

# **POLICY GUIDELINE FOR HIV COUNSELLING AND TESTING (HCT)**

**National Department of Health**

**PIC 22 October, 2009**



**health**

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Department:  
Health  
**REPUBLIC OF SOUTH AFRICA**

## **FOREWORD**

HIV and AIDS is one of the most important challenges facing South Africa today. Government has made the fight against this disease one of its top priorities. In order to guide the National response, the South African government recently updated previous commitments and developed the National Strategic Plan (NSP) for HIV & AIDS and STIs, 2007-2011. The NSP outlines four key priority areas for the country; *viz.* Prevention; Treatment, Care and Support; Research, Monitoring and Surveillance; and Human Rights and Access to Justice. Two primary goals inform all four priority areas: to reduce the incidence of new HIV infections in South Africa by half by 2011, and to ensure that at least 80% of those who are already HIV-positive have access to treatment. Knowledge of HIV status is critical to both these prevention and treatment goals. The implementation of the 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 available treatment, care and support services. HCT has become increasingly available in South Africa in recent years. Despite increasing availability of HCT in many public health facilities, uptake of Counselling and testing remains low. Government is engaged in wide scale social mobilisation in an effort to increase the uptake of this service by the all the people of South Africa.

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

This updated policy guideline seeks to help HCT service providers to provide caring, good quality, uniform and equitable HCT services in the country. The document also provides a guide for the implementation of a comprehensive National HIV Counselling and testing programme. This will be done by 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. This may or may not include an emphasis on the 15-49 age groups in a specific area if deemed necessary by the relevant health authority. 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.

Government recognises that prevention remains the cornerstone of all our efforts in the fight against 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 of us to do their part towards developing an HIV-free generation.

It is recommended that HCT service providers do all that is necessary to adhere to the recommendations outlined herein.

**HONOURABLE DR AARON MOTSOLEDI**

**MINISTER OF HEALTH**

**DATE:**

## **ACKNOWLEDGEMENTS**

Many thanks go to all the individuals who took time and made the effort to participate in the development and finalisation of this HCT Policy.

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## **GLOSSARY**

The aim of the glossary is to standardise the interpretation of terms used in existing guidelines and protocols as well as by implementers in 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 whilst 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 is without appropriate family care in the community; (g) the child at the head of a child headed household and (h) person who is caring for someone who is ill.

**CD4 count:** White blood cells (lymphocytes) that play a role in protecting 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 comes to 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 Section 28 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, aimed at providing information about health in general including HIV & AIDS and VCT education including the benefits of knowing one's status to enable clients to make an informed decision 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 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 caregivers and, may also include a person who is trained to offer the same service to the deaf community.

**HIV Counselling:** An intervention which 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 their behaviour to reduce the risk of HIV infection.

**HIV Counselling and testing (HCT):** An umbrella term used to describe services that combine both 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:** a baby born to an HIV-infected mother, whose own (baby's) status has not yet been established, or a baby who may have clinical signs of HIV where the status of the mother is unknown, or 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 information 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 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 (SOPs) 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 (NICD)

**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. Non-Governmental Organisations (NGOs), Faith Based Organisations (FBOs) and Community Based Organisations (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 treatment given after possible exposure to HIV, e.g. through needle stick or sexual assault, in order to minimise 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, 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 Testing and Counselling (PICT) (also referred to as Routine Offer of Testing):** HIV testing and counselling which is 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.

**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, 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 maybe from a health facility to a local clinic or service whereas up referral maybe 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:** This is the routine offer of HCT by health care workers to all patients entering the health care system. All aspects of care including

trauma, casualty and specialist clinics should provide the option of testing. In particular, the routine offer is made in certain sections of health care facilities where patients at risk of HIV infection are more likely to be encountered – i.e. antenatal clinics, post natal clinics, TB facilities, centres for the integrated management of childhood illnesses (IMCI), family planning (FP) clinics, sexually transmitted infection (STI) clinics, and centres offering treatment for opportunistic infections (OIs) and post exposure prophylaxis (PEP). While the offer of HIV testing is routinely made, the client should be counselled and informed consent must be obtained.

**SADHS:** South Africa Demographic Health Survey.

**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 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):** The situation where individuals or couples actively and voluntarily seek HIV counselling and testing at a facility that offers these services.

