCT beyond formal health-care settings into community, private sector and non-health care environments; and
- Ensure appropriate referral to treatment.

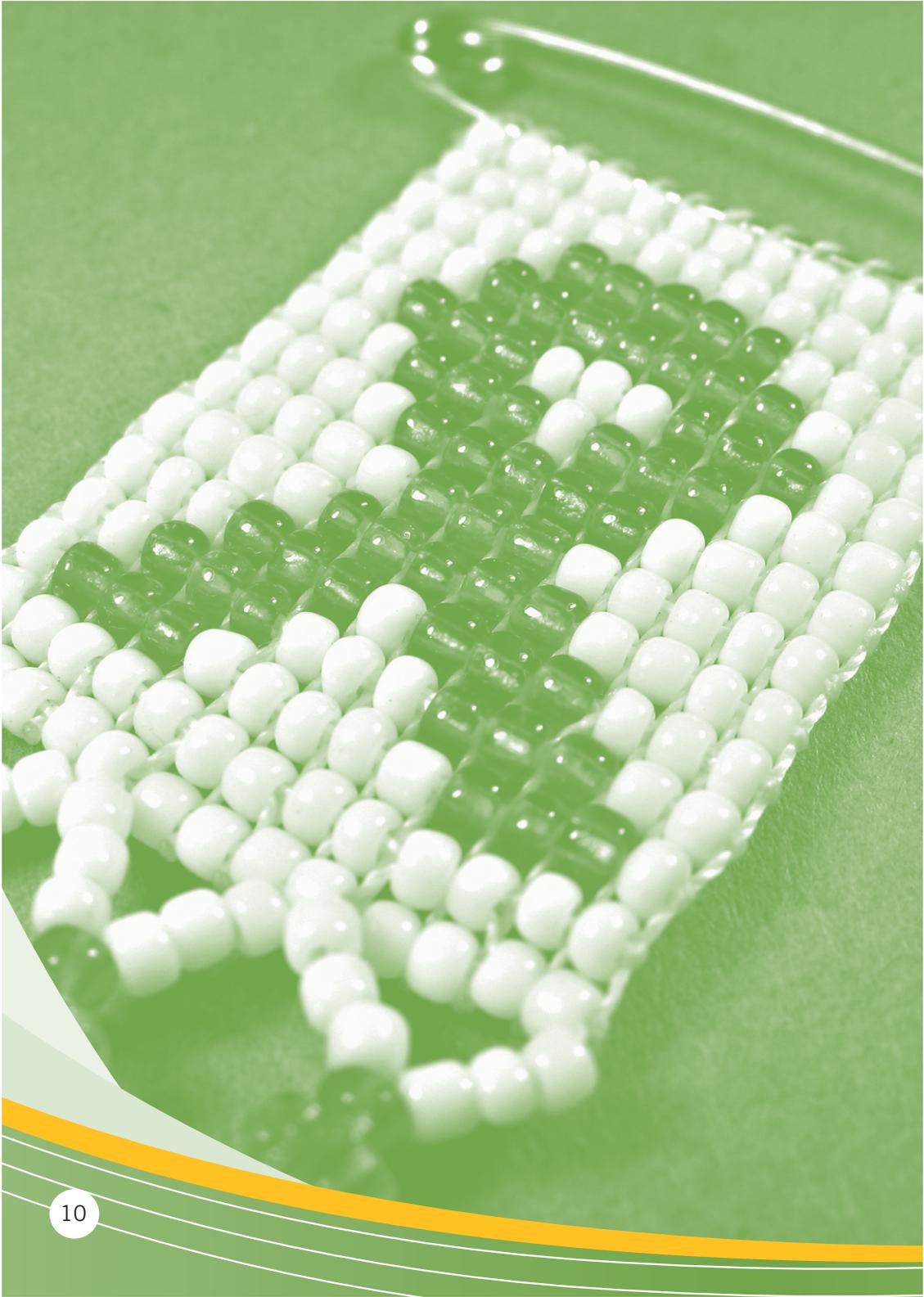
The HIV counselling and testing programme seeks to:

- Create an enabling environment that promotes universal access to safe, effective and good quality HCT services;
- Encourage individuals, couples, families and communities to test

for HIV in the interests of their own health;

- Promote support for positive living, healthy lifestyles and good nutrition;
- Encourage and support the voluntary disclosure of HIV status and to minimise stigma;
- Facilitate referral and access to prevention, treatment, care and support services following HIV testing;
- Facilitate and promote integration of HCT with family planning (FP), tuberculosis (TB), sexually transmitted infections (STIs) and other communicable and non-communicable diseases; and
- Integrate affordable, feasible, accessible, safe and sustainable HCT services into the health system.





SECTION 4: TYPES OF HIV COUNSELLING AND TESTING

4.1 Circumstances in Which HIV Testing Takes Place

There is a range of circumstances under which HIV testing occurs:

- Among individuals or couples wanting to know their status;
- Among pregnant women participating in the prevention of mother-to-child transmission (PMTCT) programme;
- During clinical diagnosis as part of basic patient care;
- During research and other screening purposes;
- Among cases of domestic violence and sexual assault;
- Prior to providing post-exposure prophylaxis (PEP) after a needle stick injury, sexual assault, rape and acts of sexual penetration - (Criminal Law (Sexual Offences & Related Matters) Amendment Act No. 32 of 2007);
- Per court order of the accused in sexual offence cases;
- Among abandoned babies/ children to facilitate PEP or placement of the child; and
- As a prerequisite for medical male circumcision.

Since HIV and AIDS is acknowledged to be one of the most important challenges facing South Africa and the fight against HIV is one of the top priorities for the government, it is appropriate that the anonymous antenatal survey be reviewed, particularly in the context of PMTCT and the accelerated PMTCT programme.

4.1.1 Individuals or Couples Wanting to Know Their Status

Individuals or couples may voluntarily seek out HCT for a range of reasons – a need to know their status before entering into a new relationship or ending one where there was infidelity, deciding to test following a risk encounter, testing because they want to plan for the future, and so on.

Individuals seeking HIV testing should always be counselled, and informed consent must be obtained before testing.

4.1.2 Clinical Diagnosis

HCT may be part of the clinical diagnostic process, particularly in cases of high-risk behavior and the clinical management of patients with or without HIV symptoms in order to provide comprehensive care. Under these circumstances, establishing a diagnosis of HIV infection is critical for clinical decision-making and for the timely provision of appropriate therapy.

Counselling must precede and follow diagnostic and clinical management testing, and informed consent must be obtained before testing.

4.1.3 Research and Other Screening Purposes

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

Research involving HIV testing can be divided into two categories:

- Unlinked and anonymous population or behavioural studies that measure prevalence of HIV and screening in health facilities. In such cases:
 - o HIV testing is done on blood that has already been collected for another purpose such as for syphilis testing; and
 - o Additional individual consent for the blood to be tested for research purposes is not required (refer to section 5.1 of this policy).
- Linked studies involving individual participants. In this case:
 - o Individual consent in order to participate in the study is required from all participants or persons authorized to act on their behalf;
 - o All legal, ethical and quality standards outlined in this HCT policy should apply;
 - o Consent of community representatives for research studies may not be substituted for individual consent; and
 - o All research subjects must be informed about HIV prevention through practicing safe sex, and effective treatment or referral must be provided for STIs.

4.1.4 Domestic Violence and Rape

Clients experiencing or reporting domestic violence, sexual assault and rape require a sensitive approach by the health-care personnel. The health-care provider should be alert to the possibility that their client may be in an existing abusive relationship which has not been disclosed. The routine offering of HIV testing is recommended as an appropriate health sector response to domestic violence.

In the case of rape, timeous (in less than 24 hours where possible) HIV testing and the administration of PEP is an essential element of the package of HCT services for survivors.

4.1.5 Abandoned Babies/Children

Abandoned babies should be tested when the status and whereabouts of the mother is unknown. Consent for such testing of the child must be obtained as outlined in Section 7.1.3 of the policy.

4.1.6 Medical Male Circumcision

Medical male circumcision (MMC) is an important and effective HIV prevention strategy. It is widely accepted that MMC not only confers partial protection against heterosexually acquired HIV infection but has other health benefits as well, reducing the incidence of STIs, penile cancer, phimosis and balanitis. Female sexual partners of men who have been circumcised have shown a decreased risk for cervical cancer. Since MMC provides partial protection for men it does not replace other prevention strategies but should be seen as part of a comprehensive HIV package.

All male patients who present for MMC services should be referred for HCT. MMC should be offered and recommended to all patients who have tested HIV negative during post-test counseling. Post-test counseling should also be used to deliver key messages including:

- Risks and benefits of MMC.
- Safer sex practices including condom use.
- Management of STIs.
- Delay of sexual debut.
- Partner reduction.
- Gender-based violence.

4.2 Types of HIV Counselling and Testing

Two main approaches to HCT are recommended in this policy and should be implemented at every health facility. These include client-initiated counselling and testing (CICT) also referred to as VCT. The second approach is provider-initiated counselling and testing (PICT).

The HCT Policy Guidelines do not support mandatory testing of individuals

4.2.1 Client-Initiated Counselling and Testing

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

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

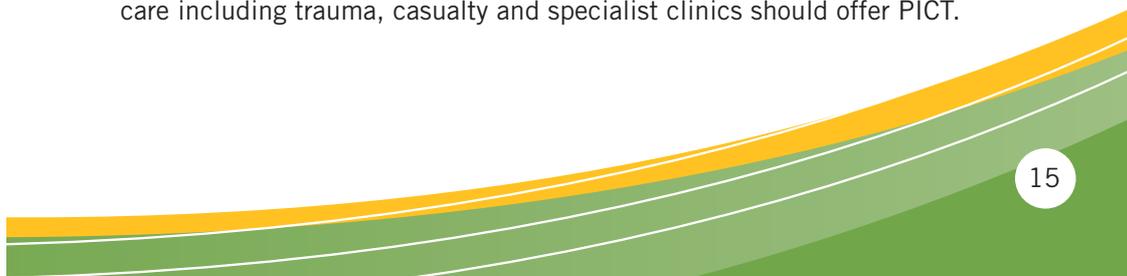
Procedure: CICT usually involves pre-test information sessions conducted individually, or with couples or in groups. Group information sessions are typically followed by a short individual session with each client. Pre-test counselling is followed by individual or couple post-test counselling. The process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

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

4.2.2 Provider-Initiated Counselling and Testing

Definition: PICT (also referred to as the Routine Offer of Counselling and Testing) is HIV counselling and testing that is initiated and recommended by health-care providers to all clients attending health-care facilities as a standard component of medical care. All aspects of care including trauma, casualty and specialist clinics should provide the option of testing.

Settings: In PICT, health-care providers recommend HIV counseling and testing to all adults, youth and children who visit health facilities. This applies to medical and surgical services, public and private facilities, in-patient and out-patient settings and mobile or outreach medical services. All aspects of care including trauma, casualty and specialist clinics should offer PICT.



PICT aims at early identification of clients for whom there may be a strong likelihood of HIV infection, either because of their symptoms, or because of high-risk sexual behavior, or in areas of high HIV prevalence.

PICT should be offered to all patients in the health facilities. In particular, PICT is emphasised but not limited to the following health service points: antenatal clinics, post-natal clinics, TB facilities, integrated management of childhood illness (IMCI) centres, FP clinics, STI clinics, and centres offering treatment for opportunistic infections (OIs) and PEP. The opt-out approach is recommended in these service points, that is, HIV testing will be done together with all other relevant tests unless the client actively refuses HIV testing. Refusal of HIV testing should be documented in the client's clinic file.

PICT is also recommended in all health services dealing with domestic or gender-based violence, child abuse and sexual violence.

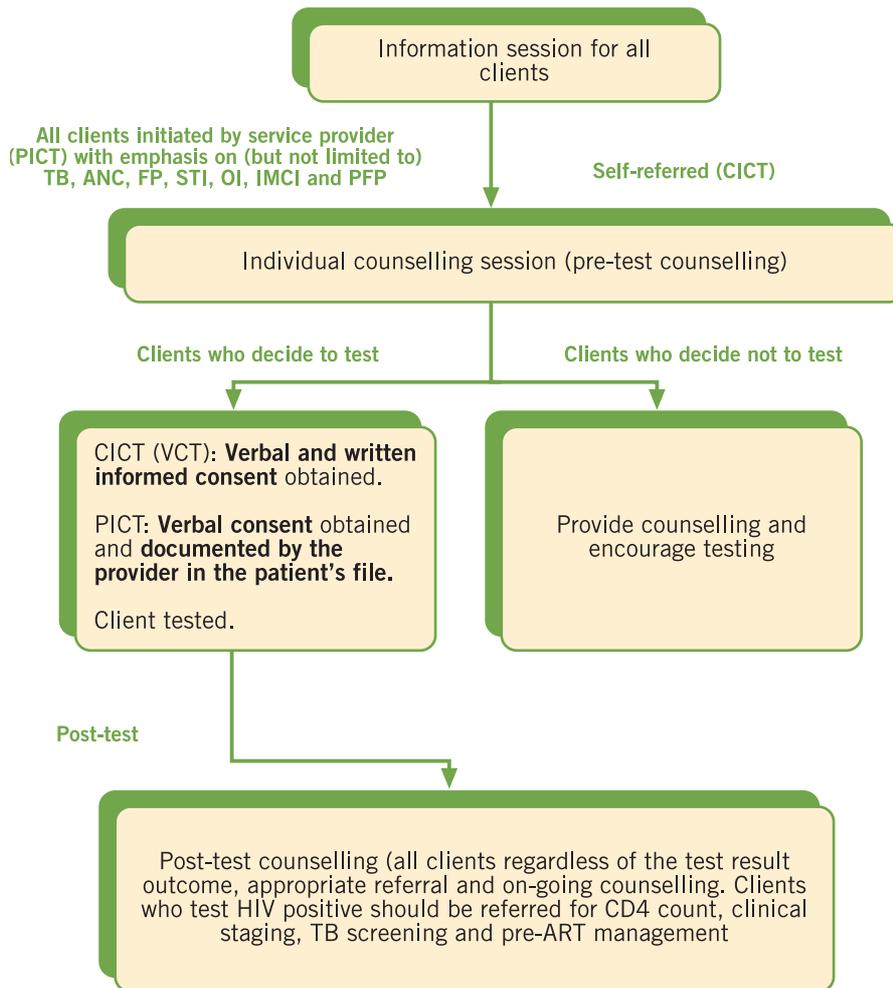
Process: PICT is initiated by the health-care provider or worker in support of scaling up HIV testing. The offer of HCT should always be done in a manner which protects and promotes the right to autonomy and dignity of all clients while recognising the duty of health-care providers to protect the right to life and to access to health services.

There should always be pre- and post-counselling and informed consent should be given for testing.

4.3. HIV Counselling Process

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

Figure 1: The HIV Counselling and Testing Process



4.3.1 Pre-Test Counselling

In public health facilities the pre-test information and education session are typically conducted in a group information session. The education session should also be followed by shorter individual counselling sessions.

Group Information Pre-test Session

A health-care worker should conduct a general group information session on general health, HIV and AIDS related issues for ALL clients including pregnant women and clients for TB, STI, FP, antenatal care (ANC), IMCI, OIs, and PEP on a daily basis. Audiovisual and information, education and communication (IEC) materials (e.g., television, videos, DVDs, posters) should be utilised when the health-care worker is not available.

