



The Ministry of Health and Social Welfare
Kingdom of Swaziland

HIV TESTING AND COUNSELLING
NATIONAL GUIDELINES

June 2006



**World Health
Organization**

REGIONAL OFFICE FOR

Africa





**Kingdom of Swaziland
MINISTRY OF HEALTH AND SOCIAL WELFARE**

**HIV TESTING AND COUNSELLING
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OPERATIONAL DEFINITIONS

For the purpose of these guidelines and the intervention in Swaziland HIV testing and counselling encompasses both the client-initiated and provider-initiated approaches to delivering the service.

1. Client - initiated approach is the traditional Voluntary Counselling and Testing (VCT) approach in which an individual, for whatever reason, seeks HIV testing and counselling at a site providing this service.
2. Provider- initiated approach is when HIV testing and counselling is initiated by the service provider in the context of clinical and preventive health care services. This includes all scenarios where HIV testing and counselling will assist in the provision of quality care services and minimises missed opportunities for knowledge of one's HIV status as part of standard of care in all health facilities in Swaziland.

DELIVERY OF BOTH CLIENT-INITIATED AND PROVIDER-INITIATED APPROACHES TO HIV TESTING AND COUNSELLING SHALL BE GUIDED BY THE PRINCIPLE OF 3Cs:

CONFIDENTIALITY, COUNSELLING AND CONSENT, MEANING THAT IT IS BOTH INFORMED AND VOLUNTARY

Ref: UNAIDS/WHO POLICY STATEMENT ON HIV TESTING, June 2004

ACKNOWLEDGMENTS

The Ministry of Health and Social Welfare wishes to express appreciation to the World Health Organisation for the technical support and guidance in the development of the second edition of technical guidelines on HIV Testing and Counseling for the country. The review and updating of the first edition was informed by the global and national recognition of the need to scale up HIV Testing and Counseling to facilitate wide access to available HIV prevention, treatment, care and support services for the population. Knowledge of HIV status is a critical entry point to these services; hence there is a need to make HIV testing and counseling available at all health service delivery points.

Special gratitude is extended to Dr Buhle Ncube, the Technical Advisor on HIV Testing and Counseling in the WHO Regional Office for Africa for providing the necessary guidance during the process of the review and finalization of the guidelines. Similar sentiments are extended to the national working team (Annex 1) that worked with Dr Ncube throughout the process. Without their remarkable dedication and commitment this document would not have been completed.

Rolling out HIV testing and counseling would not be possible without the technical guidance and quality monitoring from the laboratory services. The remarkable participation and commitment of the laboratory personnel to the review and subsequent implementation of the guidelines is thus greatly appreciated.

Particular mention must be made of major contributions both technical and financial, received from the development partners towards HIV Testing and Counseling in the country. This is greatly valued and is making a big difference in the national response to HIV and AIDS.

The active participation and contribution from all partners implementing HIV Testing and Counseling does not go unnoticed. This includes the NGOs, FBOs, CBOs, Private sector, PLWHA and

Public sector. Their commitment in providing the HIV testing and counseling services, provided the necessary experience that was important during the review and updating of the national technical guidelines. This effective partnership is greatly appreciated.

Finally the Ministry urges all current and potential providers of HIV Testing and counseling to adhere to this document as it defines the national standards for the service.



ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti Retroviral therapy
ARVs	Anti Retroviral drugs
CBCS	Community Based Care and Support
CSO	Church Service Organizations
DBS	Dry Blood Spot
DNA	De oxyribonucleic Acid
ELISA	Enzyme - Linked Immunosorbent Assay
FBO	Faith Based Organisation
FP	Family Planning
HIV	Human Immuno-deficiency virus
HTC	HIV Testing and Counselling
MCH	Maternal and Child Health
MOHSW	Ministry of Health and Social Welfare
NERCHA	National Emergency Response Council on HIV and AIDS
NGOs	Non Governmental Organisations
NRL	National Referral Laboratory
OIs	Opportunistic Infections
PEP	Post Exposure Prophylaxis
PLWHA	People Living with HIV and AIDS
PMTCT	Prevention of Mother to Child Transmission
QA	Quality Assurance
RNA	Ribonucleic acid
SNAP	Swaziland National AIDS Program
SOP	Standard Operating Procedure
STI	Sexually Transmitted Infections
TB	Tuberculosis
VCT	Voluntary Counseling and Testing

Chapter 1: INTRODUCTION

The devastating impact of HIV/AIDS continues to be felt in various parts of the world including Swaziland. The disease affects all populations including youth, children and those yet unborn. Swaziland is one of the sub-Saharan countries worst hit by HIV infection. Although the first case of HIV, was reported in 1986 and AIDS was reported in 1987, the epidemic has now reached an alarming proportion. Families, communities and the nation at large are experiencing the impact of HIV and AIDS.

According to the ninth HIV seroprevalance survey conducted in 2004 among women attending antenatal care clinics, the HIV prevalence has increased from 38.6 % in 2002 to 42.6 % in 2004. At present, it is estimated that about 210,000 to 230,000 people in Swaziland are living with HIV and AIDS of whom about 26, 000 need ART. Tuberculosis is far the most frequent opportunistic infection and more about 75-80 % of tuberculosis patients are infected by HIV. The total HIV and AIDS related deaths among adults and children were estimated at 17,000 in 2003 alone and life expectancy is projected to decline from 59.7 years in 2001 to 38.3 years in 2015. In 2004, the number of orphans was estimated at 69,000 which constitute a social burden that is becoming difficult to cope with for the Swazi society.

Since 1987 The Government of Swaziland has demonstrated a high level of commitment to fight the HIV and AIDS epidemic. In 1999, his Majesty King Mswati III declared HIV and AIDS a national disaster which led the government to launch the multi-sectoral approach to HIV and AIDS prevention and control. In 2002, the National Emergency Response Council on HIV/AIDS (NERCHA) was constituted to coordinate all HIV and AIDS responses through coordinating bodies of the different sectors of Swaziland, Ministries, Non Governmental Organisations (NGOs), Faith Based Organisations (FBOs) and other Civil Society Organisations (CSOs). In 2005, NERCHA facilitated the review and drafting of the National HIV and AIDS Policy, providing guidance for HIV and AIDS interventions and prevention strategies. These strategies include HIV Testing and Counselling (HTC) which aims at enabling people to know their HIV status and to reduce risky behaviour. The need for increased access to HTC services is increasingly compelling with the country's high HIV infection rates. The government realizes that knowledge of HIV status among Swazis is an important prevention intervention strategy that positively influences behaviour change.

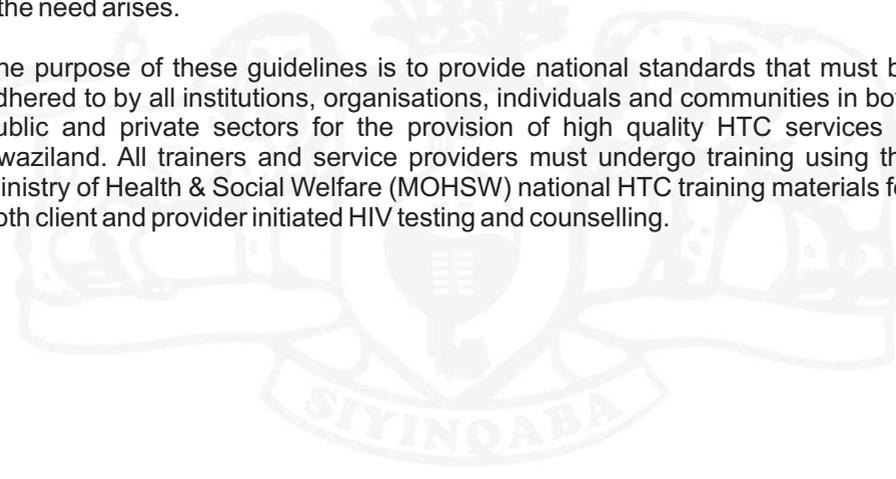
HTC is the entry point to HIV prevention, treatment, care and support. It contributes to reduction of the stigma and discrimination that surrounds HIV and AIDS. In Swaziland, access to knowledge of one's HIV status has been through the client initiated approach (VCT) and to a limited level provider-initiated approach, whereby patients who present with HIV related signs and symptoms are referred for HIV testing at the VCT centres or units for diagnostic purposes. With the new opportunities for prevention, treatment, care and support, especially

the availability of HIV anti-retroviral drugs (ARVs) for Prevention of Mother to Children Transmission (PMTCT) and anti-retroviral therapy (ART), there is need to scale-up both the client-initiated and provider-initiated approaches to HTC.