**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 utilize 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

## **ACRONYMS**

AFASS	Affordable, Feasible, Accessible, Safe and Sustainable
AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Clinic
BSS	Behavioural Surveillance Survey
CBOs	Community Based Organisations
CCMT	Comprehensive HIV and AIDS Care, Management and Treatment
CDC	Centres for Disease Control
CHW	Community Health Workers
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
FBOs	Faith Based Organisations
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
MDGs	Millennium Development Goals
MSM	Men who have sex with men
MTCT	Mother to Child Transmission
NDoH	National Department of Health
NGOs	Non-Governmental Organisations
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)
OIs	Opportunistic Infections
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

## **SECTION 1: INTRODUCTION and BACKGROUND**

South Africa has a generalised, hyper endemic HIV epidemic with prevalence exceeding 18%. HIV prevalence amongst pregnant women is estimated at 29.4% (South African 2007 National HIV and Syphilis Prevalence survey). The country has an estimated 5.7 million (UNAIDS, 2008) people living with HIV. Of this infected population, 90 000 are babies born with HIV. 85% of infections occur through heterosexual sex in the general population.

The National Strategic Plan for HIV and AIDS and STIs (NSP) 2007-2011 is a concerted and coordinated response to the state of the epidemic in South Africa. The two main goals of the NSP are: by 2011 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. Knowledge of HIV status is central to both these goals. Specifically, key strategies in the Plan are to increase access to and uptake of voluntary counselling and testing 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 of 15-49 years accessing VCT services from 25% to 70%.

HCT has become increasingly available in South Africa in recent years. With a reported 4624 government health facilities in the country by the end of May 2009, 96% are public facilities, clinics and hospitals, which offer routine testing and CICT or VCT. HCT is also offered through mobile services (8%), as well as through the delivery of VCT services at non-medical sites (7%). The Department's VCT programme supports an estimated 8000 lay counsellors on a stipend; they provide HIV counselling at medical and non-medical sites.

With increasing availability of CT 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 to 50% in 2008 (Shisana and Simbayi, 2002; Pettifor *et al.*, 2004; South African National Prevalence, Incidence, Behaviour and Communication Survey, 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 reach the goals of the NSP 2007-2011, CT services in facilities need to be improved and scaled up through the routine offer of testing (PICT). In addition, we need to expand CT services provided through mobile and community based models by NGOs, FBOs and CBOs. Furthermore there is need to encourage greater collaboration with the private sector. All these groups need to work in partnership with Government to serve the country's NSP goals.

The National HCT Programme is tasked with ensuring, together with civil society organisations, that the testing goals of the NSP are implemented. Implementation of the National HCT programme has always been on the basis of guidelines informed mainly by World Health Organisation (WHO) and other agencies like the Centres for Disease Control and Prevention (CDC). Brief guidelines that outlined the process of rapid HIV testing were adopted by the National Department of Health (NDOH) in 2000 (*Rapid HIV Testing: HIV & AIDS Policy Guideline, Testing for HIV: HIV & AIDS Policy Guideline*). *Minimum standards for counselling and training* guidelines were also adopted by the Department in the same year. These guidelines outline the process of selection and training of counsellors.

In order to provide continued guidance for the implementation of the National VCT programme, in 2003 the NDoH developed the VCT guidelines: *The South African National Voluntary Counselling and Testing (VCT): HIV Prevention and Care Strategy*. The 2003 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. They further provided an approach for the implementation of VCT services in health and non-health facilities and built on the experiences accumulated over the previous three years

(from 2000-2003) utilising documented practices from South Africa and other countries.

The implementation of the VCT 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. This has led to governmental and non-governmental implementing agencies adopting various approaches. This presents the NDoH 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 policy 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 practice regarding HIV Counselling and testing. Moreover the policy guideline seeks to provide a framework for the HCT models 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 *PMTCT (DOH, 2008)*, the *Accelerated PMTCT Plan and Management of Paediatric HIV (DOH, 2009)*, and recommendations of the Integrated Management of Childhood Illnesses (IMCI) Strategy (year). In short, the document seeks to provide the policy framework necessary for the implementation of programmes towards the attainment of the goals of the NSP 2007-2011.

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 increase 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 this policy document.