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

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

Pre-Test Individual Counselling Session

Information sessions and IEC materials in the local language should be available to all clients considering taking the HIV test. The individual counselling session should include the following components:

- Assessment to determine whether the information provided in the group session has been absorbed.
- Opportunity to respond to unanswered questions, and attempt to clarify any misunderstandings.
- Discussion of specific issues for individual and assessment of individual risk, including determining whether there is a history of domestic violence.
- Discussion on risk reduction and the window period should the client test HIV negative.
- Discussion of prevention strategies including delayed sexual debut, abstinence and regular use of condoms.
- Discussion on the way forward and management options including TB screening, clinical staging, CD4 count, pre-antiretroviral treatment (ART) management and healthy lifestyle, should the client test HIV positive.
- Discussion on partner involvement and referral for testing.
- Discussion of the option to refuse testing.
- Obtaining written or verbal informed consent for HIV testing.

4.3.2 Post-Test Counselling

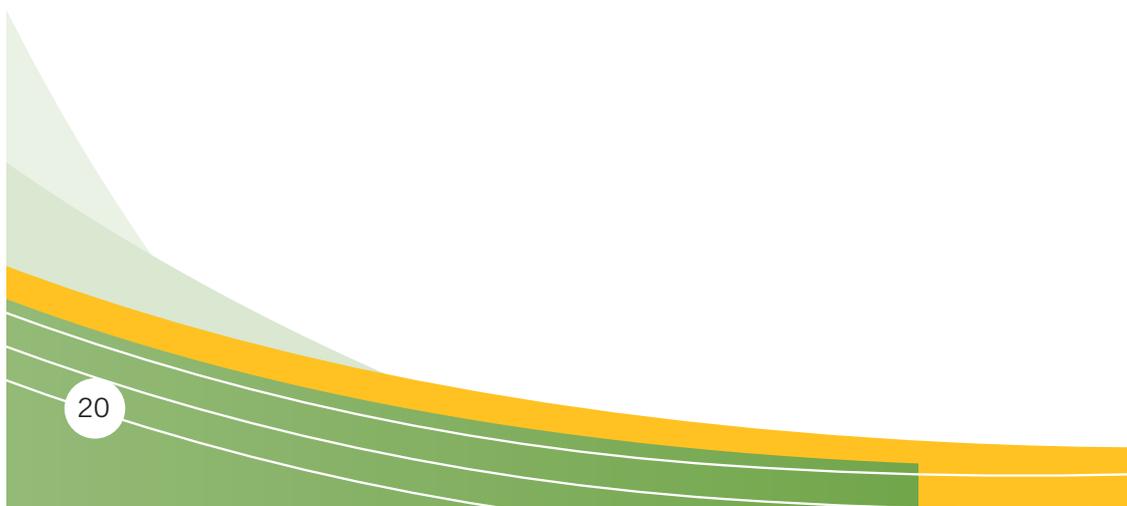
All clients, regardless of the outcome of the HIV test, should be offered and receive post-test counselling on an ongoing basis as appropriate. All results must be given clearly.

HIV-negative clients should be offered a comprehensive post-test counselling prevention package that includes information and advantages of MMC, TB screening, risk reduction and correct and regular use of condoms.

They should be encouraged to repeat the test three months after exposure to exclude the possibility of the window period. The window period should be explained.

HIV-positive clients must be given their test results and counselled post-test about their HIV status only after the second confirmatory test is also positive. Clients who test positive should be informed and counselled about possible emotional responses (e.g., denial and anger) and they should be guided as to when and how they can manifest and what impact these emotions can have on adherence to healthy lifestyle choices. These clients also need comprehensive information on how to reduce the risk of HIV transmission, ongoing positive living, healthy lifestyles and nutrition. Ongoing referral for psychosocial support (e.g., support groups) and preventative packages including correct regular use of condoms and medical services should be provided when needed.

After post-test counselling all HIV-positive clients must be referred for laboratory staging by CD4 count and clinical staging by a clinician trained in HIV and AIDS clinical management. They must also be screened for symptomatic TB signs and referred for diagnosis if suspected and either prepared for ART or referred to attend the wellness services provided (pre-ART management) if they do not qualify for ART immediately.

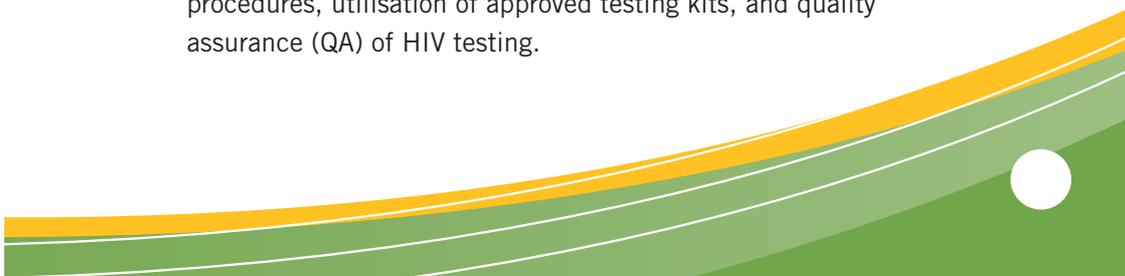


SECTION 5: HIV TESTING

HIV testing must be ethical, based on human rights, conducted within a supportive environment and performed where there is an adequate health-care infrastructure. A trained health-care professional (registered nurse, doctor, dentist, oral therapist or oral hygienist) is responsible for administering the HIV test in terms of current legislation (Human Tissue Act No. 65 of 1983 section 23).

The task shifting/sharing policy is being finalised and will be implemented for trained HIV counsellors as soon as it is adopted. This policy will result in the following changes:

- A trained health-care worker, enrolled nurse, community health worker or counsellor may then be authorised, in terms of the task shifting policy to administer the HIV test.
- All health-care workers who administer the test will receive required training to ensure adherence to the standard operating procedures, utilisation of approved testing kits, and quality assurance (QA) of HIV testing.



- HIV testing conducted by a health-care worker, should be under the supervision of a health-care professional (i.e., registered nurse, doctor, dentist, oral therapist, or oral hygienist).
- A trained health-care worker/counsellor will be responsible for performing the test, interpreting and confirming the results of the test, as well as informing the client of the result.
- A trained registered nurse will supervise the QA processes for HIV testing.

In PICT, a trained registered nurse should always be the first person initiating HCT with the patients. In addition, the following points should be adhered to:

- Verbal Informed consent should be obtained before testing as outlined in section 4.2.2 of this policy guideline.
- The counselor must adhere to the National Quality Assurance Programme, and this should cover the counselling process as well as the use of rapid test kits.
- The NDoH will facilitate quality control measures and adherence to testing protocol.
- Disclosure of test results and the implications thereof should comply with the promotion and protection of human rights.

5.1 Recommended HIV Testing Algorithm

The HIV testing algorithm that should be implemented for all HIV testing is the serial testing algorithm as discussed in Figure 2.

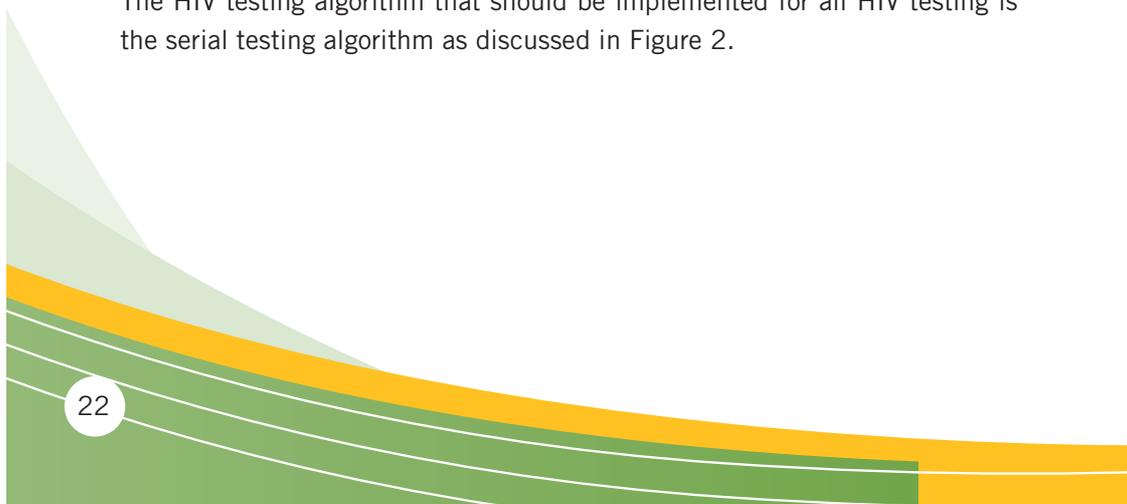
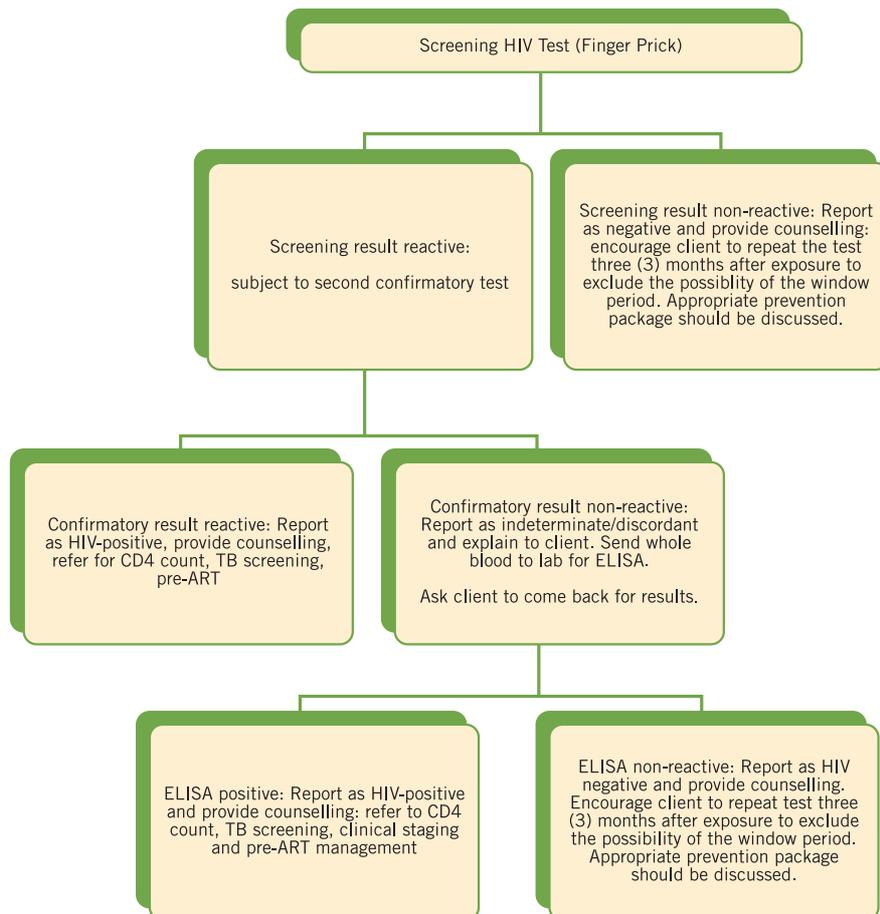


Figure 2: Recommended Serial HIV Testing Algorithm



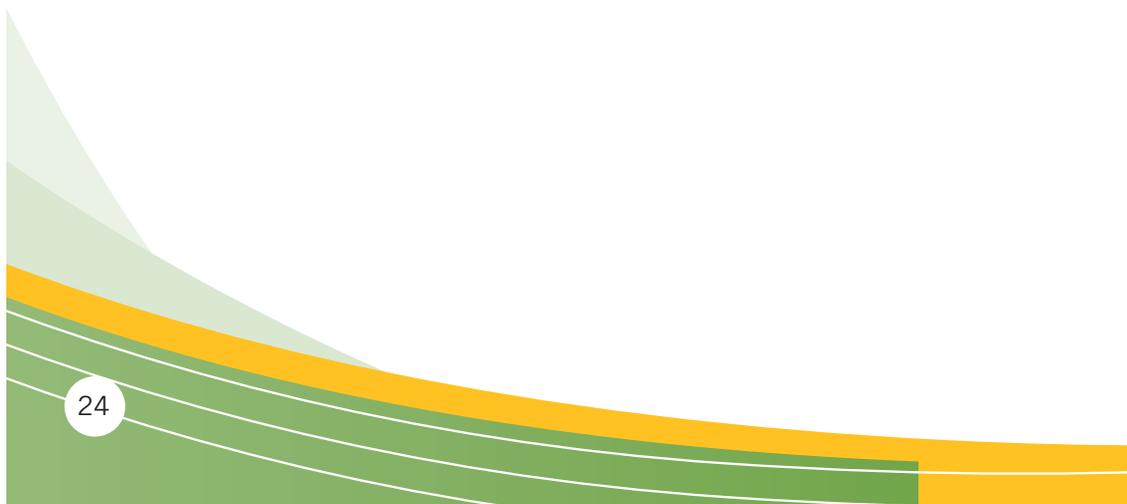
5.2 Issuing Written Confirmation of HIV Test Results

Patients may request written results which can be issued irrespective of the HIV result. It is preferable for the health-care provider to write a letter indicating the patient's HIV results rather than provide a copy of a laboratory report. All written results should clearly identify the patient by name, the date of the test, its outcome and the signature and designation of the issuing provider. There should be a facility stamp on the document. It should be emphasised to patients who test HIV negative that the written results are a documentation of the results at that specific point in time and are not a substitute for consistent periodic testing.

5.3 Frequency of Testing

HCT in clinical settings is also aimed at inculcating a culture of HIV testing for individuals. The patient's exposure should be assessed to gauge the appropriate frequency of repeat HIV testing.

All sexually active patients should be encouraged to test at least annually and this should be promoted as part of the culture of proactive self-care that individuals should adopt. However, repeat testing can be more frequent with patients who are considered to be more vulnerable to exposure.



SECTION 6: CORE ETHICAL PRINCIPLES

6.1 Counselling

- Counselling should always precede and follow testing, particularly with CICT clients.
- Counselling must be conducted by an appropriately trained, mentored, and supervised counsellor or health worker.
- Counselling should accompany testing whether provided in public or private sector facilities. This applies to all clients regardless of their legal status.

6.2 Informed Consent

HIV testing must always be voluntary and free of coercion. All HCT clients, where possible, should be given the choice of taking up the test or not.

Informed consent and information about testing should be available in braille, all official languages, and in child friendly-versions.

For CICT clients, informed consent should be verbal and written.

For PICT patients, informed consent should be verbal and documented in the patient's file by the health-care provider.

In order to make an informed decision about testing, clients should be given information about:

- HIV acquisition and transmission.
- HIV risks and risk reduction.
- Importance of early HIV diagnosis.
- The HIV testing process.
- The meaning and implications of a negative result.
- The window period.
- The meaning and implications of a positive result and information on referral.
- Disclosure.
- Confidentiality.

The health-care worker must ensure that a person with a disability, or one who has difficulty communicating, must fully understand the concept of informed consent prior to any HIV testing. Where possible, an appropriately trained worker and/or support person (family or friend) of the individual's own choice should be used to facilitate communication.

An agreement to take the test must be in verbal and/or written format using the prescribed informed consent form.

6.2.1 Illiteracy or Inability to Write

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

6.2.2 Inability to Make a Decision

According to the National Health Act, (Act No. 61, Section 7), if a client is unable to give informed consent, for example, in the case of unconsciousness or cognitive disability, such consent can be given by a person authorised to give such consent in terms of any law or court order.

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

In children: In the case of children, refer to Section 7 of this policy.

6.2.3 Appropriateness

Counselling and testing services must be appropriate and sensitive to the client's circumstances including culture, language, sex, sexual orientation, age, developmental level, reason for testing, etc.

Providers should consider these factors when designing and implementing programmes to increase the likelihood of clients' acceptance of counselling, testing and referral services.