In line with the global 3 by 5 initiative, the country met and exceeded its target of putting 13 000 people on ART by 2005. Hence the efforts are now towards achieving universal access to HIV and AIDS prevention, treatment, care and support services as part of the global universal access initiative. In this regard, the country's universal access target for HIV Testing and Counselling is to increase the proportion of people knowing their HIV status to 50% by 2010.

For the period 2006 – 2008, Swaziland's target is to increase the proportion of people knowing their HIV status from the current 10% to 40% by 2008 and to increase the number of eligible PLWHAs receiving ART to 75% by 2008. This calls for urgent scaling up of HTC services so that more people can have access to knowledge of their HIV status. Those who are HIV negative can adopt behaviours that ensure that they remain HIV negative. Those who are HIV positive can reinforce positive prevention strategies; adopt early treatment seeking behaviour for management of opportunistic infections (OIs) and access treatment with ARVs if the need arises.

The purpose of these guidelines is to provide national standards that must be adhered to by all institutions, organisations, individuals and communities in both public and private sectors for the provision of high quality HTC services in Swaziland. All trainers and service providers must undergo training using the Ministry of Health & Social Welfare (MOHSW) national HTC training materials for both client and provider initiated HIV testing and counselling.



Chapter 2: SERVICE DELIVERY MODELS

HIV Testing and Counselling (HTC) is the entry point for HIV prevention, treatment, care and support in Swaziland. Access to HTC services remains limited and yet the demand is increasing. However, the fear of stigma and discrimination continues to be an obstacle towards people accessing the services even in places where these services are offered. In the context of the high level of the HIV epidemic in Swaziland and the wider range of available HIV prevention, treatment, care and support options, there is an urgent need to rapidly scale up access to HTC at every available opportunity. Without effective HIV prevention, the number of people who require treatment will continue to rise and HTC plays an important role in this regard.

It is imperative to set up and expand HTC models that will maximise access and respond to the demand for service. Client-initiated HTC/VCT services are being offered in Swaziland and the uptake is increasing. Though provider-initiated HTC has been implemented to a limited extent in clinical care settings and PMTCT sites, there is need for a properly articulated, coordinated and integrated promotion and implementation of this approach. Swaziland has adopted the approach where HTC will be offered to all patients and clients as part of the standard of care in health facilities. It should be noted that the universal human rights, and underpinning principles of confidentiality, counselling and consent must be respected. In order to increase the uptake of HTC, both client-initiated and provider-initiated approaches will need to be scaled up to meet the needs of different people.

The following HTC service delivery models already in practice in the country incorporate both client and provider initiated approaches:

1. Free standing client initiated HTC/VCT services
2. Integrated HTC services
3. Outreach HTC services

It has become clear that one single model of delivering HTC services in Swaziland is neither suitable nor feasible for different settings and segments of the population.

Service Delivery Approaches

i. **Free Standing client initiated HTC/VCT services**

Free standing client initiated HTC/VCT services will be provided in sites that are situated outside health facilities. In some cases these sites will provide additional HIV and AIDS care and support services.

Key elements and areas needing considerations are detailed below.

Models	Key Elements	Considerations
<p>Free standing HTC/VCT services</p>	<ul style="list-style-type: none"> * High level of public awareness of the service to be created. Also need for community mobilization, advertising and community responsibility to fight HIV and AIDS * Location in a busy and easily accessible area where there will be a high volume of clients. * Staff dedicated to providing full-time HTC services * Strong linkages with providers of support services. * Anonymous and confidential testing offered * Flexible hours of operation including evenings and weekends, if possible * Targets general public, especially those who would not normally visit health facilities. * Nominal fee charged to clients who can afford to pay * Youth friendly activities could be incorporated to help de-stigmatize the service * Rapid testing promotes the provision of same day HIV test results 	<ul style="list-style-type: none"> * Sustainability - possible difficulties with long-term funding since majority are donor-funded and managed by NGOs * Entails significant commitment in terms of time, resources, infrastructure and staff * Need to ensure good referral mechanism for follow-up treatment, care and support * Possibility of stigmatization * High likelihood of staff burnout as they have little relief from HIV and AIDS counselling * Clients who cannot afford to pay should not be denied services.

ii. **Integrated HTC Services**

Integrated services are provided within health facilities, maternal and child health (MCH) services, sexually transmitted infection (STI), tuberculosis (TB), opportunistic infection (OI) in-patient and outpatient clinics. HTC will be offered to all patients and clients as part of the standard of care in health facilities. Informed consent, written or verbal, will be obtained during the normal process of consultation between the health care provider and the patient or client. In addition to the provider-initiated HTC services, all health facilities should provide client-initiated HTC/VCT services. Close proximity of other medical services within the facility promotes cross referral. In addition, referral for services not available within the facility should be established.

In-patient considerations

For in-patients unable to walk to a private room in the ward, applicable adjustments must be made to ensure that discussions are confidential with privacy assured.

Anonymity in client initiated HTC/VCT services

Clients who present for HTC in this context will use code numbers or names, if they so wish. However, for HIV positive clients who need to be referred for medical care, there will be loss of anonymity and concomitant use of the client's name. The client should, however, be assured of confidentiality.

Models	Key Elements	Considerations
Integrated HTC services	<ul style="list-style-type: none"> * Ideal for rapid scaling up of HTC as the basic infrastructure and health workers are already in place * Existing staff must receive training in HTC service provision * Close links with other medical services already exist and facilitate clinical referral * It is important to hold regular meetings among different departments to ensure good liaison and cross-referral * Potentially less expensive since existing facilities and staff are utilized * Low stigmatization as people could be attending the facility for other reasons. * Rapid testing promotes the provision of same day HIV test results 	<ul style="list-style-type: none"> * Staff must be given adequate space to provide HTC services * Limited space can also affect privacy and expansion of services * May exclude people who do not frequent formal health services e.g. men and youths * Can be perceived as translating to added responsibility for existing staff * Shortage of staff due to transfers and staff engagement in other responsibilities

iii. Out-reach HTC Services

Out-reach HTC services will be provided for special populations such as people living in underserved areas, community gatherings, workplace, highly mobile populations (long distance truck drivers, seasonal workers, commercial sex workers etc) and vulnerable groups e.g. prisoners. However, it is mandatory to ensure that a strong support system and referral mechanism are established at community level before initiating an outreach HTC service. The outreach HTC services will be provided by mobile teams from existing centres and facilities providing HTC. Premises such as community halls, school halls, youth facilities and mobile structures such as vehicles, caravans and tents can also be utilized for service provision. The table below shows some of the key elements of this model, and areas needing consideration.

Models	Key Elements	Considerations
<p>Outreach HTC services</p>	<ul style="list-style-type: none"> * Improves access for people living in remote areas, working class and other hard-to-reach populations * Rapid testing promotes the provision of same day HIV test results * Chances of clients receiving HIV test results are increased since services are taken to the clients. * Promotes counselling and care at community levels * Easy model for rolling out HTC services to communities. * May destigmatise HIV testing as more people access the service * May have more assurance of confidentiality as services are provided by HTC providers from outside the community * Convenient for those not willing to access services through public sector facilities * Convenient for employees if services are provided at work places 	<ul style="list-style-type: none"> * Need to have a well-organized schedule and strategies for serving clients who live in areas that are inaccessible. * May be difficult to ensure follow up services * Strong support system must exist at community level before outreach services are initiated * Facilities for optimizing privacy and comfort for the client may be insufficient * Challenges with client referrals may exist * Quality of testing and counselling may be difficult to monitor * Limited supervision of counsellors * May promote stigma and discrimination * Concerns about confidentiality for work-place programmes * May be expensive

Chapter 3: OPERATIONAL REQUIREMENTS

A. COORDINATION OF THE HIV TESTING AND COUNSELLING SERVICES AT NATIONAL LEVEL

In order to ensure optimal use of limited resources and maximum impact of HTC service delivery, coordination of services shall take place at the national level. Key elements of HTC coordination will include the following:

- (a) The National HTC Coordinator at the Swaziland National AIDS Program (SNAP) and the Coordinator at the National HIV/AIDS Reference laboratory (NRL) at Mbabane Government Hospital comprise the HTC coordinating unit. These work with a technical core team on HTC that meets on a maturity basis. At regional level, the unit works with the SNAP Regional AIDS Coordinators.
- (b) Standards and protocols for HIV testing, including approval of specific test kits.
- (c) Advocating for official recognition of HTC counsellors including benefits commensurate with other professional categories, establishment of selection criteria, definition of different levels of counsellors, accreditation mechanisms, training and supervision programmes, including development of standardized curricula.
- (d) Selection of common indicators for uniform monitoring and evaluation, which can be integrated into the National Health Information System.
- (e) Preparation of common reporting forms or register for a centralized data collection and analysis system.
- (f) Standardization of records for post- test referrals and follow-up.
- (g) Establishment of linkages with other health, social and HIV and AIDS prevention, treatment, care and support services.
- (h) Commitment by government to provide resources and funds for community mobilization and support for HTC
- (i) Methods for sharing lessons learnt and cross referrals with other HIV and AIDS services through national HIV and AIDS services network.