## **SECTION 2: GUIDING PRINCIPLES**

### **2.1 Guiding principles**

Government has made the fight against HIV and AIDS one of its top priorities. The implementation of the HIV Counselling and Testing (HCT) programme is a key intervention towards the realisation of the goals of the NSP.

The principles guiding the HCT policy include those of 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 2007-2011, 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 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 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:** Every person in South Africa has a responsibility to protect him or her 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:
  - Provision of relevant, appropriate and accessible information on the prevention, treatment and care of HIV during the Counselling process in the language that the child is able to understand;

- Full participation by children in any decision-making and consent process regarding HIV testing and due consideration given to the views of the child;
- HIV testing only when it is in the best interests of the child;
- Post test access to treatment, care and support; and
- Confidentiality regarding HIV test results and support with disclosure of HIV status (Children's Act 2005 as amended, Sexual Offences Act amendment, 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, HIV exposed and HIV positive infants, children and youth so that they can access HIV care. Practised within a human and child rights framework, this critical intervention should prolong life and optimise maternal and child survival (DOH PMTCTGuidelines 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 HCT programme should facilitate reduction of discrimination by creating knowledge and competence about HIV in communities.
- **Availability:** All essential commodities in VCT facilities, including rapid test kits, condoms and information, should be made available, affordable and accessible.

- **Quality of the HCT service:** All CT 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 between government and all civil society stakeholders, with appropriate messages is necessary for the achievement of the aims of the policy as well as to inform those affected and infected as to what they need to do, what is available and where as well as any latest developments with regards to the policies around testing and treatment..
- **Strengthening service delivery and integrating services:** Strengthening of health and social systems within a multisectoral approach, including the organizational capacity of NGOs, FBOs and CBOs, and ensuring integration between services, and is central to effective implementation of the policy.
- **Using scientific evidence:** The interventions outlined in the HCT policy shall, wherever possible, be evidence based.
- **Leadership role of government:** The effective implementation of the HCT Policy and the attainment of its goals depend on government leadership in resource allocation, policy development, and effective co-ordination of the programme and interventions.

## **2.2 Rationale for the HIV counselling and testing policy guideline**

The implementation of the National HCT programme has been guided mainly by recommendations from WHO and the CDC. This has led to governmental and non-governmental implementing agencies adopting a variety of approaches. This policy gap is acknowledged in the NSP 2007-2011 where a commitment is made by government to ensure the development and adoption of a revised National

policy for HCT. This policy document provides the basis for the implementation of HCT programmes in the country.

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 facilitate utilisation of 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.
- Aid the scale-up of the Comprehensive HIV and AIDS Care, Management and Treatment (CCMT) programme.

## **SECTION 3: AIMS and OBJECTIVES of HIV COUNSELLING and TESTING POLICY GUIDELINE, and PROGRAMME**

### **3.1 Vision**

To create an enabling environment for HIV counselling and testing, where the majority of people in South Africa are knowledgeable about their HIV status, able to act on this to ensure an AIDS free generation.

### **3.2 Mission**

To develop a sustainable, co-ordinated and integrated HIV counselling and testing programme in partnership with other stakeholders so as to expand access to and increase uptake of HIV counselling and testing services with the aim of appropriate referral for those in need of the continuum of care, treatment and support.

### **3.3 Aims**

**The aim of this policy guideline is:**

- 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.
- To provide a framework for conducting HIV counselling and testing among adults and children.

**The aim of the HIV counselling and testing programme is:**

- 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 this policy are to:

- Provide core requirements for and guidance to ensure the delivery of standardised, high quality, 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.
- Ensure appropriate referral to treatment

The HIV counselling and testing programme seeks to:

- Create an enabling environment which promotes universal access to safe, effective and good quality HCT services
- Encourage individuals, 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 closer integration of HCT with FP, TB, STI, and other communicable and non communicable diseases in the health system
- Integrate affordable, feasible, accessible, safe and sustainable HCT services into the health system.

### **3.5 The role of HCT service providers**

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

## **Staff**

- CT sites should have adequate human resources to provide the required services, including trained professional health workers, HIV and AIDS counsellors/ community health workers and other support staff.
- HIV counselling and testing 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 5 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 counselling guidelines appropriate for children.