6.2.4 Confidentiality and Privacy

All clients must be assured of the confidentiality of their test records, of the system of record keeping and of their test results. Note that:

- The results of the client should be documented in the client's file and may be communicated to other members of the health-care team involved in the management of the client, with the client's consent.
- Disclosure to sexual partners should be encouraged; however, the decision to disclose should be taken by the person undergoing the test.

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

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

6.2.5 Shared Confidentiality

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

- Sharing HIV status should always be voluntary and discussed with the client. The sharing or disclosure can only occur with the informed consent of the client specifying to whom such disclosure may be made.
- Disclosure by service providers should be limited only to those who contribute directly to the continuity of the client's care.
- HIV status should never be shared with the client's employer unless the client specifically requests this action.
- Discussion about sharing confidentiality should explore the barriers faced by the client in disclosing. Where the client is in an abusive relationship, he/she should not be pressurised to disclose to an abusive partner and should be referred to appropriate service providers for support.

6.2.6 Non-Discrimination

The National HCT Programme is committed to the normalisation of HIV testing and the eradication of discrimination and reduction of stigma by

encouraging knowledge and competence about HIV in health facilities, tertiary institutions, workplaces and communities.

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

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

6.2.7 Infection Control

Service providers should always practice universal infection control procedures in the management of clients regardless of their HIV status.

The employer should provide an enabling working environment with the required resources in order to minimise the risk of HIV infection (Occupational Health and Safety Act No.85 of 1993, Employment Equity Act No. 55 of 1998 -- Code of Good Practice on HIV, Guidelines for Occupational Exposure to HIV).

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





SECTION 7: HIV COUNSELLING AND TESTING FOR CHILDREN

7.1 Children

Testing infants and children for HIV is key to the early identification of HIV exposure and disease and is a critical element of their survival. Research such as the Children with HIV Early Antiretroviral Therapy (CHER) study underscore the need for early testing and early initiation of antiretroviral therapy. Achieving the Millennium Development Goal (MDG) 4 (reduction in the under-5 mortality) is dependent on mitigating the effect HIV has on young children and hence this section on testing children is a key component of this goal.

This section of the policy is based on the principles set out in the Children's Act (No. 38 of 2005, Children's Amendment Act No. 30 of 2007, Sections 130-133). References to "the Act" in this section are references to the Children's Act unless other legislation is expressly mentioned.

7.1.1 Circumstances in Which a Child may be Tested for HIV

There are specific circumstances in which a child may be tested for HIV, and these include:

- Cases when it is in the best interest of the child: an HIV test will be in the best interests of the neonate, infant or child if it is clear that the test will provide access to the continuum of care and promote a child's physical and emotional welfare.
- When the mother's status is known and the child may have been exposed to HIV.
- When the status of the mother is unknown (and or her whereabouts are unknown).
- When the child may have been wet-nursed or breast-fed by a woman whose status is unknown.
- When the child may have experienced or been at risk of sexual assault.
- When it is in the best interest of the child that the HIV test will promote the physical and emotional welfare where the child is being considered for foster or adoption placement.
- When the test conducted in order to find out whether any other person may have contracted HIV from the child, provided that the test has been authorised by a court. In such a situation the affected person must approach a court to show that they have been exposed to the child's body fluids in a manner which potentially puts them at risk of contracting HIV. A court may grant or refuse to grant an order to have the child tested for HIV.

7.1.2 Counselling Before and After HIV Testing

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

- Employ staff who are able (through experience and/ or training) to assess the developmental capacity of children and ensure that they are of sufficient maturity to understand the benefits, risks and social implications of such a test in terms of the Act, Section 132 (1) (a);
- Ensure that both pre- and post-test counselling are offered in every instance;
- Establish the child's maturity (as outlined in section 7.1.3) to understand the benefits, risks and social implications of the counseling before offering the child pre- or post-test counselling;
- Counsel children who are mature enough to understand the implications of the HIV test;
- Inform children who are not mature enough to understand the implications of the HIV test that their parents or care-givers need to be involved in the counselling process to assist them; and
- Advise children with the maturity to undergo counselling on their own that they may voluntarily involve their parents or care-givers in the counselling process.

7.1.3 Consent for HIV Testing

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

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

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



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

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

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

If the child has no parent or care-giver and they are not in the custody of a child protection organization, the health-care worker (doctor/registered medical practitioner/registered nurse) has an obligation to test the child, and may, in consultation with another health-care worker, test the child provided that the testing is in the best interests of the child with regards to preventing HIV infection and accessing PEP.

The same should apply to a child that is brought to a clinic by another child as in the case of child-headed households.

7.1.4 Confidentiality Regarding HIV Test Results

The Act says that every child has the right to confidentiality regarding their HIV status.

The HIV status of a child may be disclosed with the consent of the child, if the child is:

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

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

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



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

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

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

7.2 Testing Infants

There are several circumstances under which infants and children present for testing. These are discussed in detail below.

7.2.1 Testing Infants <18 Months of Age

HIV-exposed infants are born to HIV-positive mothers. HIV exposure occurs during pregnancy, birth, and breastfeeding. Without any intervention, mother-to-child transmission (MTCT) occurs in approximately 30% of infants of HIV-positive mothers. If followed correctly, the South African national PMTCT dual therapy to mother and child will reduce MTCT to 3% by 2011. Viral detection assays (e.g., HIV DNA PCR, viral load) should be used in children under 18 months of age to establish a HIV status and antibody detection assays (e.g., HIV ELISA or rapid tests) in children 18 months and older. Depending on the age of the child, the most age-appropriate test should be used. The following should be observed when testing HIV-exposed infants:

- The HIV exposure of every infant should be established at 6 weeks of age to identify infants requiring a PCR test.

- All HIV-exposed infants should have an HIV DNA PCR test at six weeks of age. If the PCR test is positive, a second viral detection assay (e.g. viral load) should be done immediately to confirm a positive HIV infection status at the same time as referring the infant for care.
- All HIV-exposed infants tested at six weeks should be started on cotrimoxazole prophylaxis while awaiting their HIV test results.
- All infants with a positive PCR test should be investigated as soon as possible by performing a second viral detection assay (e.g. viral load) to confirm their HIV status. A baseline immunological and clinical staging should be undertaken with a view to initiating ART.
- All HIV-exposed infants (except those already initiated on ART) should have a rapid HIV test performed at 18 months of age to confirm their HIV status.
- All breastfed HIV-exposed infants should be tested 6 weeks after cessation of breast milk with a HIV DNA PCR test if <18 months and an antibody detection assay if 18 months or older.
- If weaning is being considered, a DNA PCR test should be done 2-4 weeks prior to weaning. If the test is positive, breastfeeding should continue. If the test is negative then weaning can proceed and should be followed by another DNA PCR test 6 weeks later to ensure the infant has remained HIV-uninfected.
- An HIV-exposed infant who develops clinical features of HIV infection during breastfeeding should have an age-appropriate HIV test.

7.2.2 Testing Abandoned Babies

Abandoned babies should be tested when the status and whereabouts of the mother is unknown. Consent for such testing of the child must be obtained as outlined in Section 7.1.3 of the policy. The following is recommended:

- Abandoned babies assessed as less than 72 hours old should have a rapid test/heel prick to determine their HIV-exposure status.

- If a rapid test RESULT cannot be OBTAINED within 2 hours then PEP must be instituted without any further delay. Providing PEP prior to testing is informed by the fact that abandoned infants have high HIV exposure rates, PEP provided within 12 hours of birth has improved efficacy (note PEP can be given up to 72 hours) and antiretroviral drugs are relatively safe. A rapid HIV test should be done as soon as possible and if negative, PEP should be stopped.
- If a rapid test is negative in an abandoned baby, then the likelihood of HIV exposure is small and no PEP is required.
- If the rapid antibody test is positive, the infant should be started on PEP and a DNA PCR should be submitted to the laboratory. If the PCR comes back as positive then the infant should be referred for care as soon as possible.
- All abandoned babies should have their HIV status determined to facilitate permanent placement.

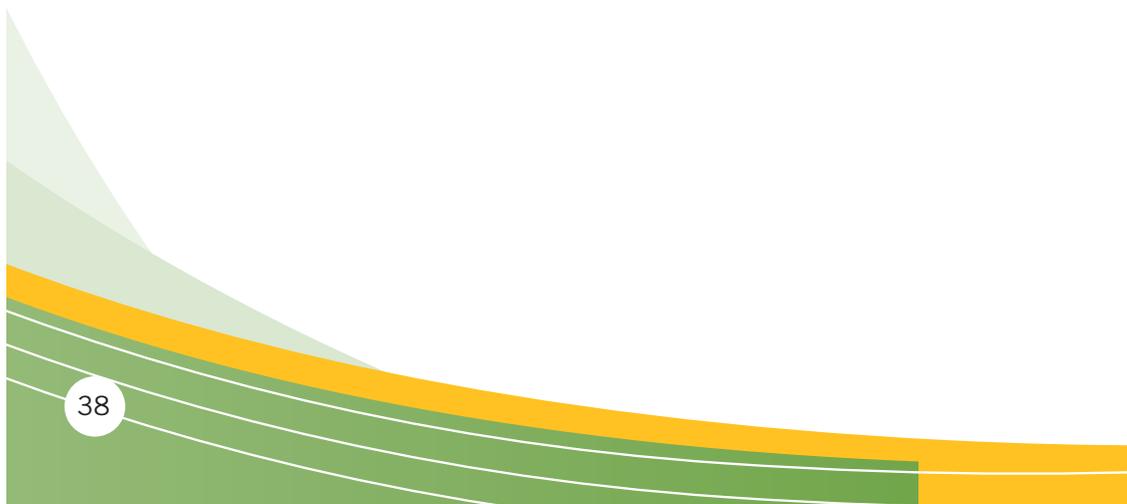
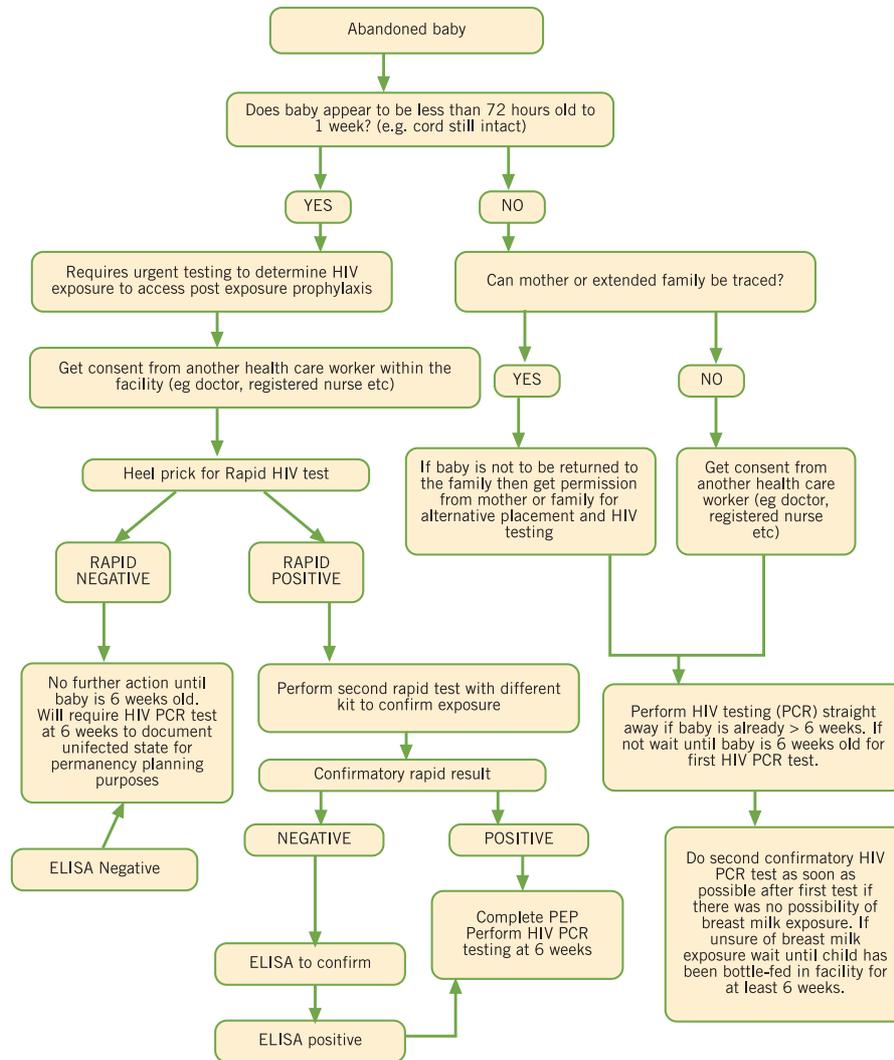


Figure 3: Recommended Algorithm for Testing Abandoned Children



7.2.3 Testing Infants at 18 Months or Older

When testing infants older than 18 months, the same algorithms as for adults can be applied and HIV status can be determined using HIV ELISA or rapid tests. Viral detection assays are not indicated.

The following guidelines should be adhered to:

- At 18 months ALL exposed children previously untested or HIV DNA PCR negative should be tested to confirm their HIV status.
- HIV rapid testing can be used to confirm HIV status in infants older than 18 months.
- All HIV-exposed children who have never had a viral load done (including children identified as being HIV-negative during early testing) should be retested at 18 months or older with a rapid test to confirm their HIV status.
- At 5 to 6 months, it is strongly recommended that an HIV PCR test should be performed on all exposed infants that are to be weaned.
- Infants should be re-tested six weeks after cessation of breast feeding using PCR if <18 months or HIV rapid test if >18 months.

7.2.4 Children not Identified by PMTCT Programme (Active Case-Finding)

All infants should have their HIV exposure status assessed at their six-week immunisation visit to ensure improved early infant testing rates with PCR by asking the mother's status and looking at the Road-to-Health Chart. If the mother's status is unknown or negative (determined from an HIV test performed more than 6 weeks previously), the health-care worker should offer the mother a rapid test to assess her and her infant's current HIV status and HIV exposure respectively. If the mother refuses a rapid test then the health-care worker should offer to do a rapid test on her baby.

If the mother/infant's rapid test is positive then the infant requires an HIV DNA PCR test and the mother requires referral for a confirmatory rapid test and care.

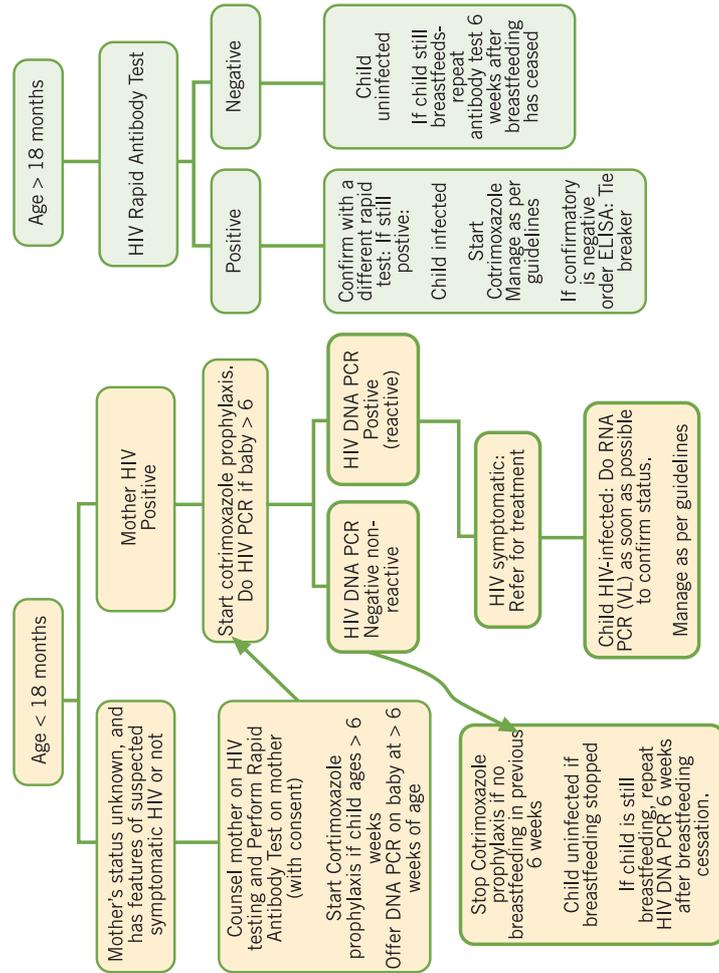
Immunisation visits up to 14 weeks of age should be used to identify babies' HIV status. All opportunities should be used to diagnose HIV in infants who display signs and symptoms suggestive of HIV.