B. MINIMUM REQUIREMENTS FOR SERVICE DELIVERY

1 Integrated HTC facilities

a. Space and equipment requirements

Although all health facilities have consulting rooms, there is need to ensure privacy during counselling sessions. Areas where rapid HIV testing is to be conducted must be equipped according to standardized national laboratory guidelines for HIV testing. For places where there is

an HTC unit, space and requirements will be the same as free standing HTC/VCT services.

b. Staffing

Integrated facilities offer both client-initiated and provider-initiated HTC services. In addition to providing clinical services, existing staff also offer HTC in clinical settings and for diagnostic purposes. However, as more resources become available, additional staffing will be provided through the deployment of Basic HTC counsellors. For places where there is an HTC unit, staffing requirements will be the same as free standing HTC/VCT facilities.

Personnel to perform rapid HIV testing

It is desirable that Laboratory Scientists conduct HIV testing where possible. However, in order to support the expansion of HTC services in Swaziland, HTC counsellors and other health workers who have received the requisite training, stipulated by the NRL will be authorized to perform rapid HIV tests. However, laboratory scientists or technicians will be responsible to ensure quality assurance.

Data entry Personnel

The integrated facilities will continue to use the National Health Information Management System (NHIMS) for collection of data on patients and clients who receive HTC services.

2 Free standing HTC/VCT facilities

a. Space and equipment requirements

The following are the minimum space and equipment requirements:

- i) Reception area should be equipped with a desk, chairs filing cabinet/s, communication gadgets e.g. telephone, IEC materials and, if possible, a computer for data entry.
- ii) Screening area - this is optional and applicable in bigger HTC sites
- iii) *Waiting areas* should be equipped with a comfortable sitting facility with a capacity of 20 people; open display area for educational materials, including those that explain the HIV testing procedure; and, if possible, audiovisual equipment.
- iv) Counselling room(s) in which rapid HIV tests can be conducted should be equipped with 3 chairs, small table with a washable surface, sink with running water, storage space for blood drawing equipment, sharps disposal container, lockable cupboard, registers and other stationery.

- v) *Laboratory* should be equipped with a desk, chair, washable work counter, storage space for medical consumables, lockable storage for test kits that do not need refrigeration, refrigerator for test kits and/or reagents needing refrigeration, standard contaminated waste disposal containers and sink with elbow taps and running water. Where the ambient temperature is above 28 degrees centigrade, rapid test kits must be refrigerated.
- vi) *Toilets for male, female and staff.* These must be adequate and provided for the number of clients visiting the site.

b. Staffing

Key staffing categories to be considered are management, technical and support

i) Management

A manager is essential in ensuring the provision of high quality HTC services. The responsibilities of this position include planning and coordination of services, supervising and supporting staff at the HTC site.

ii) Technical staff

Counsellors - There must be an adequate number of trained HTC counsellors to ensure uninterrupted services on a full-time basis. The counsellors must receive adequate supervision and support from management.

Personnel to perform rapid HIV testing

A Laboratory Scientist conducts HIV testing where possible. However, in order to support the expansion of HTC services in Swaziland, counsellors and health workers who have received the requisite training stipulated by the NRL will be authorized to perform rapid HIV tests.

iii) Support

Data entry personnel

The receptionist or data entry clerk will perform data entry duties for the facility. This information will be transmitted to the MOHSW through the existing regional AIDS coordination structures, monthly.

Receptionist

The role of the receptionist includes welcoming clients, registering them, collecting user fees if applicable, explaining procedures, providing educational materials and entering data, where applicable.

Ancillary

These include general service staff such as cleaners, security guards and drivers. They are responsible for the general upkeep and other duties at the facility.

3 Outreach HTC services

Outreach services will be provided from both the integrated and free standing facilities. It is imperative for management to ensure that the premises from which outreach services are provided meet the required standards for quality HTC in the country. It is also important that adequate staff is deployed for the services. The existence of strong support and referral systems for patients and clients who will receive HTC services is very critical.

C. SUPPLIES FOR ALL SERVICE DELIVERY MODELS

These will be procured centrally through the NRL for all facilities providing HTC services. The quantity of supplies for each facility, centre or site will depend on the volume of clients expected and testing protocols that have been adopted. The supplies include:

HIV test kits

Gloves and all other medical supplies including supplies for universal precautions.

Puncture-proof or metal containers for disposal of sharp objects.

Disinfectants

D. SELECTION OF SERVICE PROVIDERS

The recognition and training of different cadres of counsellors with different roles can enable the effective provision of HTC, ongoing supportive counselling and referral for other services.

i. Selection criteria for HTC service providers

1. Health care workers trained in provider- initiated HTC

All health care workers and practitioners interacting with patients or clients must be trained in the MOHSW stipulated, standard training for provider initiated HTC. This includes, but is not limited to doctors, registered nurse, nurse assistants, dental hygienists, environmental health personnel etc.

2. HTC Counsellors:

These work in facilities offering client initiated HTC services as well as mobile outreach services.

Requirements:

- i. At least a Diploma in a Health Sciences related field or Social Science.
- ii. Certificate in nursing assistant
- iii. Training in the MOHSW stipulated, standard training for client initiated HTC.

3. Basic HTC Counsellors:

Requirement

- i. Has completed Form 5 high school Education.
- ii. Training in the MOHSW stipulated, standard training for this new cadre.
 - a. Health facility based Basic HTC counsellors: To provide ongoing supportive counselling at facility level. With time their scope of work may be developed to include HIV testing at facility level.
 - b. Community based Basic HTC counsellors: To provide ongoing supportive counselling at community level and mobilisation of the community for HTC. With time their scope of work may be developed to include HIV testing at community level.

ii. Selection criteria for personnel performing HIV rapid test

Health workers, practitioners and HTC counsellors (and later Basic HTC counsellors) will be trained to perform rapid tests in order to support expansion of HTC services in areas where there are inadequate numbers of trained laboratory personnel to meet the demand for the testing services.

E. TRAINING OF HTC SERVICE PROVIDERS

All staff selected to serve as providers must also receive on-going training to improve their knowledge and skills. These will be organised as modules to address specific key issues in HTC such as couple counselling, counselling youths etc. These will be conducted in partnership with NGOs based on comparative advantage and expertise.

A. Health workers and practitioners

For certification in provider initiated HTC, these must undergo ALL of the following:

- a. 3 days core training following a standard MOHSW curriculum
- b. Written report on 10 cases seen in a clinical setting (at their place of employment or practice) in a period of 1 month.

B. HTC Counsellors

For certification, HTC counsellors must undergo ALL of the following according to their background:

Non health background

- i. 6 days theory training
- ii. 4 weeks supervised practical training

Health background

- i. 6 days theory training
- ii. 4 days HIV rapid testing
- iii. 4 weeks attachment

C. Basic HTC Counsellors

The training of the basic HTC counsellors will be in line with the national training manual and curriculum.

D Personnel to conduct rapid HIV testing.

Adequate numbers of persons per facility should be trained in conducting the simple, rapid HIV tests recommended for HTC purposes. This will ensure that all clients receive their results within one hour if possible, and on a same-day basis. Where feasible, these persons should include a Laboratory Scientist or Laboratory Technician

E Training of Ancillary staff.

All staff and volunteers involved with the HTC facility, including the receptionist, drivers, medical records officers, secretaries and cleaners should receive basic introductory training in the role and purpose of HTC emphasizing the importance of confidentiality.