## **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 sufficient privacy, confidentiality and protection of clients attending the service.
- Facilities must display signs or posters that inform clients about the availability of the service and where it is located.
- Facilities must have relevant HIV and AIDS information and educational materials in languages used by the facility's catchment population. Where possible, this information should also be available in Braille. Materials need to be available for clients to take home to study and discuss with their families.

- Facilities must enable access to other HIV and AIDS preventative services and where appropriate refer clients to such 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 difficult to reach populations.
- Facilities where children are tested should be child friendly and ensure that children's rights are protected.

### **HIV Testing**

- Procurement, processes and procedures should be adequate to minimise stock outs of rapid test kits and related commodities.
- Storage of rapid test kits should be in adherence with 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 National Institute of Communicable Diseases (NICD) may be used in the public sector as well as other government approved sectors where testing is undertaken to avoid the risk of poor quality kits being used on the general public. Those sectors doing HCT but not part of the government tender should be only be able to use approved test kits.

### **3.6 The role of the National Department of Health**

The National Department of Health will be the steward of the HCT programme, leading government departments and non-governmental agencies 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 CT programme.

- Facilitate the development of CT guidelines, norms and standards that are appropriate for the local environment and in line with international norms and standards.
- Facilitate collaboration between stakeholders at all levels to strengthen and improve the quality of primary health care and HCT services.
- Mobilise, disburse and account for resources available for the implementation of this policy in the public sector.
- Share lessons and evidence-based information on HCT.
- Oversee monitoring and evaluation (M&E), and quality assurance (QA) of counselling and testing.
- Establish and maintain training norms for HCT personnel in line with the appropriate accreditation body.

### **3.7 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 4 key priority areas
- Ensure the implementation of National HCT policy, 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 evaluation and quality assurance 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 CT programmes.
- Conduct or facilitate research on health and health services.

- Plan the training, management, development and support of the required HCT personnel.
- Facilitate an uninterrupted supply of all commodities.
- Facilitate community involvement in HCT.
- Facilitate effective HCT referral systems.

### **3.8 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
- Recording all activities and HCT uptake within the National monitoring framework and submitting reports timeously to the province.

### **3.9 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, standardized, ethical HCT services.
- Support the NDoH and provincial departments in the implementation of the policy guideline and related HCT programmes.

- Facilitating the management support, mentoring and debriefing of HCT personnel as needed
- Assist provinces with the identification of HCT training needs.
- Monitoring and evaluating 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 so that the NDoH may obtain an overall measure of how the country is moving towards HIV testing targets in the NSP.
- Assist the provincial departments in mobilizing communities towards expanding access to HIV counselling and testing services.

## **SECTION 4: LEGAL and ETHICAL CONSIDERATIONS**

### **4.1 Legal Framework**

Health and human rights are inextricably intertwined. Safeguarding human rights is an essential part of responding effectively to the HIV and AIDS epidemic. This policy is aligned to the Constitution of the Republic of South Africa (1996) and other relevant legislation and international law (International Covenant on Civil and Political Rights). Relevant legislative frameworks include 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
- 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. This framework is not exhaustive and will be reviewed and updated periodically.

## **4.2 Some Core Ethical Principles**

### **4.2.1 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.

### **4.2.2 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 child friendly versions.
- For CICT (VCT) 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
- Meaning and implications of a negative result
- The window period
- 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, 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

#### **4.2.3 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 in place of the signature if the client wishes to take up the HIV test and give signed consent.

#### **4.2.4 Inability to make a decision**

- According to the National Health Act, (Act No. 61, Section 7), where a client is unable to give informed consent, for example, in the case of unconsciousness, cognitive disability, such consent can be given by a person authorized 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, grandparent, 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.

## **4.2.5 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.

## **4.2.6 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.
- 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.
- 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:
    - The client consents to that disclosure in writing.
    - A Court Order or any law requires that disclosure.

#### **4.2.7 Shared Confidentiality**

- In most cases, sharing information about HIV status with partner, family, trusted friends and community members and medical staff may be of benefit to the client and their families and should be encouraged where appropriate.
- Sharing of 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.
- Discussion about sharing confidentiality should explore the barriers faced by the client in disclosing. Where the client is in an abusive relationship, the client should not be pressurized to disclose to an abusive partner and should be referred to appropriate service providers to support the client.