Clinical Features and HIV Test Results

No laboratory test is 100% accurate and where clinical symptoms and signs do not match the HIV test results, close clinical monitoring and repeat age-appropriate HIV testing should be done.



Figure 4: Pediatrics Guideline Algorithm



7.3 HIV Counselling and Testing for Child Survivors of Sexual Assault

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

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

- The informed consent of children must be obtained before testing as in 7.1.3 of this policy.
- In the case of children under 12 years who do not have sufficient maturity to understand the benefits of HIV testing, and mentally ill or disabled survivors, pre- and post-test counselling should be given to the parent, care-giver, or legal guardian of the child who should give consent for HIV testing.
- In cases where a person with a disability or mental illness is able to understand the consequences of HIV testing and informed consent thereto, then their personal consent should be obtained. (A care-giver/parent/legal guardian will only be needed where such a person cannot provide informed consent.)
- An HIV test must be performed on all child survivors of sexual assault before commencing PEP.
- If the test results are not available, the child should be started on PEP dosages appropriate for the child's weight with a three-day starter pack while waiting for results.
- If the results are negative, the full course of PEP treatment should be provided.
- If the results are confirmed positive, the parents/care-giver and child (if of sufficient maturity) should be counselled and referred to appropriate services for management and support.
- If the results are discordant, blood should be sent to the laboratory for an ELISA test which will be the tie breaker.
- Child survivors receiving PEP should be encouraged to test again at

six weeks, three months and six months after the initial exposure.

- All child survivors of sexual assault should be referred for psychosocial follow-up.
- Mandatory reporting of abused or neglected children should be followed as described in Section 7.1.5 of the Act for all child survivors of sexual assault.
- The parents/care-givers of children who have experienced sexual assault, or the children themselves may apply for testing of the alleged offender if:
 - o The application is made within 60 days of the assault.
 - o The offender is identified.
 - o The procedure laid down in the standard operating procedure is followed.

Test results of an alleged offender may be disclosed to the child (if of sufficient maturity) and to the parent/care-giver. The parents/caregiver and child must be counselled on the implications of the results and encouraged to continue with PEP regardless of the outcome of the alleged offender's HIV test (National Sexual Assault Policy, 2005; Regulations to Criminal Law (Sexual Offences and Related Matters) Amendment Act No. 32 of 2007, Government Gazette 31076, 22 May 2008; National Directives and Instructions on Conducting a Forensic Examination (Government Gazette 31957, 6 March 2009).

7.3.1 Mandatory Reporting of Abuse

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

concludes that a child has been abused in a manner causing physical injury, sexually abused or deliberately neglected, must report this information to:

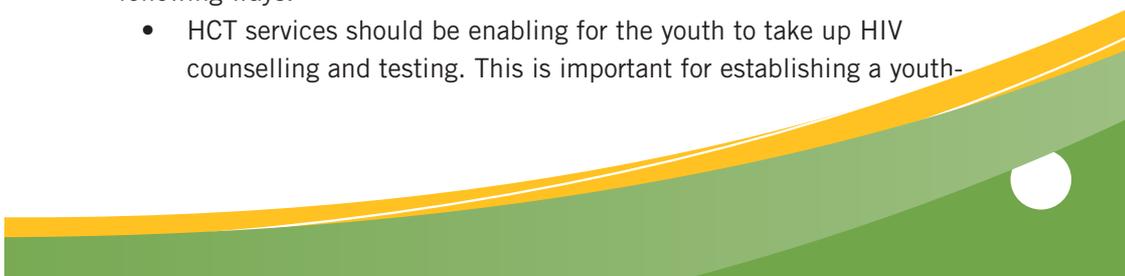
- a social worker in a designated child protection organisation,
- the Department of Social Development, or
- a police official.

The law also protects children from sexual offences such as rape, sexual assault, sex work, under-age sex or sexual exploitation in terms of the Criminal Law (Sexual Offences and Related Matters) Amendment Act, No. 32 of 2007. Any person who is aware of a sexual offence having been committed against a child must report this to the police or social workers. This means that any person counselling or testing a child for HIV who suspects that their client is a victim of sexual offence must report this information to the police or social workers. Failure to report is a criminal offence according to Criminal Law (Sexual Offences and Related Matters) Amendment Act No 32 of 2007, Section 54. It should be noted that children over the age of 16 can consent to sex and where no sexual offence is apparent, no reports should be made to the police.

7.4 HIV Counselling and Testing of Young People

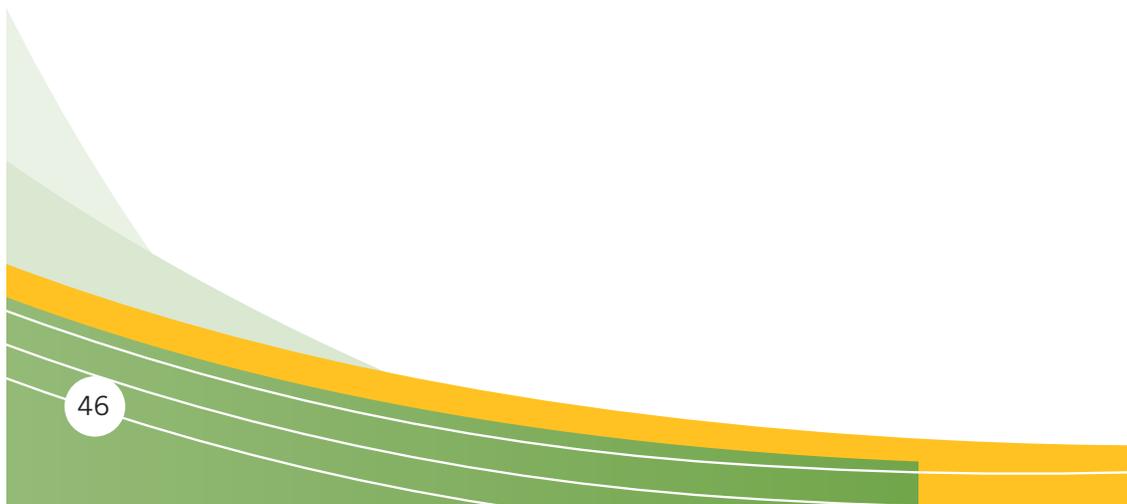
Following the Children's Act no. 38 of 2005 as amended, a child is referred to as anyone under the age of 18. The NSP also specifically targets the 15-49 age groups, and subsumed under these two broad categories are "young people" (i.e., those who fall in the 10-24 age group). As a group, young people face particular risks for HIV: early sexual debut, sex with multiple sexual partners, unprotected sex, substance and drug abuse leading to unprotected sex, high risk of sexual coercion and abuse, high frequency of sex, age differences in relationships, and peer pressure and a need to belong. HIV counselling and testing services and providers need to address this target group in the following ways:

- HCT services should be enabling for the youth to take up HIV counselling and testing. This is important for establishing a youth-



friendly environment where young people can be at ease during the interaction and can comfortably communicate their needs, questions and personal concerns.

- As far as possible, HCT services should attempt to provide services to young people in a “one-stop-shop” fashion: whenever young people are sent to a further location for another service there is an increased risk that they will not show up.
- Where comprehensive, “one-stop” service provision is not possible, it is important that HCT staff refer and link young people to responsible agencies that provide appropriate, youth-friendly support.
- Service provider training should include the following: a sound understanding of youth-friendly pre- and post-test counselling approaches; understanding adolescent development; and providing appropriate medical, psychosocial and developmental options according to age and maturity.



SECTION 8: COUNSELLING AND TESTING SPECIAL POPULATIONS

The *HCT Policy Guidelines* refers to the all people in the 15-49 age group, as well as children under the age of 18. Over and above these individuals, the general population is also included. Furthermore, there are several other special populations that need to be targeted for HCT, or who present to HIV counselling and testing under particular circumstances that warrant some adjustment to the generic HCT guidelines.

8.1 HIV Counselling and Testing of Pregnant Women for the PMTCT Programme

The identification of HIV-infected women during pregnancy is critical to the success of this programme. Routine screening of all pregnant women should be done in line with basic antenatal care (ANC). Rhesus factor, haemoglobin,

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

- All pregnant women should be offered PICT (opt-out approach) and if they chose to opt out, they should sign a refusal/opt-out form and this should be documented in their files.
- Women who refuse to test should be counselled and encouraged to take up the HIV test. The benefits of testing should be explained.

HIV-negative: Women who test HIV-negative should receive post-test counselling on risk reduction interventions, focusing on how to maintain their HIV-negative status while continuing to receive routine antenatal care. They should also be offered a repeat HIV test at or around 32-34 weeks to detect late seroconversion and to allow time for PMTCT prophylaxis.

Unknown Status: Unbooked women and women of unknown status reporting in labour should be offered HCT in the latent phase of labour, preferably during the first stage of labour. They should be offered a PMTCT intervention if positive for HIV and their infants should be offered PEP.

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

- Be screened for TB, in line with basic ANC procedures; and
- Receive ARV regimens prescribed by a registered health professional (i.e., registered midwives and professional nurses) in line with the relevant legislation and regulations for PMTCT short course or highly active antiretroviral therapy (HAART).

Women attending postnatal clinic at six weeks who may have tested negative in early or late pregnancy may continue to report negative status based on the results of an earlier test. However, a recent HIV infection could have occurred, and the woman should be offered a repeat HIV test as a way of screening her

and her infant for HIV infection and exposure respectively.

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

8.1.1 HIV Counselling and Testing of Pregnant Women

All women attending ANC (first attendees and women attending follow-up visits) should be given routine information about HIV testing and the PMTCT programme.

Furthermore, they should be offered PICT (opt-out approach). The procedures outlined in Section 5.3 of this policy should be observed when counselling pregnant women. If the woman refuses testing, this should be documented in the clinic file. HIV testing must always be in the client's best interests and with consent.

8.2 HIV Counselling and Testing of Health-Care Providers and Workers Exposed to HIV

In the case of health-care workers and providers who are exposed to HIV through a needle stick injury, it is important to establish the HIV status of the worker following exposure so that antiretroviral treatment -- PEP -- can be administered (refer to guidelines for occupational exposure). PEP is given within 24 hours and up to 72 hours of exposure in order to minimise the risk of seroconverting to HIV. Such exposure should be reported to the employer as per guidelines. In the case of accidental exposure, the following is recommended:

- If a client is not ready to test after pre-test counselling, they should be started on PEP with a three-day starter pack.
- If, after testing, the results are HIV negative, the full course of treatment should be provided.
- If, after testing, the results are HIV positive, the treatment should be

discontinued and the client should be referred to appropriate services for management and support.

- Counselling should precede and follow testing.
- Informed consent must be obtained before testing

8.3 HIV Counselling and Testing Survivors of Sexual Assault

Survivors of domestic violence or rape require an empathetic approach by the health-care professionals. The routine offer of HIV testing is recommended as part of the comprehensive clinical management post-sexual assault.

In the case of sexual assault, HIV testing and the administration of PEP is an essential element of the package of HCT services for survivors. The policy recommends the following:

- Counselling should always precede and follow testing.
- Informed consent must be obtained before testing.
- An HIV test should be one of the screening tests performed on every client before commencing PEP. Syphilis, Hepatitis B and C should be screened for and retested as for HIV.
- Discussion about confidentiality should explore the barriers faced by the client in disclosing. If the client is in an abusive relationship, the client should not be pressurised to disclose to his or her partner and should be referred to appropriate service providers for support.
- If the client is not emotionally ready to be counselled and tested, they should be started on PEP with a three-day starter pack while waiting for to be tested or waiting for the test results.
- If the results are HIV negative, the full course of treatment should be provided. Clients should also be encouraged to return to collect the remainder of PEP and for adherence monitoring.
- If the results are HIV positive, the client should be counselled and referred to appropriate services for management and support.

- Clients receiving PEP should be encouraged to test again at six weeks, three months and six months after the initial exposure.

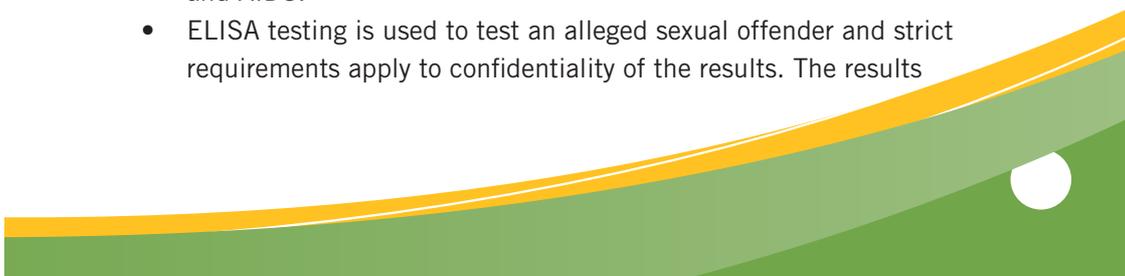
8.4 HIV Testing of Alleged Sexual Offenders

The Criminal Law (Sexual Offences & Related Matters) Amendment Act No. 32 of 2007 outlines procedures for testing sexual offenders for HIV. The requirements for testing alleged offenders are stipulated in the *National Directives and Instructions on Conducting Forensic Examinations in Survivors of Sexual Offences* in terms of the Criminal Law (Sexual Offences and Related Matters) Amendment Act, No. 32 of 2007 (Government Gazette 31957, 6 March 2009). The forms for testing are contained in the regulations to the Act.

Any victim/survivor or interested person on behalf of the victim may apply to a magistrate for an order that the alleged offender be tested for HIV and that the results be disclosed to the victim or interested person and to the offender. If the application meets the necessary requirements the magistrate must order that the alleged offender be tested for HIV in accordance with the state's prevailing norms and protocols and the prescribed time frame of 60 days (Criminal Law (Sexual Offences and Related Matters Amendment Act, No. 32 of 2007).

A health-care worker may only test an alleged sexual offender when presented with a court order by an investigating officer, and should follow these procedures:

- The health-care worker should offer the alleged sexual offender pre-test counselling or ensure that pre-test counselling has been done. In addition, the alleged sexual offender should be provided with all the necessary information with regard to HIV and AIDS.
- ELISA testing is used to test an alleged sexual offender and strict requirements apply to confidentiality of the results. The results



may only be handed to the investigating officer (Criminal Law (Sexual Offences and Related Matters) Amendment Act, No. 32 of 2007).

- The survivor or the interested person who applies for the testing of the alleged sexual offender should be counselled prior to receiving the HIV results of the alleged sexual offender. The investigating officer must ensure that such counselling occurs before handing over the test results (Criminal Law (Sexual Offences and Related Matters) Amendment Act, No. 32 of 2007).

8.5 HIV Counselling and Testing of Male and Female Prisoners

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

- Screen detainees for STIs and TB, and follow this with treatment where necessary.
- Offer HIV counselling and testing according to the protocols outlined in this policy.
- Advise detainees of risks of sexual transmission of STIs in a prison context and provide condoms to prisoners. The difference between consensual and non-consensual sex must be explained.
- Encourage detainees and provide confidential facilities to report rape; inmates must be informed about PEP at the time that they enter a detention facility.