Chapter 4: HIV AND AIDS COUNSELLING

Definition of HIV and AIDS counselling

Counselling, in relation to HIV and AIDS, is a confidential dialogue between a person and a care giver aimed at enabling the person cope with stress and make informed personal decisions relating to HIV and AIDS.

i. Pre-test counselling

Pre-test counselling helps the client/patient to:

- Assess their own risk
- Understand the benefits of HIV testing
- Be aware of a range of options and services available to them, including post-test support and ongoing psychosocial support
- Make an informed decision about having an HIV test
- Cope with a positive HIV test result
- Develop a risk reduction plan

Major components of the pre-test counselling session

- Basic facts on HIV and AIDS
- Discussion of benefits and potential difficulties of being tested for HIV
- Exploration of personal HIV risk behaviour and options for reducing risk including dual protection (condom use plus any other family planning method)
- Explanation of HIV rapid test process and meaning of HIV test results
- Assessment of client's/ patient's readiness for HIV testing
- Exploration of support system and discussion positive living
- Discussion of disclosure mechanism
- Obtaining consent for HIV testing

ii. Post-test counselling

Post-test counselling is provided to ALL clients/patients who have undergone HIV testing.

Post-test counselling prepares the client/patient to:

- Cope with the HIV test result
- Review their risk reduction plan
- Review ongoing post-test and psychosocial support,
- Discuss disclosure of test results and partner referral

Major components of the post-test counselling session

- Provision of HIV test results highlighting window period for patients or clients whose HIV test results are either negative and inconclusive
- Review of risk reduction plan including condom skills building
- Discussion of positive living and ongoing support
- Discussion of referral for other services such as clinical care, family planning, TB and STI screening and management services
- Discussion of disclosure of test results
- Discussion of partner referral for HIV testing
- Provision of information on family planning

iii. Follow-up counselling and referral for care and support

Follow up counselling must be provided to all clients or patients who have undergone HIV testing. This counselling empowers the HIV negative patients/clients to adopt risk reduction strategies so as to remain HIV negative. Those who are HIV positive will also reinforce their positive prevention strategies, live positively, and can be referred for appropriate services such as for opportunistic infection (OI), STI, TB management, ART, PMTCT, family planning, nutrition and psychosocial support. Basic HTC counsellors will play a critical role in the provision of this service, at both health facility and community levels.

Referral is the process by which immediate client/patients needs for HIV prevention, treatment, care and support services are assessed and prioritized, and clients/patients are assisted to access these services. Referral should include the basic follow-up necessary to facilitate initial contact with HIV prevention, treatment, care and support service providers.

iv. Counselling scenarios

Requesting testing only

Patients or clients who request HIV testing but decline counselling must have the benefits of counselling explained to them by the service provider. All clients/patients requesting to be tested for HIV must always be counselled before they are tested. Testing without counselling must be discouraged.

Requesting counselling only

Sometimes clients/patients may attend HTC services to learn about HIV and AIDS but do not want to receive HIV testing. Others may decide, after pre-test counselling that they do not want to be tested or that they want to go away and think about testing. The service provider should accept the client's/patient's decision not to be tested, and encourage the client/patient to come back for further counselling, with or without being tested. The

service provider should view counselling without testing as being just as important as counselling with testing.

Premarital HIV testing and counselling services

Premarital HTC services should be encouraged in all sectors of society with emphasis on confidentiality and consent (informed and voluntary). It is recommended that the couple is seen together where possible. However, the individuals can be seen separately if they so desire, but should be encouraged to share their test results, and be made aware of the potential implications of the results on marriage decisions.

Couple counselling

Couple counselling is recognized as an important and effective intervention in which the two clients are counselled and provided with HIV test results as a couple, with emphasis on confidentiality and consent (informed and voluntary). This encourages the couple to start planning for their future and discuss a realistic risk reduction plan that they can implement together. It also helps in addressing possible violence between the partners emanating from the seeking HTC services. In situations where the couple refuses to receive services together, they can be counselled and receive results separately, and then encouraged to disclose results to each other.

In some cases, the results can be discordant. This is when one partner is HIV positive while the other is HIV negative. The need for disclosure and mutual support in such a situation cannot be overemphasized. It is also crucial that the window period and need for retesting of the HIV negative partner after 3 months are discussed with the couple.

Group information sessions

Group information sessions, with skilled facilitation, can be used where there is high demand for HTC services. It can be offered prior to provision of both client-initiated and provider-initiated HTC services. These sessions are aimed at providing information rather than counselling. They can be utilized in settings such as PMTCT, TB, STI, family planning clinics and HTC, VCT sites. The goal of the session is to discuss general information about HIV and AIDS including HTC specifically. Opportunities for individualised counselling must then be offered to the clients or patients

Prevention of Mother to Child Transmission (PMTCT) of HIV

In PMTCT, HTC is offered as part of the standard of care for Antenatal Care (ANC) clients in accordance with the National PMTCT

Guidelines.

HIV and TB

TB is the most common condition associated with HIV infection. In 2002, it was estimated that about 78% of TB patients in Swaziland were co infected with HIV. This high coinfection rate provides an opportunity for identifying individuals with HIV among TB patients, and those with TB among HIV positive patients. HTC is offered as part of the standard of care in these situations will done according to TB/HIV guidelines.

Youths

Youths might be reluctant or have difficulty accessing HTC services where adults are also receiving the same services. The number and coverage of youth-friendly services offering HTC, should therefore be increased. Specially trained youth counsellors and peer educators will work with this age group, and offer flexible hours of service in these facilities. Youths will be strongly encouraged to abstain from sex through intensified and targeted behaviour change communication strategies and materials. In addition to encouraging abstinence, condoms will be promoted as a strategy whenever the need has been identified. The provision of HTC services will be guided by the Age of Consent in Swaziland.

Children

Children infected with HIV sometimes have delayed milestones, with their level of maturity not always matching their chronological age. This has an impact on the conduct of counselling sessions and stage at which the HIV status of the child is disclosed. HTC service providers will ensure that the child, parents and legal guardians are intimately involved with all issues pertaining to the child's illness including the counselling and disclosure process. HTC service providers should explore reasons for parents or legal guardians wanting to know the child's HIV status, and refer accordingly. It is important that children are not tested for the wrong reason such as parents wanting to know their own HIV status indirectly through the child, or as an excuse by the guardian to abandon their responsibilities. Parents or guardians of HIV positive children will be counselled for HIV and encouraged to test so that they develop better understanding of the child's circumstances and emotional needs.

HTC service provider self-care and support

“Burn-out” has been described as a physical, emotional, psychological and spiritual phenomenon, characterized by progressive loss of idealism, energy and purpose experienced by people working in helping professions.

All HTC service providers need formal support, stress management and mentoring strategies to prevent or mitigate the effects of burnout.

HTC service providers support strategies include the following:

Ensuring that there are clear roles and responsibilities for HTC service providers.

Ensuring periodic medical screening for all HTC service providers as they may be exposed to other diseases in the course of their work. All areas used for counselling must be well ventilated, and HTC service providers should receive routine preventive health screening, especially for TB. Those who are HIV positive should be provided access to preventive services such as TB preventive therapy, (check with TB programme) medication to prevent opportunistic infections, and ongoing medical and psychosocial support.

All HTC providers are encouraged to go through the process of HTC because knowledge of their own HIV status will also help them to access prevention, treatment care and support services.

Every measure must be taken to reduce the risk of occupational transmission of blood-borne diseases. It is advisable that HTC providers receive hepatitis B immunization. In cases of occupational exposure - such as needle-stick injuries - post-exposure prophylaxis (PEP) must be available as soon as possible within 72 hours of exposure. National guidelines on procedures to be followed for PEP must be adhered to at all times. Counselling for adherence must accompany the administration of PEP.

A more experienced counsellor must act as a mentor for a less experienced counsellor. The mentor must be readily available and accessible for support at all times.

Periodic counselling review meetings should be held at least once a month. During these meetings the counsellors can discuss challenging cases, share experiences and be updated on new developments in HIV and AIDS.

Counsellors should form support groups in order to support and assist each other in an informal environment where both social and work-related activities will be discussed. This mutual support will help in minimizing stress and burn-out.

Quality assurance

Quality assurance is a way of monitoring and evaluating the quality of services provided in accordance with established national guidelines, policies and standards. Approaches for assessing HTC services include mystery client surveys, client exit interviews to measure client satisfaction, counsellor self-assessment, regular training, supportive supervision, stress management sessions and operations research. These approaches will be implemented based on an availability of resources.