#### **4.2.8 Stigma and discrimination**

- The 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 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).
- Non-compliance by health care providers with these legal and ethical frameworks should be reported to and dealt with by the relevant authorities.

#### **4.2.9 Occupational Exposure to HIV**

- 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).
- 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 5: TYPES of HIV COUNSELLING and TESTING**

#### **5.1 Circumstances in which HIV testing takes place**

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

- Individuals or couples wanting to know their status
- In pregnancy as part of the PMTCT programme
- Clinical diagnosis as part of basic patient care
- Research and other screening purposes
- Domestic violence and sexual assault
- Prior to providing post exposure prophylaxis after a needle stick injury or rape
- Per court order of the accused in sexual offence cases
- Abandoned babies/ children

In view of the fact that 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

### **5.1.1. Individuals 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.

### **5.1.2. Clinical diagnosis**

- HIV testing takes place as part of the diagnostic process, where there has been any past high risk behavior and the clinical management of patients with or without HIV attributable symptoms in order to provide comprehensive care.
- Under these circumstances, establishing a diagnosis of HIV infection is critical for clinical decision-making and the timely provision of appropriate therapy.
- Counselling must precede and follow diagnostic and clinical management testing.
- Informed consent must be obtained before testing.

### **5.1.3. Research and other screening purposes**

HIV testing often takes place in the process of 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 and how the testing is being performed.

Research involving HIV testing can be divided into two categories:

- Unlinked and anonymous population or behavioural studies that measure prevalence of HIV and screening in health facilities. In such cases:
  - HIV testing is done on blood that has already been collected for another purpose such as for syphilis testing.
  - In this case individual additional 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:
  - Individual consent is needed to participate in the study by all participants or persons authorized to act on their behalf.
  - All legal, ethical and quality standards outlined in this HCT policy should apply.
  - Consent of community representatives for research studies may not be substituted for individual consent.
  - All research subjects must be given information about how to prevent HIV transmission by practicing safe sex and effective treatment or referral must be provided for sexually transmitted infections.

#### **5.1.4 Domestic violence and rape**

Clients experiencing or reporting domestic violence, sexual assault or 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 appropriately is an essential element of the package of HCT services for survivors.

### **5.1.5 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.

## **5.2 Types of HIV Counselling and Testing**

Two main approaches to HIV counselling and testing are recommended in this policy and should be implemented at every health facility.

- Client-Initiated Counselling and Testing (CICT, also referred to as VCT) and
- Provider-Initiated Counselling and Testing (PICT).

### **5.2.1 Client-Initiated Counselling and Testing (CICT)**

#### **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.

#### **Process:**

- 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). 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.

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

## **5.2.2 Provider-Initiated Counselling and Testing (PICT)**

### **Definition:**

- PICT (also referred to as the Routine Offer of VCT) is HIV counselling and testing which 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 seen in 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.
- This approach is aimed at the 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 unprotected sexual behaviour or where there is a high background prevalence of HIV.
- PICT should be offered to all the 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, IMCI centres, family planning clinics, STI clinics, and centres offering treatment for opportunistic infections (OIs) and post exposure prophylaxis (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.

- The routine offer of testing is also recommended in all health services dealing with domestic or gender based violence, child abuse and sexual violence.