8.5.1 Female Prisoners

On admission to a detention facility:

- Female prisoners who are accompanied by minor children should be offered screening for HIV, STIs and TB as outlined above.
- Pregnant prisoners should receive basic ANC including HIV testing and counselling by health professionals and in accordance with the

approved PMTCT programme.

- Female prisoners who deliver in prison, a local maternity facility or midwife obstetric unit should have access to continuation of the PMTCT programme for themselves and the infant.





SECTION 9: QUALITY ASSURANCE

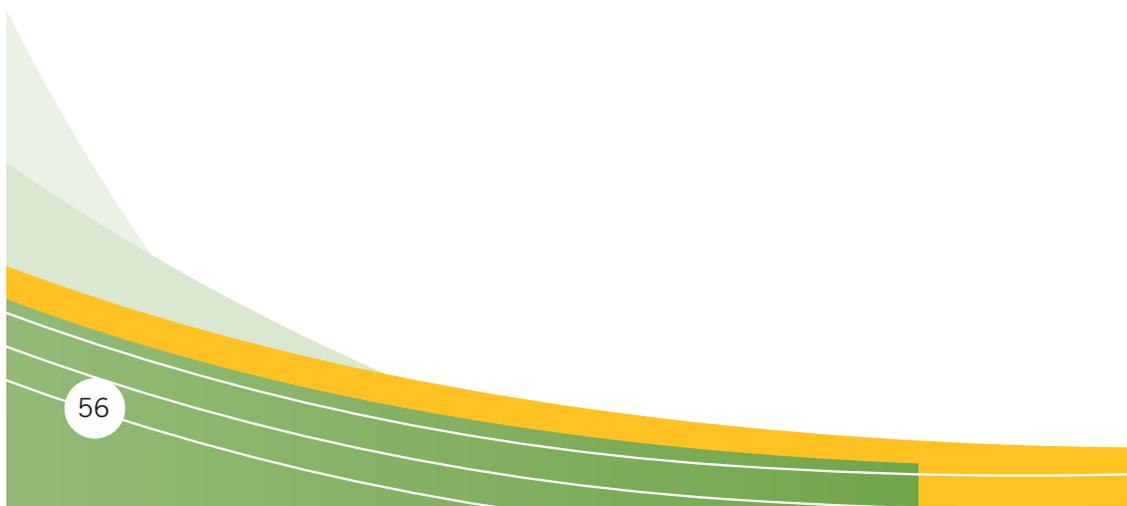
9.1 Basic Requirements

Quality assurance (QA) refers to mechanisms for monitoring and evaluating the quality of counselling and testing services in accordance with established national guidelines. Test kits used in private and public facilities are also subject to QA. The following are the national standard operating procedures for QA of counselling that must be followed by all service providers:

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

Quality assurance of testing is defined as those strategies employed by HCT services that ensure that the final HIV test results are correct. All service providers should adhere to the following QA steps:

- Follow all nationally prescribed standards of practice for performing HIV tests;
- Maintain effective linkages with the National Reference Laboratory at the National Institute for Communicable Diseases (NICD) to ensure that sites meet the national QA standards for HIV testing;
- Assess HIV rapid test kits for validity and reliability according to the national protocol;
- Procure supplies regularly to ensure uninterrupted supply of all equipment and commodities;
- Establish good information and data management systems for performing HIV tests;
- Ensure appropriate storage requirements to guarantee that test kits are at their optimum and transportation of blood specimens adhere to good laboratory practice; and
- Adhere to infection control procedures at all times.



SECTION 10: COMMUNICATION AND SOCIAL MOBILISATION

10.1 Background

HCT is the entry point to the continuum of prevention, treatment, care, support and wellness for clients with HIV and AIDS. The primary goal of the HCT communication and social mobilisation strategy is to increase personal knowledge of HIV status through the uptake of HIV counselling and testing services. It is an integral component of the effort to raise awareness that will reduce transmission and to improve early access to care through the increase of the availability, quality, provision and acceptance of care for HIV-positive and HIV-negative people.

10.2 Objectives

The communication and social mobilisation strategy in support of HCT aims to:

- Create an enabling environment for HIV counselling and testing;

- Mobilise communities, couples, families, and individuals for HIV counselling and testing;
- Expand access to HCT beyond formal health care into areas such as community and non-health care settings;
- Expand access to include information and communication in an appropriate mode and format to deaf and blind persons;
- Facilitate prevention programmes targeting marginalised groups, women, men and youth;
- Facilitate counselling on condom use and family planning;
- Facilitate interventions to reduce HIV acquisition and transmission by HIV-positive persons;
- Facilitate implementation of programmes supporting voluntary disclosure of HIV status; and
- Facilitate referral to relevant prevention, treatment, care and support services.

10.3 Guiding Documents

This strategy is informed by the following documents:

- The National Strategic Plan for HIV & AIDS and STIs, 2007-2011.
- The National Operational Plan for Comprehensive HIV and AIDS Care, Management, Treatment and Support (Comprehensive Plan) 2003.
- The Policy and Guidelines for the Implementation of the PMTCT Programme, February 2008.
- The National Department of Health (2003) The South African National Voluntary Counselling and Testing (VCT) HIV Prevention and Care Strategy.

10.4 Target Audience

All South Africans are the target audience for mobilisation and communication regarding HIV testing. Within this population there is an emphasis on sexually

active men and women aged between 15-49 years, including children aged less than 18 years, and with special efforts to reach the following groups:

- Men.
- Couples/sexual partners.
- Pregnant women and family planning clients.
- Vulnerable and marginalised groups such as commercial sex workers, men who have sex with men (MSM), migrants, intravenous drug users, alcohol and other drug abusers, clients in drug rehabilitation centres, prisoners and male youth in detention centers, etc.
- Men and women presenting with TB, STIs and OIs.
- Clients seeking PEP.
- Survivors of rape and domestic violence.

10.5 Key Communication Areas

In order to increase uptake of HCT, messages should pinpoint what South Africans perceive to be the main benefits and barriers of HCT. Communication should also aim to reach those who have already undergone HCT.

Communication should be directed to clients testing HIV negative, strengthening the message of reducing the risk of subsequent HIV infection, and it should promote understanding of the window period and of the need to re-test. It should also promote regular testing for clients for whom there may be a strong likelihood of HIV infection, either because of their symptoms, or because medical or counselling interactions confirm that they are engaging in unprotected sex. Communication should also address people who test HIV positive to ensure that they have information necessary to access relevant services, lead healthy lifestyles and inform their partners of their HIV status. Communication should be available in the appropriate language, mode and form to accommodate people's needs and, where appropriate, disabilities.

10.6 Campaigns and Mass Media

Key messages must focus on:

- Promoting prevention for women, men and youth, with a focus on risk reduction and reduction of partners, and on using condoms consistently and correctly to encourage people who are negative to retain their status.
- Increasing uptake of HCT services and encouraging regular testing for marginalised and vulnerable groups such as commercial sex workers, MSM and intravenous drug users.
- Promoting the benefits of counselling and testing for individuals and couples/sexual partners.
- Promoting prevention with positives to reduce risk of re-infection and transmission.
- Promoting primary prevention targeting clients testing HIV negative, strengthening the message of reducing the risk of subsequent HIV infection, and promoting understanding of the window period and the need to re-test.
- Encouraging a continuous focus on positive living, healthy lifestyle and nutrition.
- Establishing an enabling environment for HIV counselling and testing.
- Establishing an environment to combat stigma and discrimination.
- Establishing programmes that support voluntary disclosure of HIV status.

10.7 Service Points

Messages highlighted at service points must:

- Encourage everyone to take up HIV counselling and testing;
- Strengthen integration of HCT services into the primary health-care package by promoting communication about HCT to all clients

accessing services, and especially clients accessing services such as FP, ANC, TB, PEP, IMCI and STI;

- Promote messages targeting health-care workers to maximise HCT service delivery (e.g., to increase uptake of couple counselling and testing);
- Strengthen counselling on HIV prevention including condom use, partner reduction and family planning;
- Develop and disseminate messages at health facilities to encourage referral to relevant prevention, treatment, care and support services; and
- Strengthen awareness of HCT services among clients at health-care facilities through signage placed prominently next to service points and within the health facility.

10.8 Mechanisms of Communication

Mechanisms of communication on general HIV information that include all the elements covered by IEC pre-test sessions may need further review and should include the following:

- Mass media such as websites, twitter, facebook, print, mobile telephone messages, television and radio.
- Small media such as brochures, pamphlets and audiotapes (similar to IEC materials).
- Interpersonal communication and peer education programmes.
- Academic papers for conferences and journals.
- Community mobilisation to reach community leaders and communities.
- Outreach in the workplace.

10.9 Organisational Arrangements

Communication activities will involve several role players, including:

- **National Department of Health:** The HCT sub-directorate will

coordinate a team involving the following directorates: Government AIDS Action Plan, Care and Support, and the Health Promotion and Communication directorates to develop communication and social mobilisation for the programme.

- **Provincial Health Departments:** Provincial HIV and AIDS, STI & TB (HAST) and HCT units will coordinate a team comprising the provincial health promotion and communication units.
- **District Level:** The health promotion coordinators and/or HIV and AIDS coordinators at district level will be the critical link between the province and individual health facilities.
- **Facility Level:** Facility-based health promoters and HCT counselors, with the support of the facility manager and under direction of the designated district coordinator, will undertake communication activities at this level.

10.10 Roles and Responsibilities

The roles and responsibilities of various role players are summarised as follows:

10.10.1 National Department of Health

The National Department of Health, in conjunction with the relevant service providers undertakes to:

- Coordinate and direct HCT communication across provinces.
- Conduct national campaigns on HCT using national mass media and community structures. These will be ongoing to ensure that every generation of school children are exposed to the same messaging as part of the baseline information on HIV and its pathogenesis and spread as well as incremental messaging about the changing strategies of prevention, treatment and care. Critical to this communication plan is the ongoing adherence messaging (i.e., adherence to wellness appointments, to safer sex and other

positive life style choices, and to treatment).

- Conduct other national campaigns on prevention, treatment, care and support that strengthen the HCT campaign.
- Develop IEC materials for use in marketing the HCT programme.
- Facilitate capacity building services to provinces.
- Monitor implementation of social mobilisation at all levels.
- Monitor the impact of the communication of HCT on communities and on services.

10.10.2 Provincial Health Departments

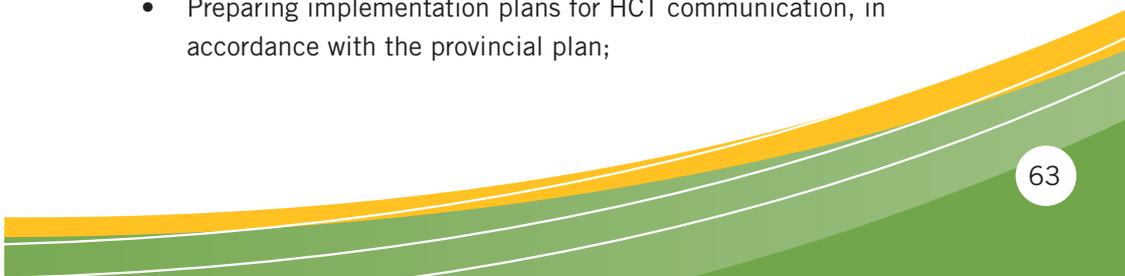
Every province is responsible for the functions listed below. The provinces will:

- Direct HCT communication in the province and its districts through the preparation of an annual communication plan.
- Coordinate HCT communication initiatives undertaken in the province and the districts (including activities at facility level).
- Undertake high intensity provincial campaigns on HCT.
- Introduce and ensure the maintenance of low-intensity, regular HCT communication at district/facility level.
- Secure appropriate community and small media and/or produce materials where necessary.
- Provide capacity building in communication skills for district and facility personnel.
- Monitor provincial HCT communication activities and ensure monitoring of district/facility activities.

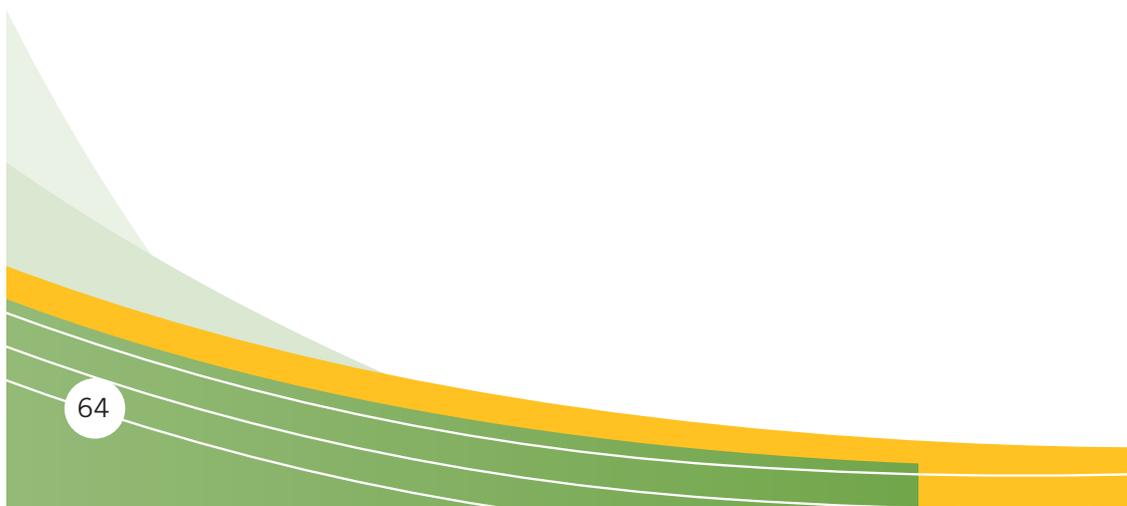
10.10.3 District and Facility Level

Every district – mainly through its primary health-care clinics – is responsible for:

- Preparing implementation plans for HCT communication, in accordance with the provincial plan;



- Identifying personnel to undertake these activities where dedicated health promotion and communication personnel do not exist;
- Participating in national and provincial campaigns where appropriate;
- Conducting regular, low-intensity communication activities on HCT in clinics and surrounding communities;
- Securing supplies of small media from the province for its own needs; and
- Recording all communication activities and HCT uptake within the mutually agreed national monitoring framework and submitting them timeously to the province.



SECTION 11: MONITORING, EVALUATION AND REPORTING

11.1 Importance of Monitoring and Evaluating the HCT Programme

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

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

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

There are three chronological phases of *evaluation*. The first phase is process evaluation. It uses information such as HCT service delivery data, supervisory reports, client surveys, counsellors' views, and quality assurance data, to ensure that HCT services are delivered according to policy. It is recommended that process evaluation of the HCT programme be conducted after two years of implementation of the revised policy.

The second phase is *outcome evaluation*. It measures the short- and long-term effects of the HCT programme on the total population with special emphasis on the child and adult population (men, women, and children aged 15-49 years). It is recommended that outcome evaluation of the HCT programme be conducted as an integral part of the outcome evaluation of all interventions as envisaged in the NSP.

The third phase is *impact evaluation*. It ensures that information on the impact of HCT is obtained from periodic population surveys such as the *South African Demographic and Health Survey*. It measures the long-term impact that HCT may have on the target groups it reaches.

11.2 Guiding Principles

The M&E system is guided by a number of important principles namely:

11.2.1 Comprehensive Integration of M&E Systems

The M&E system for the HCT programme should form an integral part of the M&E Framework of the NSP. All indicators or data from public health and non-health facilities, NGOs and private facilities providing HCT services should be aligned and integrated at district level through the DHIS to

facilitate attainment of goals and objectives of the HCT policy. Data should also be aligned with health management information system of the country. It is important that all indicators pertaining to special groups of the population should be incorporated and integrated at the district level.