Chapter 5: HIV TESTING

BACKGROUND

The indications for HIV testing include:

- Knowledge of one's HIV status
- Screening of donated blood for transfusion
- Surveillance of HIV prevalence or trends over time in a given population
- Diagnosis of HIV infection in individuals
- Research

Establishing the presence of Human Immunodeficiency Virus (HIV)

The presence of an HIV infection may be established in body fluids or organs by:

1. Isolation of HIV

The HIV may be isolated through viral culture methods. In practice however, it is not possible to use viral culture methods in routine clinical situations. These methods are difficult to perform and require high levels of technical skills. They are usually reserved for use in research laboratories.

2. Detection of the presence of antibodies to HIV

The presence of HIV antibodies may be detected using Enzyme-Linked Immunosorbent Assays (ELISA) or simple rapid HIV tests. Usually ELISA tests are used in a clinical laboratory where there are large volumes of samples (more than 50 at a time) and expertise, while the rapid tests are more applicable where there are few samples and highly skilled laboratory personnel may not be available.

In the past, the Western Blot (WB) assay was used to confirm positive ELISA tests. With the improvement of antibody tests, it is no longer necessary to confirm positive screening tests with WB. This is as long as the screening tests are performed using the proper algorithms. A WB test has the capacity to demonstrate an antibody profile to HIV specific proteins. Different organisations have developed their own criteria for reporting positive WB results.

3. Detection of the presence of virus particles

In recent years, a number of virologic assays have been introduced to assist in the establishment of a diagnosis of an HIV infection. Used quantitatively, the tests may also be used to monitor the progress of the infection and response to therapy.

The tests include assays that detect virus particles e.g. the p24 antigen test or the presence of HIV viral nucleic acid sequences (RNA and DNA) by means of nucleic acid amplification techniques. The HIV-RNA found in

plasma forms the basis for the viral load tests while the HIV-DNA found in mononuclear cells forms the basis for the infant diagnosis of an HIV infection. Circulating P24 antigen appears early in the course of the infection, and is detectable 2-4 weeks after infection. It then disappears or falls to low levels until the onset of clinical illness when it rises again. Therefore, p24 antigen test on its own is not adequate for making a diagnosis of an HIV infection. However, it could have a role in early diagnosis of an HIV infection and the screening of donor blood. HIV test kits that can detect both the antibodies and p24 antigen at the same time are now available on the market and are mainly used in blood bank testing laboratories because they are expensive.

HIV TESTING IN SWAZILAND

HIV testing is carried out by public and private health facilities including NGOs, at the following tiers of care

1. Clinical laboratories located in the NRL in the Mbabane Government hospital, Regional hospitals, Sub-regional hospitals, Health centres and Industrial clinics
2. Integrated HTC with or without out reach capacity located in Public Health Units, and Rural Health Clinics
3. Free standing Client-initiated HTC/VCT sites with or without out reach capacity
4. National Blood Transfusion Service

A. HIV testing for adults and children more than 18 months

HIV testing for adults and children in the country is mainly carried out by antibody detecting techniques which consist of Enzyme-Linked Immunosorbent Assay (ELISA) or simple rapid tests.

Persons who become infected with HIV produce HIV antibodies over a period of 3 months. Different tests and methods are available for detection of these antibodies in adults and children over 18 months of age.

i) Enzyme-linked immunosorbent assay (ELISA)

ELISA tests are used in all facilities where there are adequate laboratory facilities, personnel and infrastructures. Results are not usually available on the same day. Early availability of results depends on the workload and the number of patient samples available for processing at a time.

ELISA tests were originally developed for donor blood screening and therefore are more suitable for batch testing in settings where large numbers of clients are seen. Only Laboratory Scientists using specialized equipment can perform these tests.

ii) Rapid tests

Rapid tests are recommended for HTC services. They are simple to

perform, even in clinics without laboratories or specialized laboratory equipment. They are as accurate as ELISA tests when Standard Operation Procedures (SOPs) are followed. A very small sample of blood is taken from the client, and the result is ready within the same day. Most available rapid test kits are either cold chain dependent or cold chain independent and use serum, plasma, whole blood or body fluid depending on specifications.

Due to logistics constraints, poor infrastructure and shortage of skilled laboratory experts in most health facilities in Swaziland, whole blood-based, cold chain-independent test kits are recommended for HIV testing.

iii) Recommended HIV test kits

An essential requirement of all HIV testing is accuracy of the test result. The rapid test kits used in the country are those that are recommended by World Health Organization (WHO) and have been evaluated and approved in the country before local use. The list of recommended rapid test kits can be obtained from NRL and SNAP.

iv) Testing algorithms (ELISA or Rapid)

1. Parallel testing

Parallel testing involves testing all blood samples with two different HIV test kits (paired according to SOP) simultaneously (in parallel) and the results given if both tests give the same result. If one test is positive and another is negative (meaning the results are discordant) the tests are repeated using the same test kits. If the results are still discordant, a recommended tie-breaker- according to SOP - is used and the results of the tie-breaker given to the client.

2. Serial testing

With serial testing an initial blood sample is taken and tested using one kit. If the result is negative the result is given to the client as HIV negative. If the result is positive the blood sample is re-tested using a second, different rapid HIV test. If the second test is also positive, the result is given to the client as HIV positive. However, if the second test is negative the same tests are repeated in parallel. If the results remain discordant, use a tiebreaker and the results of the tiebreaker given to the client.

TESTING ALGORITHM FOR SWAZILAND

For Swaziland a modified serial testing algorithm is recommended for HIV testing in adults and children over 18 months. All samples that give discordant results are **not** to be done on site but are to be sent to the NRL for tie breaking. The serial testing strategy as recommended by WHO is more economical since a second test is required only when the initial sample test is positive. Use of specific test kits in the algorithm should be based on National consensus and as determined by the NRL.

NRL shall be responsible for disseminating information on and monitoring compliance with the consensus algorithm(s). As such, all laboratories/facilities carrying out HIV testing in the country will be mapped to ensure adequate monitoring and dissemination of information.

v) Window period

The window period is the period from getting infected with HIV to the time when the body has produced enough antibodies to be detected with an HIV antibody test. This period is usually within 3 months. This means that a client who has just been infected may test negative for the HIV antibody because their body has not produced enough antibodies to be detected by the test. Such a client can still pass the virus to others. Clients who test HIV negative but who may have been exposed to HIV infection, including high-risk behaviour, should be encouraged to return for a repeat test in 3 months. Virologic tests as indicated below could be used to narrow the window periods but are currently not widely available in the country.

B) HIV testing of children less than 18 months

i) Early diagnosis of HIV/AIDS infants is crucial in ensuring that children benefit from interventions that prolong life. The natural history of children perinatally infected with HIV fits in one of the following categories:

Category 1: Rapid progressors who die by age 1 and are thought to have acquired the infection in utero or during the early perinatal period (about 25-30%)

Category 2: Children, who develop symptoms early in life, followed by a downhill course and death by age 3-5 years (about 50-60%)

Category 3: Long time survivors who live beyond the age of 8 years (about 5-25%)

While infants in category 3 and some of the infants in category 2 may benefit from laboratory diagnosis using antibody tests, infants below the age of 18 months cannot because of the passive transfer of maternal antibodies across the placenta.

Breastfeeding may further complicate diagnosis in infants. HIV exposed infants who are breast fed are at risk of acquiring HIV infection through the breast feeding period, a factor that must be taken in account when requesting or interpreting HIV test results in children.

Despite this limitation, antibody tests (ELISA or rapid tests) may be used to provide (or exclude) evidence of exposure for infants below 18 months.

A definitive diagnosis however, can only be established using virologic tests such as viral culture, p24 antigen assays and HIV DNA PCR assays on blood. This would distinguish the status of the baby from that of its mother. Viral culture methods are difficult and expensive and are not usually available for routine use. Therefore, the most commonly used tests for diagnosis of HIV/AIDS in infants is the DNA PCR assay or the p24 antigen assay.

The p24 antigen test identifies actual HIV viral particles in blood. However, the p24 test is generally only positive from about one week to four weeks after infection with HIV. This is because it generally takes that long for the virus to multiply to sufficient numbers to be detected. The p24 proteins become undetectable because sufficient antibodies to HIV have been produced to bind to the p24 protein and eliminate it from the blood. During this time, the p24 antigen test will register negative even in people who are infected with HIV. However, at this point, the regular HIV antibody test will be positive. Later in the course of HIV infection, p24 protein levels again become detectable. Since the p24 antigen is only detectable during a short window of time, its utility is limited. It is therefore recommended to use the HIV DNA PCR test for making a definitive diagnosis in infants who are less than 18 months.

DNA PCR assays amplify the pro-viral DNA sequences within the mononuclear cells present in peripheral blood, and results of such assays are the accepted standard for diagnosis in infancy.