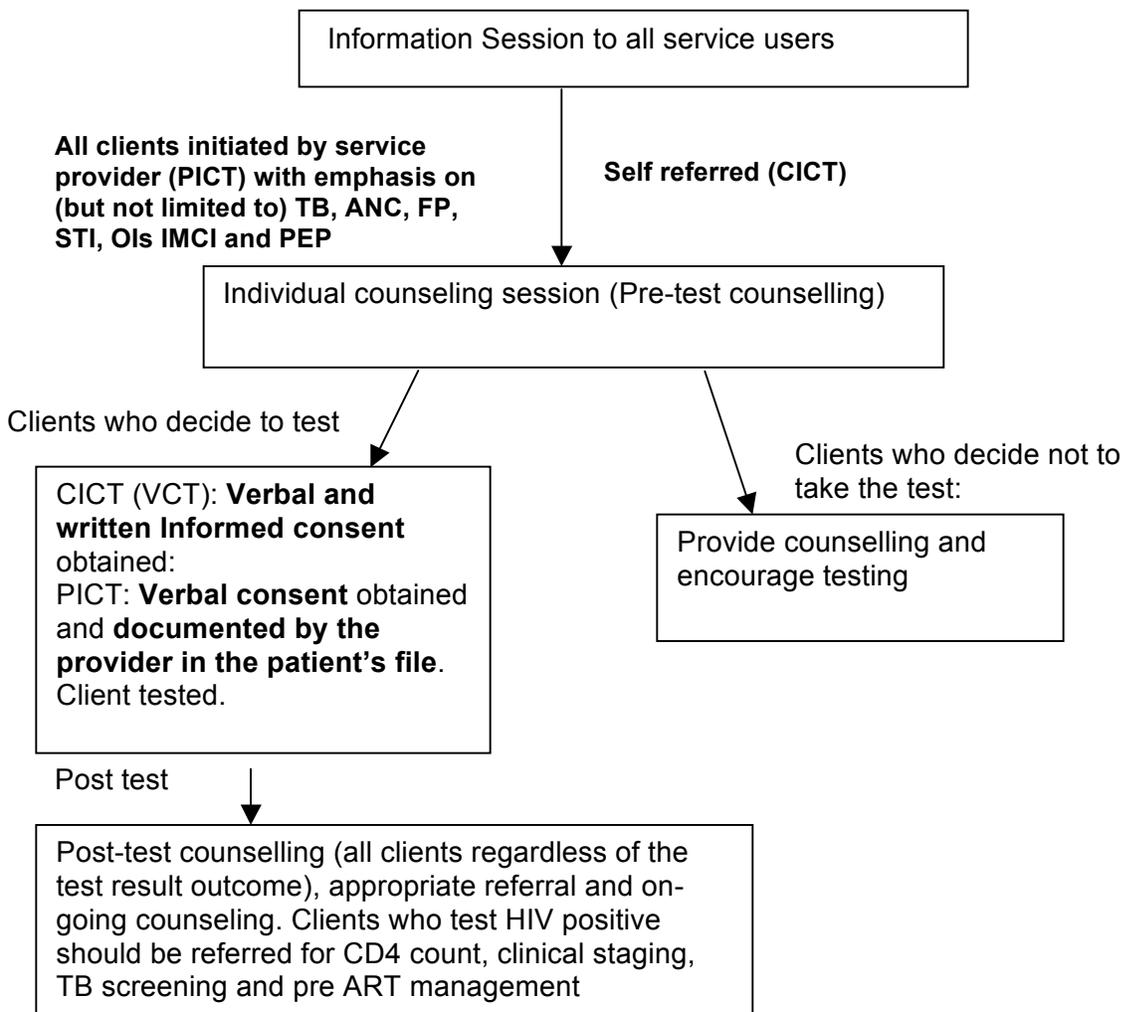
**Process:**

- The routine offer of HIV counselling and testing is initiated by the health care provider or worker in support of the scaling up of HIV testing.
- This 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 counselling pre and post testing and informed consent should be given for testing in the language that the client understands

### **5.3. HIV Counselling Process**

The counselling process for both PICT and CICT conducted in public health facilities is illustrated in the diagram below and is provided 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 briefer individual sessions that address individual HIV risk (see Figure 1 below).

**Figure 1 - The HIV counselling and testing process**



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

#### 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, ANC, IMCI, OIs and PEP on a daily basis. Audiovisuals should also be available (Television, videos, DVDs, posters) for clients when the health care worker is not available
- A group information session should include the following key components beneficial to the client, as appropriate to the circumstances:

- Information about HIV acquisition and transmission.
- Information about effective 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 as well as preventing transmission.
- Information about the HIV testing process.
- Discussion on confidentiality and shared confidentiality.
- Option not to take the test.
- An opportunity to test at a later date should the client decline the test.
- 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

- Individual information should be available to all clients considering taking the HIV test in their local language.
- The components of the individual counselling session include:
  - Assessment to determine if the information provided in the group session has been absorbed.
  - Answering remaining questions, and seeking to clarify any misunderstanding.
  - Discussion of specific issues for individual and assessment of individual risk, including enquiring whether a history of domestic violence exists.
  - 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 of the way forward and management options including TB screening, clinical staging, CD4 count, pre 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 of written or verbal informed consent for HIV-testing.
- This information should be provided in the local language of the client.