11.2.2 Alignment to Commitments on HIV and AIDS

The indicators must facilitate measurement of progress in the implementation of major commitments such as those to the Brazzaville Declaration on Universal Access to HIV and AIDS Prevention, Treatment, Care and Support (national), Maseru Declaration (regional); Abuja Declaration (continental) and UNGASS (global), and in addition they must strengthen the monitoring and evaluation of the NSP. They must align with a number of the Millennium Development Goals (MDGs), such as MDG 4 (to reduce child mortality), MDG 5 (to improve maternal health) and MDG 6 (to combat HIV and AIDS and other diseases).

11.2.3 Essential and Strategic Indicators

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

11.2.4 Indicator Relatedness

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

11.2.5 Reporting Requirements

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



11.3 Monitoring and Evaluation Objectives

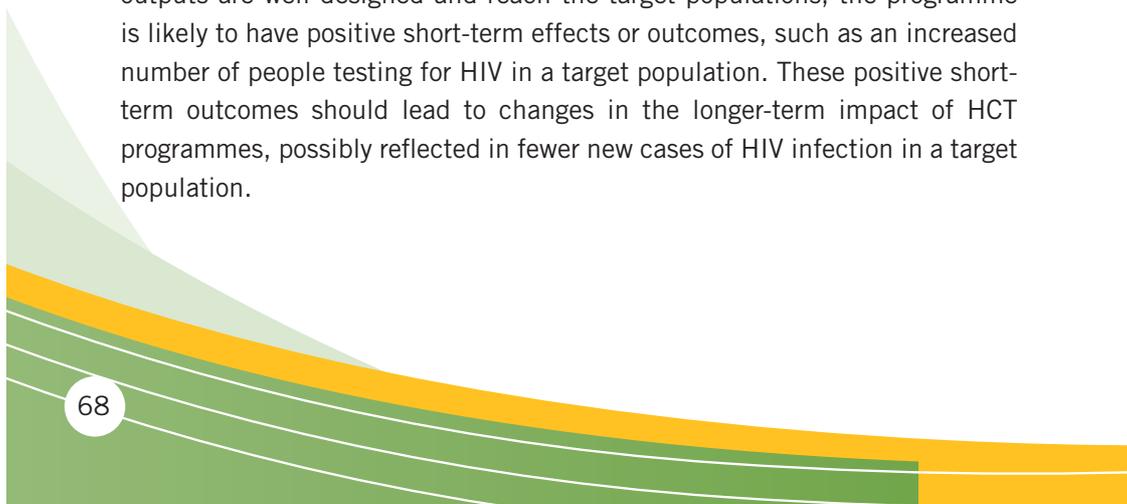
The M&E objectives are to:

- Monitor progress on the provision of HCT services and measure its effectiveness;
- Identify gaps and weaknesses in service provision and address these;
- Inform planning, prioritisation, allocation, and management of resources for HCT; and
- Maintain data and referral tracking systems in accordance with existing systems.

11.4 The Monitoring and Evaluation Framework

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

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



11.5 HCT Programme Indicators

The minimum set of indicators for the National HCT Programme should be collected at the following service points offering HCT services: ANC, TB, OI, STI, PEP, primary health clinics and community health centres. Indicators about referral to appropriate services (e.g., TB screening, STI treatment, CD4 testing) should also be collected. The following set of indicators is recommended for the purpose of reporting on the implementation of the HCT programme and policy.

TABLE 1: LIST OF HCT INDICATORS

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

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

11.6 Data Management

All HCT service points will collect data related to service provision using the national standardised data collection tool (HCT registers). Only health workers, including lay counsellors and data capturers/information officers permanently designated to work with health information, at all levels (facility, district, provincial, and national), should have access to data for verification and quality checks (completeness, correctness and accuracy). The confidentiality of clients' records should be maintained at all times.

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

11.7 Information Flow

All required information should flow from the HCT service points to and from the district, provincial, and national health offices ultimately to the South African National AIDS Council's (SANAC) M&E Unit depending on how frequently indicators are collected (monthly, quarterly, annually, etc.). Compliance with data flow policy and the data user agreement must be maintained at each level.

11.7.1 Roles and Responsibilities

Generally, the chain of HCT data and information flow in health information systems will be established in the following ways.

At the Service Points

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

as described above will be completed at the service points and transmitted to the appropriate health districts.

District Office

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

Provincial Office

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

National Office

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

The typical information flow of data is illustrated in Figure 5 on the following page.

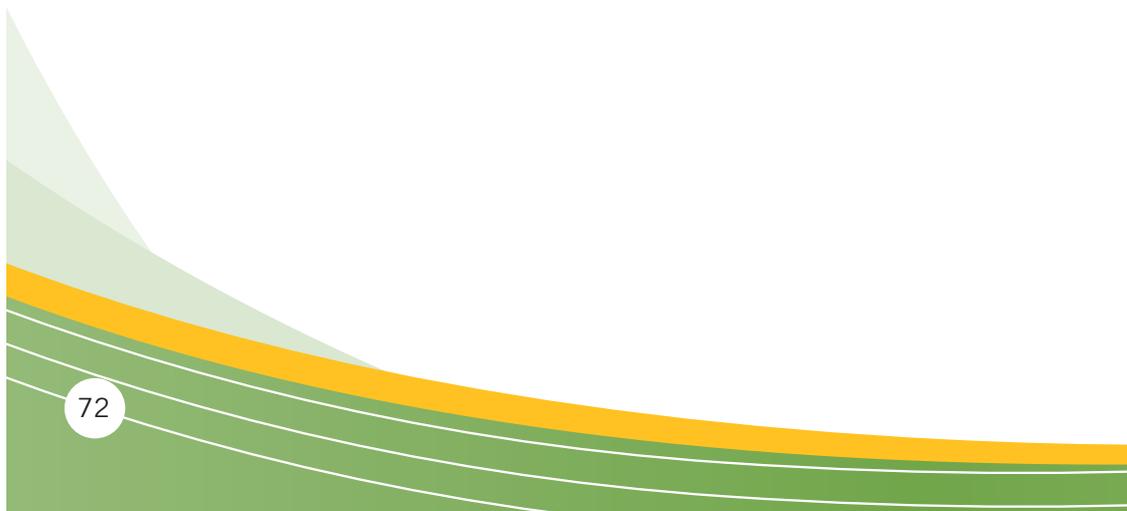
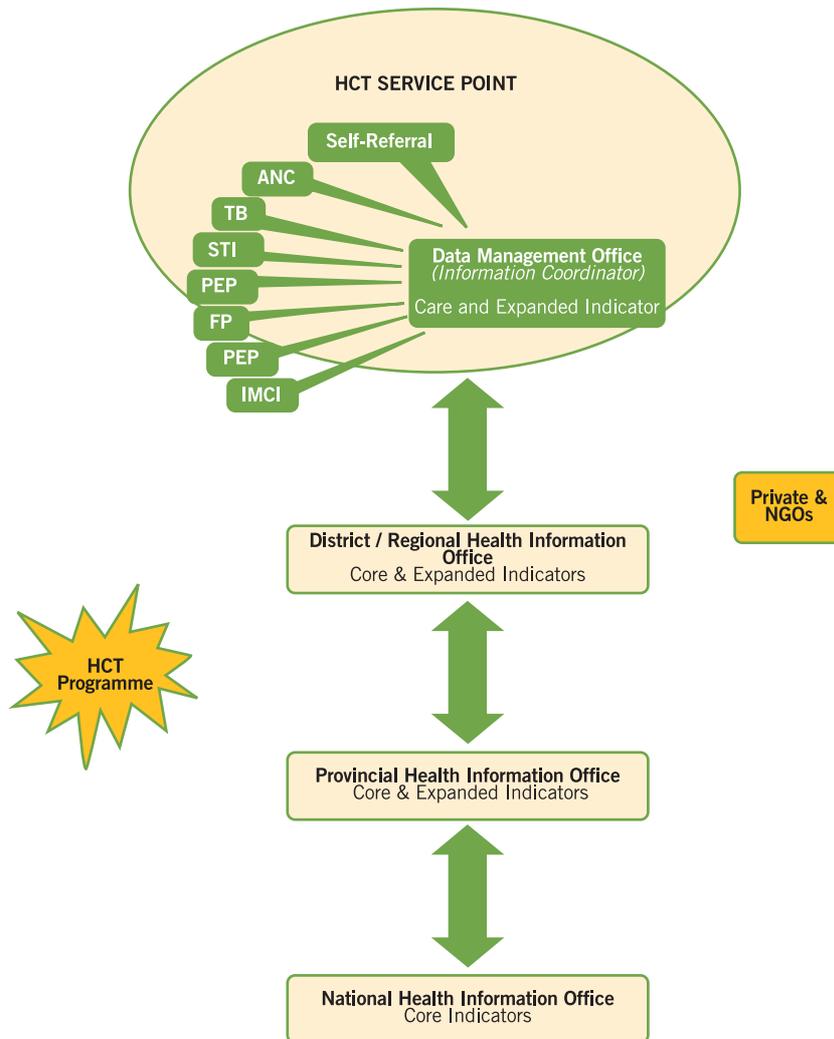


Figure 5: Flow of HCT Data





SECTION 12: CONCLUSION

The aim of the *HCT Policy Guidelines* is to provide a national framework that will direct the provision of HIV counselling and testing services for children, youth and adults in the public and private sectors in South Africa. The main purpose of these policy guidelines is to ensure better quality and greater consistency of the delivery of the many elements of HCT. For these guidelines to take root and to have meaning in the lives of clients who access and ultimately use HCT services, all service providers, programme planners and policy makers must commit and adhere to the spirit and intention behind these policy guidelines. We need not only collective commitment, but also consistent implementation of the policy if we are to achieve greater quality and improved standardisation of HCT services across the country.





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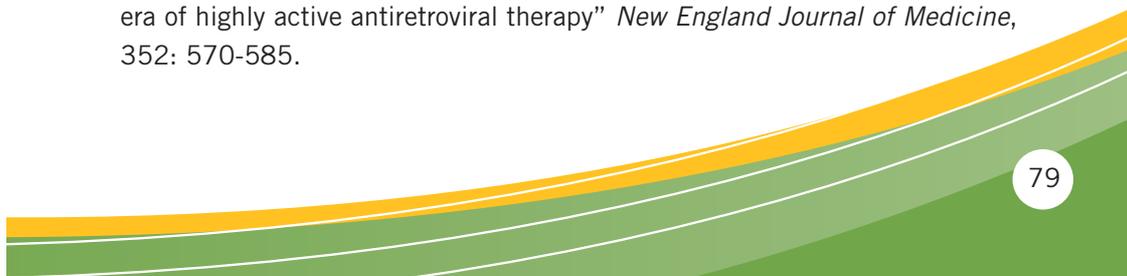
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ANNEXURES

Annexure I: Acts of Parliament

Children's Act No. 38 of 2005; Children's Amendment Act (Act No. 41 of 2007).

Criminal Law (Sexual Offences and Related Matters) Amendment Act, No. 32 of 2007.

Constitution of the Republic of South Africa, Act No. 108 of 1996.

Health Profession's Act, No. 56 of 1974.

Human Tissue Act, No. 65 of 1996.

Labour Relations Act, No. 66 of 1995.

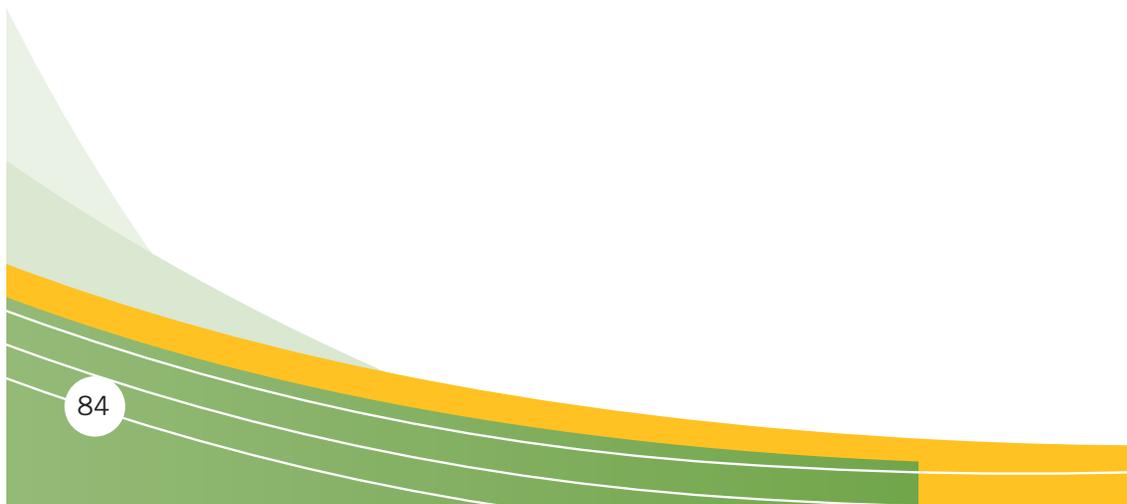
National Health Act, No. 61 of 2003.

Nursing Act, No. 50 of 2005.

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Annexure II: Glossary

The aim of the glossary is to standardise the interpretation of terms used in existing guidelines and protocols as well as by implementers of HCT service provision in South Africa.

Adherence: The degree to which a client accepts an active role in following a treatment regimen which has been designed in a consultative partnership between the client and health-care worker/counsellor.

Care-giver: any person other than a parent or a guardian who cares for a child, including (a) a foster parent; (b) a person who cares for a child with the implied or express consent of a parent or guardian; (c) a person who cares for a child while the child is temporarily in safe care; (d) the person at the head of a child and youth care centre or other children's facility where the child has been placed; (e) the person in charge of a shelter; (f) a child and youth care worker who cares for a child who does not have appropriate family care in the community; (g) the child at the head of a child-headed household; and (h) a person who is caring for someone who is ill.

CD4 count: White blood cells (lymphocytes) that help protect the body against infection. The CD4 cell count broadly reflects the state of the human immune system.

Child: All individuals under the age of 18 years.

Child-friendly: A child-friendly or child-centred approach involves children as far as practicable as active participants in the prevention and treatment of HIV. The views of children are of critical importance. A family-centred approach complements a child-centred approach by involving the child's family in the prevention, treatment, care and support of a child affected by HIV or AIDS, without compromising the child's right to participate in decision-making.

Client: An individual who visits a facility seeking services for counselling and/or testing and/or support for HIV and AIDS related conditions.

Client-Initiated Counselling and Testing (CICT) (also called Voluntary Counselling and Testing): HIV counselling and testing that involves individuals and couples actively seeking out these services. The process is voluntary, and the “three Cs” – informed consent, counselling and confidentiality – must be observed.

Confidentiality: The HCT service provider is required to keep secure and not discuss any information revealed by a client or the outcome of an HIV test without the knowledge and consent of a client. Confidential information may be shared with other providers giving direct care and management to the client.

Confidential disclosure of results: Results of HIV and AIDS testing may be given to the victim of a sexual assault who has followed the procedure in sections 30 and 32 of the Criminal Law (Sexual Offences and Related Matters) Amendment Act No. 32 of 2007, requesting the HIV testing of the alleged offender.

Couple counselling: HIV counselling and testing provided to sexual partners or intending sexual partners who receive the service together.

Disclosure: A process whereby a client discloses or shares the results of his or her HIV status with their partner, family, trusted friend, community members or care-givers, that is in the best interests of the client and others for the purpose of gaining their support from an emotional perspective as well as for healthy lifestyle choices that include active prevention of the spread of HIV either vertically or horizontally.