The sensitivity of HIV PCR is low during the first 1 to 2 weeks of life because this test is not able to detect very low levels of HIV DNA in babies infected a few minutes/hours/days earlier during delivery and early breast-feeding. It is recommended that blood samples (venous whole blood in a tube or dry blood spot-DBS) should be taken at 6 weeks after birth and sent to the testing laboratory following the prescribed SOPs. In instances where the baby is being breast fed, the test should be repeated 3 months after cessation of breast-feeding.

Summary of HIV testing in infants

Infant testing categories:

- i. Infants less than 18 months and not breast feeding: Do DNA PCR any time between 6 weeks after birth to 18 months of age.
- ii. Infants less than 18 months and breast feeding: Do DNA PCR 6 weeks after cessation of breast feeding.
- iii. Infants more than 18 months and not breast-feeding: Do HIV antibody testing using the adult algorithm.

- iv. Infants more than 18 months and breast-feeding: Do HIV antibody testing using the adult algorithm.

Important notes:

- a. Irrespective of the PCR result, it is the national policy to do an HIV test on all exposed babies at 18 months after birth
- b. If a baby has signs and symptoms suggestive of AIDS irrespective of the PCR result or breast feeding status the baby should be referred for clinical evaluation for ART.
- c. Critical Information required for HIV testing interpretation:
 - Client identification
 - Child's age
 - Breast feeding status
 - Mother's status (if available)
- d. The sample to be used for HIV DNA testing may be whole blood collected in an EDTA (purple top) bottle or Dry Blood Spots (DBS) made from a finger or heel prick.

C. HIV testing standards

1) Quality assurance

Quality assurance (QA) is defined as the overall programme that ensures that the final HIV test results reported are correct. A false result may irrevocably damage the reputation of the HTC service. The NRL is to co-ordinate a national program of QA for HIV testing in clinical laboratories and HTC facilities. The QA program for clinical laboratories will be directly managed by the NRL while, in some instances; the NRL will designate certain collaborating laboratories to oversee QA procedures at some HTC facilities.

In general, however, the QA system will cover the following:

i) Internal QA

Internal QA involves some of the following:

- Good laboratory practices with set standards of practice for performing HIV tests.

- Systems for management of HIV test results (laboratory records)

- Stock records on available test kits, batch numbers and expiry dates.

- Periodic inclusion of previously characterized samples in order to identify problems with competency of the personnel performing the HIV tests, and also identifying problems with the test kits.

ii) External QA

At least one or more QA methods will be used to externally assess the quality of HIV testing in Swaziland. This includes:

Blinded rechecking: 5-10% of all blood samples obtained and selected by systematic sampling must be sent to the NRL for re-testing. If this is not sustainable as a result of high numbers of patients or clients, the percentages can be reduced with guidance from the NRL.

Proficiency testing: All facilities providing HTC services should receive HIV proficiency sample panels from the NRL at least once a year in accordance with national and international guidelines.

All facilities with consistently unreliable Q/A tests need to receive additional technical supervision and support.

iii) Assay selection

HIV test kits to be used in the country will have to be evaluated by the NRL following WHO evaluation protocols using sera obtained from the Swaziland population. In general, assays with the following characteristics will be selected: desired characteristic of test (high level of sensitivity and specificity, antigen or antibody); long shelf life at ambient temperatures; reasonable cost; ease of performance; rapidity of performance and simplicity of test procedure.

The choice of whether a rapid test or ELISA test should be used will depend on factors such as the volume of work at the site, the availability of the appropriate skills and appropriate equipment and the urgency with which the results are required. **All new kits in the country will have to be submitted to the NRL for evaluation before they can be used in the country.**

iv) Training and support supervision

All eligible persons, selected according to the national criteria, will be trained to perform HIV tests and awarded proficiency certificates by the NRL. Only persons that have HIV testing proficiency certificates will be allowed to perform HIV tests. The NRL QA unit will visit HIV testing facilities on a regular basis in order to identify problems and provide technical support.

2) Handling and disposal of contaminated items

Sharps, such as lancets and needles, must be placed in a specially designed sharps disposal container, or alternatively, in a plastic bottle where a hole has been cut and can be sealed when the bottle is full. Used test kits and blood-contaminated materials should be placed in a separate container. All containers, including sharps disposal containers, must be incinerated or

disposed of according to standard health facility practices. Free standing HTC facilities should send medical waste and sharps to the nearest health facility that has an incinerator.

3) Laboratory Safety

Standard Universal precautions and strict laboratory safety precautions must be followed. Additionally, all testing facilities are required to have on hand site-appropriate SOPs on laboratory safety precautions. These should be displayed conspicuously (pasted on the walls) in corresponding key areas where the testing is performed. All precautions to protect against blood contamination should be observed. In cases where there is accidental exposure, the post exposure prophylaxis (PEP) guidelines should be followed.

4) Logistics

Communication facilities must be introduced between all HIV testing points, (clinical laboratories and HTC facilities), SNAP and NRL in order to facilitate access to technical support from experts.

Procurement, storage and distribution of test kits will be facilitated by NRL which will oversee the maintenance of the cold chain from manufacturers to the testing points as part of the QA activities.

Chapter 6: SCALING UP HIV TESTING AND COUNSELLING SERVICES

HTC is a key entry point to accessing HIV prevention, treatment, care and support services. Therefore, a number of strategies have been put in place by the Government of Swaziland to mitigate the impact of HIV and AIDS and ensure increased access to ART for those who are eligible.

A. Ensuring a conducive policy environment

i) *National Multisectoral HIV and AIDS Policy*

The National *Multisectoral HIV and AIDS Policy* (2006) supports the provision of HTC services, which should be made available and accessible to everyone. It is the fundamental human right for all Swazis to know their HIV status if they so wish.

ii) *Multi-sectoral coordination of HIV and AIDS activities*

NERCHA was established to coordinate, facilitate, mobilise resources, support and monitor a decentralised national multi-sectoral response to HIV and AIDS. The National Strategic Plan 2006 – 2008 articulates increasing access of the population to HTC services as one of the key strategies.

iii) *Local resource mobilisation efforts*

Efforts will be made to mobilise local resources to support HTC as well as HIV/AIDS impact mitigation at all levels of the society.

iv) *Mainstreaming HIV and AIDS in all Sectors*

All public and private sectors, including CSOs will be encouraged to mainstream HIV and AIDS in all their programmes, including HTC.

v) *HIV testing and counselling as part of Standard of Care*

All health facilities in Swaziland will adopt HTC as part of the standard of care for all patients.

B. Capacity building

i) *Training of HTC providers*

In order to enhance the counselling capacity in all facilities providing HTC services, the country will implement the following strategies:

Incorporating HTC into pre-service training curricula for cadres such as health workers and other professionals to increase the number of service providers who can offer HTC in their areas of work.

Continuation of in-service training to update existing cadres in HTC.
Training community service providers such as community-based counsellors (CBCs) to provide psychosocial support to the infected and affected

ii) Training of personnel to conduct HIV testing

In order to enhance the capacity of personnel to conduct HIV testing to meet the country's demand, the following strategies are recommended:

Training of HTC providers to conduct HIV rapid testing

Continuation of in-service training to update existing cadres in HIV testing

C. Increasing demand for services

i) Community mobilization

It is essential that communities are aware of the importance of HTC in the fight against HIV and AIDS. Consequently:

Existing and new strategies on creating community awareness and mobilization will be intensified and implemented. This will ensure that HTC is accepted as an entry point to HIV prevention, treatment, care and support for the infected and affected people.

Information will be made available, through multi-media campaigns, to create awareness that HTC will be part of standard of care in all health facilities. This is in an effort to normalize HTC in the community and country as a whole.

Approaches for reaching those who are illiterate, visually handicapped, and mentally challenged will be implemented at all times.

The social marketing approach of branding the client-initiated HTC/VCT service and charging a small affordable fee for HTC services will continue in defined settings.

ii) Male involvement

In Swaziland, the role of males in the decision-making process is important, especially for married women. The government will continue to intensify efforts to inform and educate men so that they understand and support such programmes as PMTCT for the benefit of the family. Men should also be encouraged to be tested and counselled together with their partners so that they benefit from HIV prevention, treatment care and support programmes.

iii) Reducing stigma and discrimination in the community

Public HIV testing will be encouraged, especially for opinion leaders and role models in the society. This will result in the reduction of stigma and the normalization of HIV testing. Political leaders will continue to publicly discuss HIV and AIDS issues as a means of de-stigmatizing HIV as well as increasing public awareness of the importance of knowing one's status.

iv) *Rolling out the Anti Retroviral Therapy (ART) Programme*

As part of the roll out plan for ART, the country has embarked on a programme that will ensure that Swazis have easy access to affordable treatment. The rolling out of the ART programme calls for urgent need for scaling up HTC services in the country. This will be influenced by the nation's move towards universal access to HIV prevention, treatment, care and support services for all Swazis.