### **5.3.2 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.
- HIV negative clients should be offered post test counselling that includes risk reduction and should be encouraged to repeat the test three months after the negative result to exclude the possibility of the window period.
- It is vital that HIV positive clients must only be given their test results and counselled post-test about their positive status if the second confirmatory test is also positive.
- Clients who test HIV positive should be informed and counselled about their possible emotional responses to a positive test that includes denial and anger and when and how they can manifest and what impact these emotions can have on adherence to healthy lifestyle choices. They also need information on how to reduce the risk of transmission, ongoing positive living, healthy lifestyles and nutrition and ongoing referral for psychosocial support (e.g. support groups), preventative and medical services when needed
- After post test counselling all HIV positive clients need to be referred for laboratory staging by CD4 count and clinical staging by a clinician trained in HIV and AIDS clinical management, screened for TB and either prepared for ART or referred to attend the wellness services provided if they do not qualify for ART yet.
- Post-test counselling must follow these steps:
  - Give the results clearly.

- Explain the meaning of an HIV test and the window period.
- Encourage the client to repeat the test after three months in order to exclude the possibility of the window period.
- Discuss the way forward including risk reduction and the window period and ongoing testing should the client test HIV negative.
- Discuss prevention strategies and safe sex practices including delayed sexual debut, abstinence and regular use of condoms. Deal with feelings arising from positive and negative results.
- Identify the client's immediate concerns and help with them.
- Discuss what support the client has and what he or she needs.
- Discuss with whom the client may want to share the results.
- Where the client is in an abusive relationship, ask the client how he or she thinks the abusive partner will respond and refer the client for appropriate support if necessary.
- Discuss the importance of TB screening, clinical staging, CD4 count, pre ART management and healthy lifestyle.
- Discuss the importance of partner testing.
- Encourage the client to ask questions.
- Provide information on and discuss a continuing healthy lifestyle.
- Provide information on future family planning choices/options.
- This information and follow up counselling must be provided in the local language (or the language of choice) of the client.

## **SECTION 6: HIV TESTING**

The following recommendations regarding HIV testing apply:

- HIV testing must be ethical, based on human rights, conducted within a supportive environment and be performed where there is adequate health care infrastructure.
- Currently, 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 currently being finalized and will be implemented for trained HIV counsellors as soon as it is adopted.
  - For example:
    - 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 should receive required training to ensure adherence to the standard operating procedures, utilisation of approved testing kits and quality assurance of HIV testing. HIV testing conducted by a health care worker, should be under the supervision of a health care professional.
    - The health care professional will continue to be responsible for interpreting and confirming the results of testing by the authorised community health worker/ counsellor who administered the test.
    - The community health worker/counsellor will inform the client of the result.
  - Informed consent should be obtained before testing as outlined in section 4.2.2 of this policy guideline.
  - The National Quality Assurance Programme must be adhered to. This should cover the counselling process as well as the use of rapid test kits.
  - 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.