Discrimination: Making an unjust distinction in dealing with people on the grounds of their revealed or perceived/assumed HIV status which results in them being denied access to opportunities, benefits, care or services.

Early polymerase chain reaction (PCR) test: An HIV test done on an infant less than four weeks of age. Ideally the test should be repeated after six weeks of age or within six weeks to three months.

Enzyme-linked immunosorbent assay (ELISA): A laboratory test that detects HIV antibodies in the blood.

Evaluation: The activities designed to determine the value and impact of a specific programme, intervention or project.

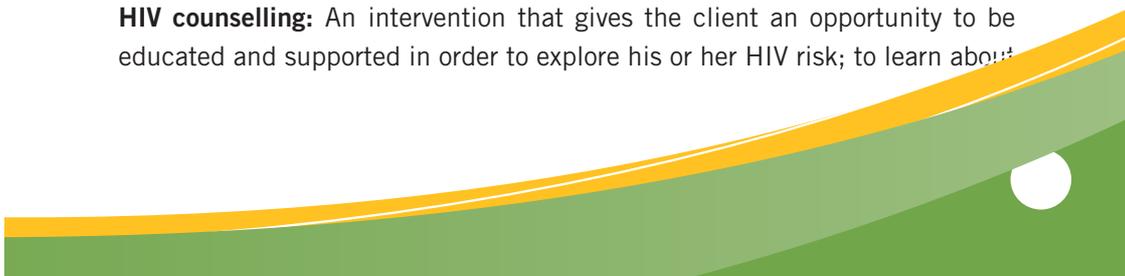
Group information and education session: Discussion between a health-care provider or trained health-care worker and more than one client, who may or may not be couples/sexual partners and where the discussion aims to provide information about health, in general including HIV & AIDS and HCT education including the benefits of knowing one's status, and encouraging clients to make informed decisions about HIV testing.

Health-care provider: Any person providing health services in terms of any law, including the:

- Allied Health Professions Act, 1982 (Act No.63 of 1982)
- Health Professions Act, 1974 (Act No. 56 of 1974)
- Nursing Act, 2005 (Act No. 33 of 2005)
- Medicines and Related Substances Act, 1965 (Act No. 101 of 1965)
- Pharmacy Act, 1974 (Act No. 53 of 1974)

Health-care worker: Any person involved in the provision of health services to a client, not including health-care providers. This includes lay counsellors and community care-givers and may also include a person who is trained to offer the same service to the deaf community.

HIV counselling: An intervention that gives the client an opportunity to be educated and supported in order to explore his or her HIV risk; to learn about



his or her HIV status and manage the consequences; to learn about HIV prevention and HIV and AIDS treatment, care and support services; and to learn how to modify behaviour to reduce the risk of HIV infection.

HIV counselling and testing (HCT): An umbrella term used to describe services that combine HIV counselling and testing. The policy distinguishes between two types of counselling and testing services – those that are client-initiated and those that are provider-initiated.

HIV counsellor: A trained individual who has successfully completed an HIV counselling course prescribed in the *National Minimum Standards for Counselling and Training*.

HIV DNA Polymerase chain reaction (DNA PCR) test: An HIV test used to diagnose infection in cases where antibody tests are not sufficiently reliable.

HIV-exposed infant: An infant falling into one or more of the following categories: (a) a baby born to an HIV-infected mother, whose own (baby's) status has not yet been established; (b) a baby who may have clinical signs of HIV where the status of the mother is unknown; or (c) a baby wet nursed (breast fed) by other mothers of unknown status and whose own HIV status has not yet been established.

Human immuno-deficiency virus (HIV): The virus that causes suppression which leads to destruction of the human immune system.

Informed consent: A process by which a client voluntarily confirms his or her willingness to provide a written or verbal consent to be tested for HIV or to provide information about his or her HIV status to a health-care provider, health-care worker or researcher. This agreement is obtained after the client has received information about the HIV test and understands the purpose of the procedure, or after understanding the purpose of the exchange of infor-

mation as being in the best interests of his or her own health or that of the partner or in the case of a pregnant woman, the foetus (baby in utero) or the infant being breastfed. Informed consent should be voluntary and conducted according to the legal and ethical requirements as outlined in this document.

Informed refusal: A process where a client with or without clinical signs of opportunistic infections consults a health-care worker, and is counselled and offered HIV testing which the client refuses. Such refusal should be recorded in the client's file and signed by the client and health-care worker.

Integrated service delivery: A service delivery approach that encourages and allows the health-care provider to review the client as a whole, assessing needs beyond the primary reason for the visit. This provides the basis for providing additional services or referring the client to receive services from another provider or facility. Its aim is to increase the efficacy of service delivery and reduce the stigma associated with HIV and AIDS.

Medical HCT or VCT service point: These are HCT service points within the medical services linked to medical care. They provide HCT with other services such as primary health care, hospital and social services. They include private practitioners, pharmacies, occupational health centres, laboratories, private hospitals and wellness programmes.

Mobile or outreach facilities: These are temporary rotating services, using mobile vehicles, caravans or tents that take HCT services to hard-to-reach populations. They are aimed at increasing HCT access to these populations.

Monitoring: The ongoing assessment of the utilisation of resources invested in a project or programme, services delivered by the project or programme, and outcomes related to these activities.

Mother-to-child-transmission: Transmission of HIV from an HIV-positive woman to her child during pregnancy, delivery or breastfeeding. The term is

used because the immediate source of the infection is the mother. It does not imply blame on the mother.

National minimum standards for counselling: A set of guidelines that outlines the minimum criteria for selection of lay counsellors adopted by the Department of Health in 2000.

National Reference Laboratory: The laboratory that provides national technical support for the development of standard operating procedures and quality assurance of the HIV rapid test kits and testing procedures. This role and function is performed by the National Institute for Communicable Diseases.

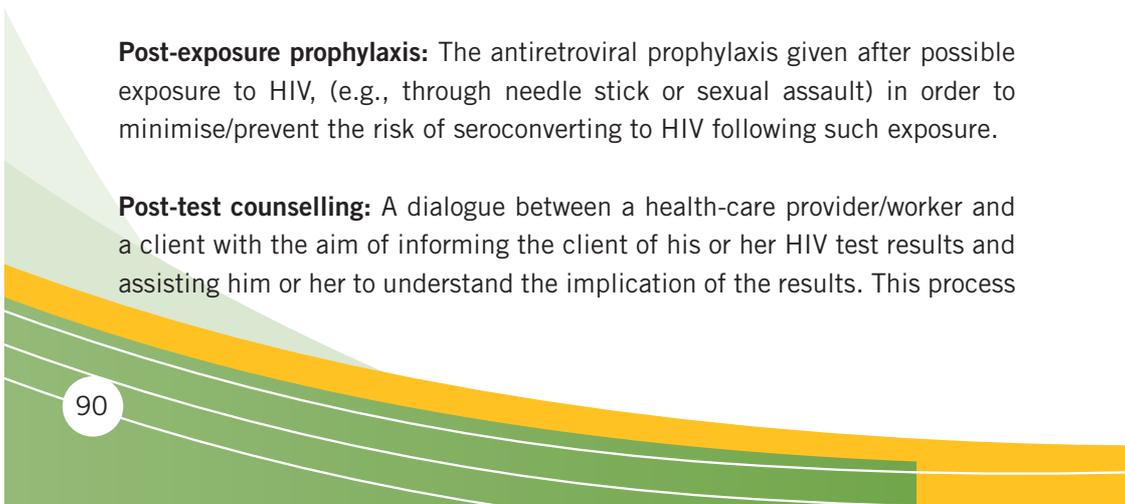
Non-governmental organisation (NGO): A civil society organisation usually registered as not-for-profit.

Non-medical HCT or VCT service points: HCT service points that are situated away from medical services though they have relationships with them (e.g. NGOs, FBOs, and CBOs.) The main focus of HCT in these settings is to increase access to counselling and testing by groups not receiving them in government facilities, and to provide HIV and AIDS services and other social support to communities. The services provided need to be integrated with those in government facilities.

Ongoing counselling: Provision of follow-up psychosocial support to individuals, families or groups after an HIV test result.

Post-exposure prophylaxis: The antiretroviral prophylaxis given after possible exposure to HIV, (e.g., through needle stick or sexual assault) in order to minimise/prevent the risk of seroconverting to HIV following such exposure.

Post-test counselling: A dialogue between a health-care provider/worker and a client with the aim of informing the client of his or her HIV test results and assisting him or her to understand the implication of the results. This process



assists the client to reduce the risk of infection and to facilitate access to appropriate services.

Pre-test counselling: A dialogue between a health-care provider/worker and a client with the aim of assisting the client to assess his or her own risk from HIV and to make an informed decision about whether or not to take an HIV test.

Prevention-of-mother-to-child-transmission: Any intervention that aims to reduce the spread of the HI Virus from an HIV-positive mother to her child.

Private sector facilities that offer HCT: These facilities include private medical practices, pharmacies, occupational health centres, laboratories, private hospitals and wellness programmes. These facilities must conform to National standards for delivering HCT services. At minimum, such facilities should have personnel, space for counselling and access to an HIV testing laboratory. They should offer on-going care and support for HIV and AIDS patients or should have an established referral system or links with other HIV and AIDS services. The facility should adhere to the national HIV testing algorithm and have a quality control link with established reference laboratories.

Provider-Initiated Counselling and Testing (PICT) (also referred to as Routine Offer of Testing): HIV counselling and testing which is routinely initiated and recommended by health-care providers to all clients attending health-care facilities as a standard component of medical care. Informed consent is required for HIV testing.

This routine offer of HCT by health-care workers to all patients entering the health-care system should be offered in all aspects of care including trauma, casualty and specialist clinics. In particular, the routine offer is emphasised but not limited to certain sections of health-care facilities such as antenatal-, post-natal clinics, TB facilities, centres for the integrated management of childhood illnesses, family planning clinics, sexually transmitted infection

clinics, and centres offering treatment for opportunistic infections and post-exposure prophylaxis. While the offer of HIV testing is routinely made, the client should be counselled and informed consent must be obtained. Patients will still receive their medical care even if they refuse the offer.

Quality assurance: Arrangements that safeguard, maintain and promote the quality of counselling and testing services according to defined national and international standards.

Quality control: Effective management and standard operating procedures that are stipulated for each service point in order to ensure good quality services according to defined national and international standards.

Rapid HIV test: A test, usually from a finger-prick (or heel-prick in babies), used to determine the presence of HIV antibodies in blood and normally taking 10-30 minutes to perform. This test is not performed in children under 18 months as they continue to carry maternal antibodies in their blood to this age.

Referral: A process of referring a client/patient to another health-care worker/ service for further investigation, management and treatment. This may be horizontal or vertical referral including up and down referral. Down referral may be from a health facility to a local clinic or service whereas up referral may be from a district or local service to a health facility.

Risk reduction counselling: Counselling with a client that focuses on HIV risk behaviour and the acquisition and transmission of HIV with the goal of getting the client to assess their behaviour and reduce their risk of infection.

Routine offer of testing (Also known as Provider-Initiated Counselling and Testing): HIV counselling and testing which is routinely initiated and recommended by health-care providers to all clients attending health-care facilities as a standard component of medical care. Informed consent is required for

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This routine offer of HCT by health-care workers to all patients entering the health-care system should be offered in all aspects of care including trauma, casualty and specialist clinics. In particular, the routine offer is emphasised but not limited to certain sections of health-care facilities such as antenatal clinics, post natal clinics, TB facilities, centres for the integrated management of childhood illnesses, family planning clinics, sexually transmitted infection clinics, and centres offering treatment for opportunistic infections and post-exposure prophylaxis. While the offer of HIV testing is routinely made, the client should be counselled and informed consent must be obtained. Patients will still receive medical care even if they refuse the offer.

Service provider: Any person qualified to provide a service to the benefit of a client.

Shared confidentiality: Other professional health workers providing direct care may access a client's medical information with the client's consent and for the purpose of providing the continuum of care to the client.

Stand-alone HCT service point: A HCT or VCT facility situated away from but integrated with formal medical services in that they are part of the referral network to and from the public health services and facilities. The rationale is to target NGOs, CBOs, and other private sector organisations already involved in HIV and AIDS programmes. These facilities offer VCT services only and refer clients to other services for further assistance.

Stigma: Negative attitudes or perceptions towards individuals who are known or perceived to be infected or affected by a condition such as HIV and AIDS.

Task shifting/Task sharing: A process of delegation whereby tasks are moved or shared, as appropriate, to less specialised health workers within the health-care team. By reorganising the workforce in this way, task shifting may facilitate a more effective use of human resources currently available. For

example, when doctors are in short supply, a qualified nurse can initiate and manage treatment. Furthermore, trained community health workers including counsellors and community care-givers can deliver a wide range of HIV services, thus freeing the time of other health-care workers.

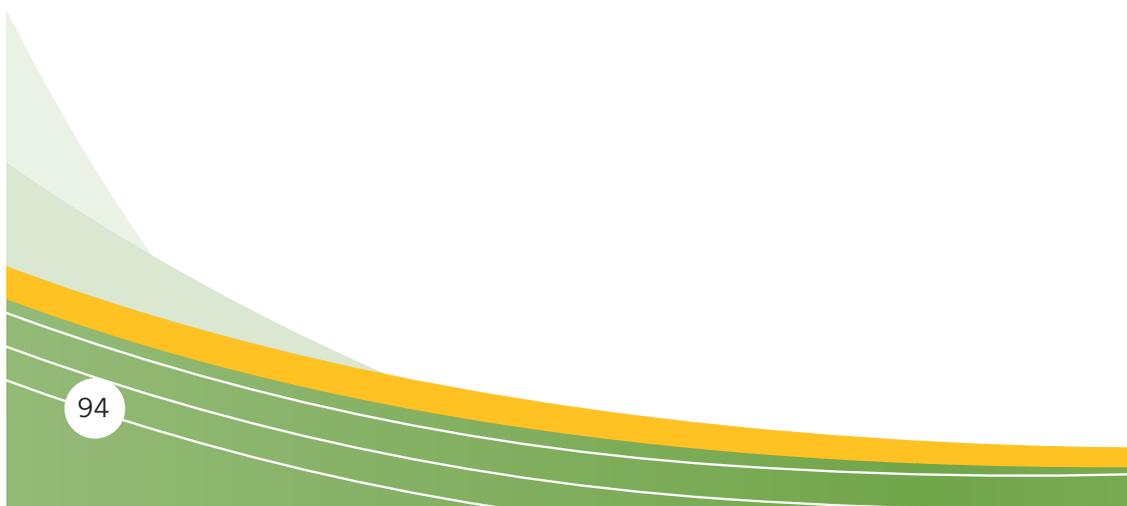
Voluntary counselling and testing (also called Client-Initiated Counselling and Testing): HIV counselling and testing that involves individuals and couples actively seeking out these services. The process is voluntary, and the “three Cs” – informed consent, counselling and confidentiality – must be observed.

Window period: The time between HIV acquisition and the presence of detectable HIV antibodies in the peripheral blood.

Workplace health facilities: These facilities are situated at the workplace to provide staff with health and wellness programmes including those relating to TB, HIV counselling and testing and occupational health and safety.

Youth-friendly services: Services that offer a conducive environment for young people to access and utilise health services.

Youth services: These are youth-friendly services attached to health facilities. They are aimed at targeting youth through youth groups, school health services and community based health services. They aim at facilitating the full involvement of young people in HIV testing services.