D. Increasing access to services

i) *Involvement of various sectors in service provision*

Different sectors and organisations in the country will continue to be involved in the provision of HTC services, following national policies and guidelines. This involvement leads to standardization of HTC services, improved access and meets the different needs of the various segments of the community.

ii) *Reducing waiting period for HIV test results*

Rapid HIV tests will be conducted in all facilities providing HTC services in Swaziland. The use of rapid HIV tests ensures availability of test results on the same day. This reduces the need for repeat visits for collection of results, and ensures timely implementation of HIV prevention, treatment, care and support strategies.

iii) *Targeting Special groups*

a. *Most-at-risk groups*

Most at-risk groups such as long distance transport workers, prisoners, alcoholics, commercial sex workers (CSWs), Intra venous Drug Users (IDUs), Men who have Sex with Men (MSMs) and uniformed services personnel, face challenges in accessing HTC services. It is imperative that they are specially targeted on information and education pertaining to HTC. In the case of these groups, it is essential to target their client communities at the same time so as to facilitate behaviour change. Education and mobilization around the benefits of HTC for the entire community will enhance their capacity to negotiate for safer sex, primarily through condom use.

b. *Vulnerable groups*

Targeting vulnerable groups such as children, youth, women, and the physically and mentally challenged is crucial to increasing access to services. Women, in particular, face economic and social challenges that lead them to engage in high-risk behaviour. Care must be taken to ensure that confined groups such as prisoners, physically and mentally challenged persons know their HIV status without being coerced to take the HIV test. Condoms should also be provided to those who need them. HIV testing without consent may be justified in rare circumstances in which the patient

is unconscious, severely mentally ill, his or her parent or guardian is absent, and knowledge of HIV status is necessary for purposes of optimal treatment.

iv) Integrating HTC and Family Planning (FP) Services

HCT services will be integrated into FP services as a key HIV prevention strategy to increase access of HTC services, increase awareness of healthy sexual behaviour, provide a channel for most appropriate FP methods based on serostatus and serve as a key intervention strategy for PMTCT. HIV counselling will be incorporated into FP services and where feasible, testing will also be carried out at the site or referrals for testing will be provided. FP counselling and, where feasible, FP services integrated into HTC services to holistically address clients' needs for dual protection. This will provide an opportunity to reach clients who might never traditionally access reproductive health services such as men and youth.

E. Referral and linkages

Referral for HTC services will be a two-way process that creates linkages between the community and the facility providing the service. The MOHSW recognizes that community care and support services contribute significantly to the continuum of care through home-based and family care. Community-based linkages include networking with religious, traditional and youth leaders, partners of PMTCT clients, peer educators, community home based care team, NGOs, CBOs, and FBOs, nutrition support organizations, and post-test support groups or clubs. Existing community structures will be assisted to ensure effective linkages between the health facilities and the community. This will contribute to strengthening of the referral process.

HTC service providers will engage in community mobilization and support efforts. Deliberate efforts need to be made to develop a region-specific referral framework that is based on the national framework to ensure that HTC is indeed an entry point to a continuum of care for individuals.

F. Post-test groups

Post-test support groups and clubs are often a useful feature of HTC services.

i) Support groups

These support groups for PLWHA, will be formed in all communities. They will develop close links with HTC facilities, and make plans for cross referrals. PLWHA will be involved in the planning, implementation and evaluation of HTC services. They will also ensure good linkages with post-test support groups.

ii) Post-test clubs

These clubs comprise clients who have undergone HTC regardless of their

HIV status. These clubs are a forum to promote positive behaviours and messages, as well as to increase knowledge and demand for the services. Post-test club formation will be actively promoted.



Chapter 7: ETHICAL AND LEGAL CONSIDERATIONS

A. HIV Testing and Counselling and Human Rights.

HTC providers must recognize the fundamental right, dignity and worth of all people.

The guiding principle is that every Swazi has the right to know his or her HIV status. Opportunities for knowing one's HIV status should be increased by all stakeholders.

The human rights principles most relevant to HTC, and which every service provider and patient or client should be made aware of include:

- The right to information for making choices about one's health and well-being

- The right to education

- The right to privacy

- The right to non-discrimination, equal protection and equality before the law

- The right to marry and found a family

- The right to the highest attainable standard of physical and mental health.

In Swaziland, all health care workers are bound by an ethical principle to do all that is necessary and available to provide the best possible care through the use of diagnostic tools and follow-up treatment. Therefore an HIV test must be provided when requested or indicated, in accordance with the 3Cs principle. Treatment and follow-up must also be provided as necessary and available. HTC providers will continue to provide services to people irrespective of their race, culture, religion, values or belief system.

B. Ethical issues relating to Informed Consent/Patient

The term "informed consent" refers to a client being given an opportunity to consider the benefits and potential difficulties associated with having access to information regarding their HIV sero-status, an understanding of the testing procedure, and then taking the decision to be tested for HIV. The client should be able to consider the implications of a positive test result on their personal and professional lives.

HIV testing must be voluntary, with clients and patients making an informed decision about accepting an HIV test. In both provider-initiated and client-initiated HTC, the counsellor should explain the procedure and ensure that the client/patient is requesting HIV testing without coercion. While approaches to obtaining informed consent can be flexible, the fundamental value to be applied is respect for the choices of individuals. All clients or patients attending HTC facilities must be able to refuse HIV testing if they do not think that it is in

their best interest. HTC providers are expected to ensure that clients/patients have adequately understood all of the issues involved in HTC before giving informed consent for HIV testing. It is important that counsellors recognize the client's/patient's right to withdraw their consent at any time even after their blood has been taken for HIV testing.

When anonymous HIV testing is carried out, clients are required to give verbal consent or put their signatures or fingerprints on an informed consent document.

C. Legal issues relating to Informed Consent

i) Minimum age for HIV testing

According to the National Multisectoral HIV and AIDS Policy (2006), anyone aged 12 years or above, requesting HTC, should be considered able to give full informed consent. A parent's or legal guardian's consent is required before testing of children below the age of 12 years. Counsellors providing services to adolescents and minors should receive additional training on the unique issues relating to HTC for these groups and ensure the availability of follow-up post-test support services.

ii) Testing of children

The welfare of the child must be of primary concern when considering testing a child for HIV. When children are brought to an HTC facility, the counsellor should meet with the parents or guardians to determine the reason for testing. If the counsellor feels that testing is not in the best interest of the child then the counsellor reserves the right to refuse testing. Counselling should be provided to both the child and the parent or legal guardian. The child can then be referred to an appropriate medical or child health facility.

iii) Testing of mentally challenged persons

The welfare of people who are mentally challenged should be the primary concern of the counsellor when HTC is requested. The counsellor reserves the right to refuse testing if he or she feels that the testing is not in the best interest of the client. HTC, however, can be provided in the company of a legal guardian, in deserving cases. HIV testing without consent may be justified in rare circumstances in which the patient is unconscious, severely mentally ill, his or her parent or guardian is absent, and knowledge of HIV status is necessary for purposes of optimal treatment.

HTC services must not be provided to clients who cannot give true informed consent for testing because they are under the influence of alcohol or illicit drugs. The service should be withheld until they have recovered.

iv) Persons with different language

Steps must be taken to interpret the discussion. If no interpreter is available, HIV testing should be deferred. If an HIV test is required for urgent reasons a senior medical/nursing official may be legally able to provide consent. In the latter circumstance the counsellor must seek legal advice.

D. Mandatory testing

Mandatory HIV testing is neither effective for public health interventions nor ethical, because it denies individuals choice, and violates principles such as the right to health, including the right to privacy. However, it can be considered in special circumstances e.g. for blood donation and rape perpetrators. In this case the testing shall still be accompanied by counselling.