Annexure III: Guiding Principles

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

The principles guiding the *HCT Policy Guidelines* include the Constitution of The Republic of South Africa, Act No. 108 of 1996, the Bill of Rights, Batho Pele, and those guiding the implementation of the NSP, the Operational Plan for Comprehensive HIV and AIDS Management, Treatment and Care and the PMTCT programme. The conditions under which people undergo HIV testing must be anchored in an approach which protects their human rights and pays due respect to ethical principles.

These principles are:

RIGHT TO DIGNITY

(Constitution of the Republic of South Africa, Act No. 108 of 1996 Section 10; National Health Act No. 61 of 2003 Sections 7, 8 and 9).

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

Right to Privacy and Confidentiality

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

All information concerning a client, including information relating to his or her health status, treatment or stay in a health establishment is confidential. No one shall be subjected to arbitrary or unlawful interference with his or her privacy. There are certain instances when information may be disclosed, for example the test results of an alleged perpetrator of a sexual assault.

Personal Responsibility and Commitment to Prevention of HIV

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

RIGHT TO REFUSE HIV TESTING

Clients should be able to refuse HIV testing without compromising their access to standard health care.

Promoting Equality for Vulnerable Groups

The particularly vulnerable position of women and girls and persons with disabilities with respect to HIV and AIDS and its social impact is recognised.

Promoting the Best Interests of Children

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

The following principles should guide any interactions with children:

- Providing of relevant, appropriate and accessible information on the prevention, treatment and care of HIV during the counselling process in the language that the child is able to understand;
- Ensuring full participation by the child in any decision-making and consent process regarding HIV testing and due consideration given to the views of the child;

- Testing only when it is in the best interests of the child;
- Providing post-test access to treatment, care and support; and
- Ensuring confidentiality regarding HIV test results and support with disclosure of HIV status (Children’s Act 2005 as amended, Criminal Law (Sexual Offences and Related Matters) Amendment Act, No. 32 of 2007)
- **The South African National HCT policy is aligned with the Joint United Nations Program on HIV AND AIDS (UNAIDS) and the World Health Organisation (WHO) Policy Statement on HIV testing, which states that:** “The conditions under which people undergo HIV testing must be anchored in a human rights approach which protects their human rights and pays due respect to ethical principles”.

Duty and Responsibility of ALL Health-Care Personnel

It is the duty and responsibility of ALL health-care workers to identify HIV-positive men, women and their partners, and HIV-exposed and HIV-positive infants, children and youth so that they can access HIV care. Practiced within a human and child rights framework, this critical intervention should prolong life and optimise maternal and child survival (NDoH PMTCT Guidelines 2008).

Challenging Discrimination

Discrimination against people with HIV undermines dignity and hinders an effective response to HIV and AIDS. Unfair discrimination against an employee in any employment policy or practice, including discrimination on the grounds of HIV status, should be eliminated (Employment Equity Act No. 55 of 1998). The National HCT Programme should help reduce discrimination by creating knowledge and competence about HIV in communities.

Availability

All essential commodities in HCT facilities, including rapid test kits, condoms and information, should be made available, affordable and accessible.



Quality of HCT Services

All HCT services (including testing and testing kits) shall be subject to quality assurance according to defined national standards and should be monitored and evaluated. Lay counsellors should be trained to provide quality HCT service according to the policy framework.

Effective Partnerships

All public and private sectors of government, all partners and all stakeholders of civil society shall be involved in the HIV and AIDS response.

Effective Communication

Clear and ongoing communication (with appropriate messages) between government and all civil society stakeholders is necessary for the achievement of the aims of the policy. Effective communication also helps to inform those affected and infected with HIV as to what they need to do, what is available and of any new developments with regards to the policies around testing and treatment.

Strengthening Service Delivery and Integrating Services

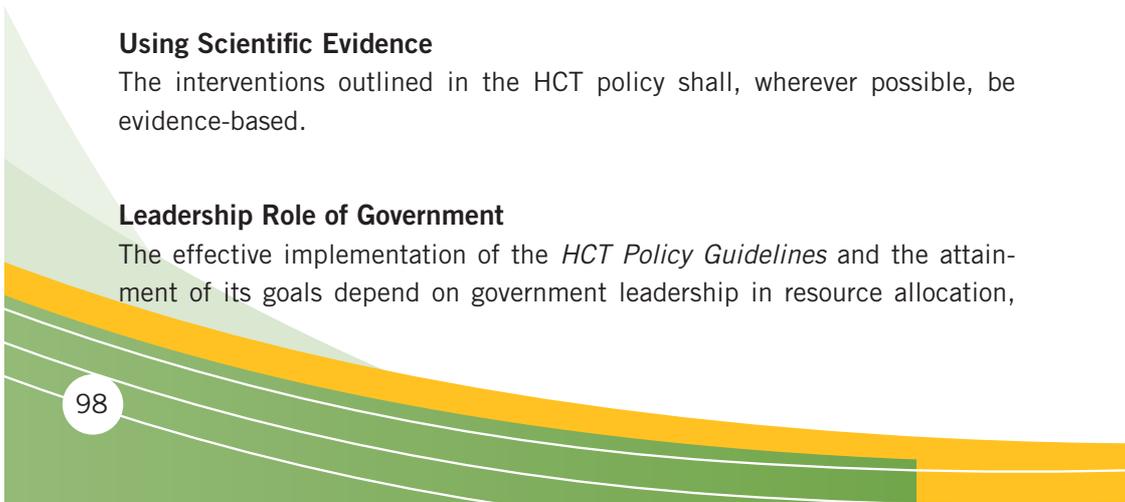
Strengthening health and social systems within a multisectoral approach, including the organisational capacity of NGOs, FBOs and CBOs, and ensuring integration between services, and is central to effective implementation of the policy.

Using Scientific Evidence

The interventions outlined in the HCT policy shall, wherever possible, be evidence-based.

Leadership Role of Government

The effective implementation of the *HCT Policy Guidelines* and the attainment of its goals depend on government leadership in resource allocation,



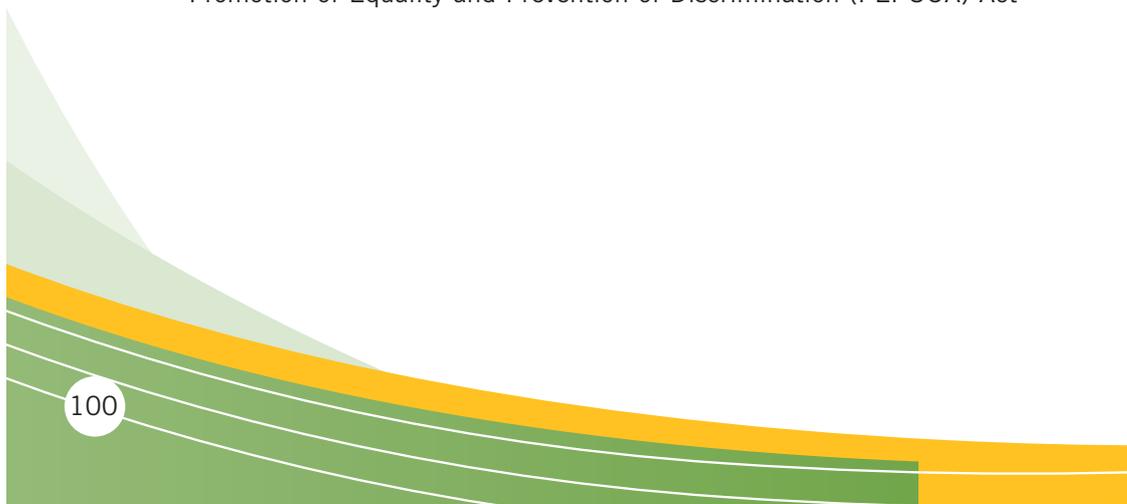
policy development, and effective coordination of the programme and interventions.



Annexure IV: Legal Framework

Health and human rights are inextricably intertwined. Safeguarding human rights is an essential part of effectively responding to the HIV epidemic. This policy is aligned with the Constitution of the Republic of South Africa (1996) and other relevant legislation and international law (including the International Covenant on Civil and Political Rights). Current and relevant legislation includes the following:

- The Constitution of the Republic of South Africa 108 of 1996
- National Health Act No. 61 of 2003
- Local Government: Municipal Demarcation Act 1998 (Act 27 of 1998)
- Children's Act No. 38 of 2005
- Children's Amendment Act No. 30 of 2007
- Human Tissue Act No. 65, 1983 (Until the adoption and implementation of the Task Shifting/Sharing Policy)
- Health Professions Act No. 56 of 1974
- Nursing Act No. 33 of 2005
- Occupational Health and Safety Act No. 85 of 1993
- Labour Relations Act No. 66 of 1995
- Basic Conditions of Employment Act No. 75 of 1997
- Public Service Regulations Amendments, 2001
- Employment Equity Act No. 55 of 1998
- International Covenant on Civil and Political Rights
- Criminal Law (Sexual Offences & Related Matters) Amendment Act No. 32 of 2007
- Promotion of Equality and Prevention of Discrimination (PEPUOA) Act



Annexure V: The Role of HCT Service Providers

HCT service providers must ensure that the following requirements are in place for the delivery of standardised, high quality and ethical HIV counselling and testing services.

Staff

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

HCT Facilities

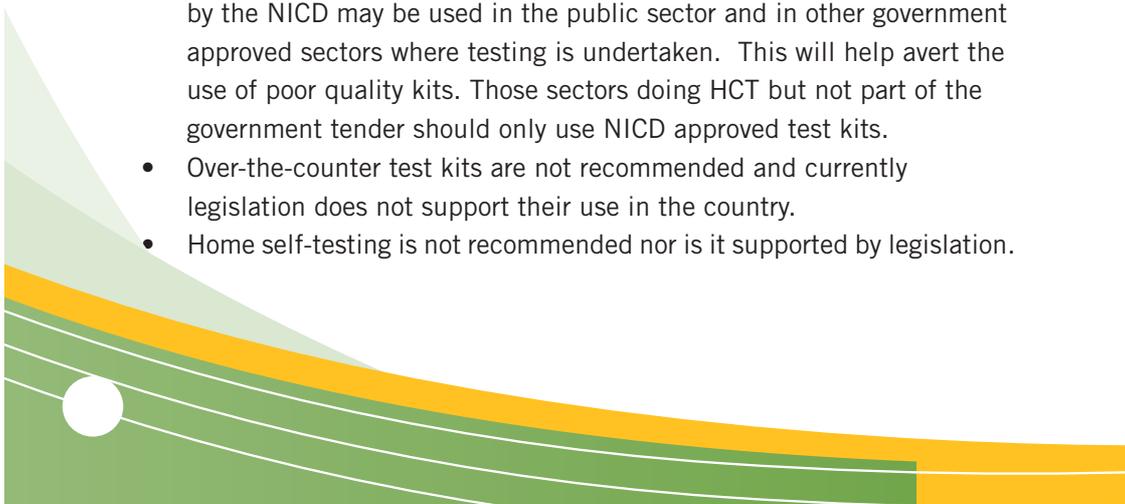
- Standard operating procedures (SOPs) that detail all elements of the HCT process should be available at all facilities.
- Staff should be trained in the use of these SOPs.
- SOPs should be updated as the need arises.
- Facilities must have adequate and appropriate space for conducting counselling and testing. This will ensure adequate privacy, confidentiality, and protection of clients utilising the services.



- Facilities must display signs or posters that inform clients about the availability and location of the service.
- Facilities must have relevant HIV and AIDS IEC materials in languages used by the facility's catchment population. Where possible, this information should also be available in braille. IEC materials must be available for clients to take home to study and discuss with their families.
- Facilities must facilitate access to other HIV and AIDS preventative services and, where appropriate, refer clients to treatment, care and support services.
- Facilities must be accessible and convenient to all segments of the population, men, women and children, citizens, and foreigners alike, including people with disabilities and other marginalised and hard-to-reach populations.
- Facilities where children are tested should be child-friendly and ensure that children's rights are protected.

Standard Operating Procedures for HIV Testing

- Procurement, processes, and procedures should be rigorous enough to minimise stock-outs of rapid test kits and related commodities as outlined in the SOPs.
- Rapid test kits should be stored according to the quality assurance guidelines.
- Rapid test kit quality assurance standards must be followed. Only rapid test kits received through the national tender and approved by the NICD may be used in the public sector and in other government approved sectors where testing is undertaken. This will help avert the use of poor quality kits. Those sectors doing HCT but not part of the government tender should only use NICD approved test kits.
- Over-the-counter test kits are not recommended and currently legislation does not support their use in the country.
- Home self-testing is not recommended nor is it supported by legislation.



THE ROLE OF THE NATIONAL DEPARTMENT OF HEALTH

The National Department of Health (NDoH) is the steward of the National HCT Programme, leading government departments and NGOs in the implementation of this policy. In particular the NDoH will:

- Facilitate the participation of all stakeholders from government and civil society in the development, adoption and implementation of this policy as well as in monitoring and evaluating the National HCT Programme;
- Facilitate the development of HCT guidelines, norms and standards that are appropriate for the local environment and in line with international norms and standards;
- Facilitate collaboration among stakeholders at all levels to strengthen and to improve the quality of primary health care and HCT services;
- Mobilise, disburse, and account for resources for the implementation of this policy in the public sector;
- Share lessons and evidence-based information on HCT;
- Oversee M&E and QA of counselling and testing; and
- Establish and maintain training norms for HCT personnel in line with the appropriate accreditation body.

THE ROLE OF THE PROVINCIAL DEPARTMENTS OF HEALTH

Each provincial department of health must:

- Establish appropriate provincial and local structures that support the NSP and the achievement of the targets in terms of the four key priority areas;
- Ensure the implementation of the National HCT Programme, norms and standards in the province;
- Adhere to all the elements outlined in this policy document;
- Develop sustainable business plans;
- Identify HCT training needs and conduct training as needed in the province;

- Conduct programme planning, budgeting and monitoring, and the M&E and QA of HCT in the province;
- Ensure efficient and timeous support of non-governmental agencies, working in partnership with them to implement HCT programmes;
- Facilitate the establishment and maintenance of information management systems for HCT programmes;
- Conduct or facilitate research on health and health services;
- Plan the training, management, development, and support of the required HCT personnel;
- Facilitate uninterrupted supply of all commodities;
- Facilitate community involvement in HCT; and
- Facilitate effective HCT referral systems.

THE ROLE OF THE DISTRICT HEALTH SYSTEM

The District Health System (DHS) consists of various health districts and, mainly through primary health care clinics (PHC), is responsible for service delivery by:

- Providing the resources needed for health services;
- Developing and implementing HCT within the district health plan for comprehensive services in accordance with provincial HIV and AIDS plans;
- Identifying training needs and facilitating training and workplace mentoring and support for HCT as needed;
- Facilitating the support, mentoring and debriefing of HCT personnel as needed;
- Developing and implementing a referral system that ensures that, following CICT or PICT, clients are not lost to follow-up but rather enter the continuum of services;
- Monitoring and evaluating performance assessment and service delivery; and
- Recording all activities and HCT uptake within the national

monitoring framework and submitting reports timeously to the province.

THE ROLE OF NON-GOVERNMENTAL IMPLEMENTING AGENCIES

Non-governmental agencies implementing HIV counselling and testing should:

- Adhere to all the elements outlined in this policy to ensure the delivery of high quality, standardised, and ethical HCT services;
- Support the NDoH and provincial departments in the implementation of the policy guideline and related HCT programmes;
- Facilitate the management, support, mentoring, and debriefing of HCT personnel as needed;
- Assist provinces with the identification of HCT training needs;
- Monitor and evaluate performance assessment and service delivery;
- Work with the national and provincial departments of health to implement high quality HCT services inside and outside government facilities;
- Provide HIV testing data to provinces to allow the NDoH an overall measure of the country's movement towards HIV testing targets in the NSP; and
- Assist the provincial departments in mobilising communities towards expanding access to HCT services.





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