E. Confidentiality

Confidentiality is one of the guiding principles for provision of HTC services and must be protected. It is important that HTC facilities and centres develop policies to protect the confidentiality and privacy of clients. Those testing must be assured of the confidentiality of their records, the record keeping system and their test results. There are many benefits of sharing HIV test results with sexual partners and family members, therefore involvement of partners and family members should be encouraged. However, the decision to do so should be made by the persons undergoing HTC.

i) Anonymity

Anonymity is practised when only code numbers or pseudo names of clients are used in a facility providing HTC. Counsellors should clearly explain the procedure to all clients and still maintain the same standards of confidentiality. In the provider-initiated HTC, anonymity is not used.

ii) Confidential record keeping

All medical records, including those with HIV-related information, must be managed in accordance with appropriate standards of confidentiality. Only persons with a direct role in the management of the client /patient should have access to these records.

iii) Shared confidentiality

Shared confidentiality is when information about the patient or client is disclosed to another person (who could be a family member, health worker, friend or relative) directly involved in the care of the patient/client, with the client's express consent.

iv) Written results

It is not recommended that free-standing sites for HTC provide written HIV test results as it may compromise patient or client confidentiality. However, there are laid down procedures for referral and continuum of care for those who test

HIV positive. Facilities providing client-initiated HTC /VCT services must not be used for mandatory testing, such as for pre-employment, insurance, education or travel-related purposes. Clients requesting such services should be referred to the appropriate institutions such as health facilities.

F. Ethical disclosure

HIV test results should be disclosed in person only to the client. Disclosure of the results to anyone else should only be done with the client's consent. Disclosure of HIV status to children will depend on thorough assessment of the child's knowledge level on HIV and AIDS issues and level of maturity. In situations where the child is assessed to be immature or unable to deal with the implications of a positive HIV test result, the counsellor can disclose to the parent or legal guardian.

G. Partner notification

All patients and clients, both HIV positive and HIV negative, should be encouraged to inform their sexual partner(s) about their HIV test results. For HIV positive clients who are reluctant or fearful to disclose their results, the counsellor should offer additional, on-going counselling to help the client inform the partner. The counsellor may inform the sexual partner(s) of the client about the HIV test results in the presence of the client, upon the client's request.

H. Issues relating to rape

All persons who have been raped should be offered HIV testing and counselling. For those who are HIV negative, post-exposure prophylaxis (PEP) should be offered as soon as possible after exposure but within 72 hours. If the client is HIV positive, referral must be made to ART services and management must follow the national ART guidelines. These clients need more information and education on ARV adherence.

Mandatory testing and counselling for the rape perpetrator can only be performed with a court order, and the results disclosed to the magistrate or judge handling the case.

Chapter 8: LOGISTICS AND DATA MANAGEMENT

A. PROCUREMENT AND DISTRIBUTION PROCEDURES

Logistics is the processes involved in the sourcing, warehousing, distribution and rational use of supplies especially in a complex setting. Supplies in this regard refers to the various commodities employed in the programme(s).

Issues of logistics and supplies must therefore take account of several factors, namely:

- Source(s) of funds for the implementation of the logistics programme
- Scope of the programme
- Effective forecasting
- Effective procurement
- Warehousing/Storage and distribution
- Rational use
- Monitoring and evaluation
- Feedback mechanism

It is important to establish a procurement and delivery system that ensures a regular supply of test kits and other consumables to HTC facilities to ensure non-interruption in supplies. HIV test kits selection and testing protocol will be in conformity with the national guidelines.

i) Procurement of test kits

All test kits for the public sector will be procured centrally, at the national level. Other service providers must only procure test kits recommended by the NRL. All procured kits will be in line with the agreed national algorithms in the standard operating procedure manual. Rapid HIV test that do not require refrigeration will be more appropriate for all HTC facilities. Long shelf life is equally important in remote areas and facilities performing smaller numbers of tests.

ii) Distribution of test kits

The NRL will distribute test kits to all facilities providing HTC services and will also maintain an emergency or buffer stock of rapid HIV test kits for distribution when needed.

iii) Stock Management of test kits

As much as possible test kits that can be stored at room temperature should be used. However if climatic conditions require refrigeration of test kits, provision should be made for a refrigerator.

Every facility providing HTC services will have a designated staff member in charge of ensuring that test kits are stored properly and used before their

expiry date. Test kits should be stored in household refrigerators where available, but not in the freezer compartments. An inventory system should be developed to track usage and projection of needs. Storage facilities for test kits, condoms and other consumables should take into account special requirements of the test kits and capacities of the facilities.

B. DATA MANAGEMENT, MONITORING AND EVALUATION OF HIV TESTING AND COUNSELLING

Data management for HTC services will be in line with the National Health Management Information System (NHMIS). Handling of HTC records and data will require confidentiality and efficiency. This will give the client a sense of security as well as provide reliable data for the government. It includes:.

Data Collection System: The national HTC data collection and analysis system developed by the SNAP monitoring and evaluation unit in conformity with the national monitoring and evaluation framework should be used by all HTC facilities across the country.

Data Collection Instruments: National HTC and Data Collection Forms should be used at all HTC sites.

Data Recording: HTC record forms should be filled for all clients before they leave the counselling room or immediately after. Old HTC records will be managed according to the national guidelines for management of medical records.

Coding System: A standardized system of assigning codes or reference numbers to clients for identification purposes should be developed and used within each institution.

Record Keeping: A filing system for HTC records should be developed and followed within each institution. All records must be kept confidential and stored in a secure room with lockable cabinets.

Data Entry and Transfer: At each HTC site, the data collection form should be completed and forwarded to the Regional Health Information Officer on a monthly basis. Data should be forwarded from the regions to the national level on a monthly basis.

Data Analysis and Reporting: Data collected will be analyzed and findings will contribute to the on-going strategic developments of the national response including the periodic review of the National HIV/AIDS Policy. SNAP will design feedback mechanisms to ensure that each level of services and management is informed on a quarterly basis regarding HTC services.

1. Quality Assurance: Measures should be adapted to assess staff competency, client satisfaction and the adherence to counselling and testing protocols.

A systematic plan for periodic external data quality checks will be conducted by SNAP in partnership with other stakeholders. These checks will include a review of site registers and reporting forms for completeness and accuracy, as well as to verify that previously submitted summary forms represent accurate tallies of the register information.

2. Monitoring and Evaluation:

The HTC database should be used to monitor and evaluate the services in each site, region and at the national level. This information will be used to identify program areas that need to be refined for more efficient and effective program implementation. Special studies, including Operations Research, may be required for specific issues, but in general the emphasis should be on using the HTC database to maximize the utilization and to ensure the quality of services.

C. MONITORING ACTIVITIES

SNAP will provide HTC facilities with registers and summary forms, aligned with the health sector monitoring and evaluation framework. SNAP shall ensure that providers are trained in proper completion of the registers and forms.

D. EVALUATION ACTIVITIES

Process and outcome evaluations will be periodically conducted to assess current program success and inform future revisions of the National HTC guidelines and strategic plans.

E. HIV TESTING AND COUNSELLING PROGRAMME REPORTS

Best practices will be documented by all facilities.

All facilities/ sites will produce monthly, quarterly and annual reports of HTC activities.

National annual HTC reports will be produced by the MOHSW and give feedback given to the HTC facilities.

The annual reports will be discussed in annual meetings where progress to date, challenges faced in service provision, best practices and the way forward will be agreed upon.

Annex 1: Working team to review national HTC guidelines

NAME	ORGANISATION	EXPERTISE
1. Dr. Tembisa Kanya	MOHSW - HQ	Policy level
2. Faith Dlamini	NERCHA	Health sector Coordinator at National response coordination level.
3. Winnie Nhlengethwa	Nazarene Nursing Collage	Pre service training of nurses
4. Futhi Ndzinisa	Good Shepherd VCT centre	Intergrated VCT hands on experience with ART, PMTCT, TB and HBC linkages
5. Harriet Kunene	TASC	VCT training and Free standing VCT experience
6. Victoria Masuku	PSI	VCT marketing, networking and referral
7. Sibongile Mndzebele	SNAP	HBC and STI programming
8. Dr Velephi Okello	SNAP	ART programming
9. Bonsile Nhlabatsi	SRH	PMTCT programming
10. Richard Phungwayo	SNAP	BCC programming
11. Thembi Dlamini	SNAP Lubombo region	Coordination of regional AIDS activities.
12. Themba Dlamini	TB Program	TB/HIV Dual infection
13. Lungi Kanya	SNAP	Psychological support
14. Thembe Nkambule	SWANNEPHA	Representative of PLWH/A
15. Lindiwe Mkhathshwa	TASC	HTC Co-ordinator
16. Rejoice Nkambule	MOHSW - SNAP	National HTC Co-ordinator