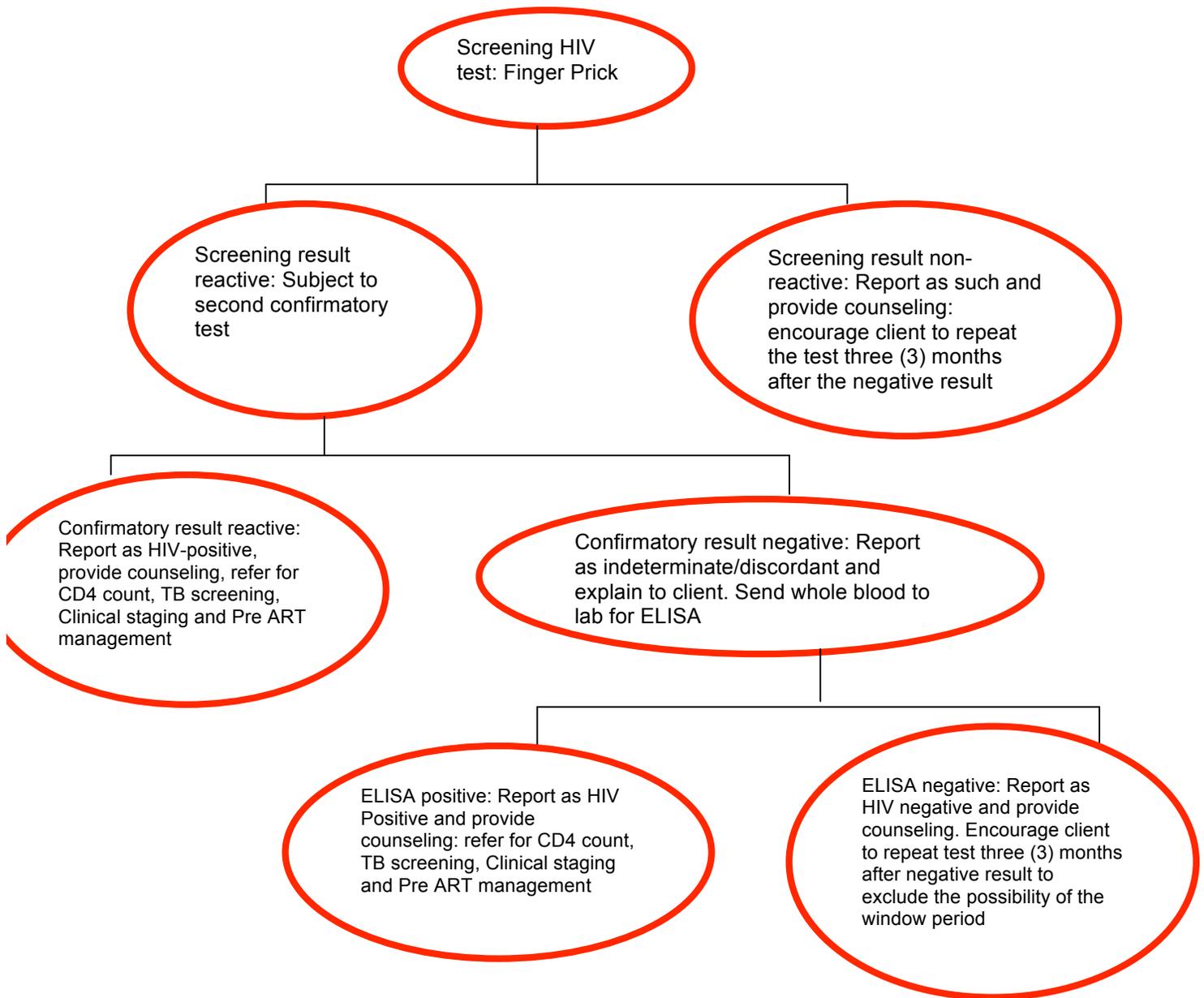
### **6.1 Recommended HIV Testing Algorithm**

- The HIV testing algorithm that should be implemented for all HIV testing is the serial testing algorithm as discussed below.

- Where written and/or verbal consent has been obtained, a rapid HIV test should be carried out with a finger prick using an approved testing kit.
- If the first test is negative (non-reactive), the client is considered to be HIV negative and should be given post test counselling and encouraged to repeat the test three months after the negative result to exclude the possibility of the window period.
- If the first rapid HIV test is positive (reactive), a confirmatory HIV test (second rapid test) should immediately be performed from a second finger prick utilising a different rapid test kit product.
- A client is considered to be HIV-positive if the second rapid test is also positive. A record should be kept and updated on all identified relevant indicators.
- The client must then be given the results by the counsellor, given post-test counselling in the language of choice of the client and referred for appropriate individualised services, especially for CD4 count tests, TB screening, clinical staging, pre-ART and wellness management for HIV positive clients.
- If the two rapid test results are discordant, i.e. the first rapid HIV test is positive and the second rapid HIV test is negative, venepuncture should be performed. A specimen of blood should be collected and sent to the laboratory for the HIV ELISA antibody laboratory test. This should be explained to the client. The results of the ELISA test should be considered confirmatory.
- In this case the client should be asked to return within five days for the laboratory HIV results following the completion of the ELISA test. The importance of coming back for results should be stressed.

The following algorithm, illustrated in Figure 2 below must be applied for HIV testing:

**Figure 2: Recommended HIV Testing Algorithm**



**SECTION 7: HIV COUNSELLING and TESTING for CHILDREN**

## **7.1 Children**

Testing of infants and children for HIV is key to the early identification of HIV exposure and disease and, is a critical element of their survival. Studies such as the CHER study underscore the need for early testing and early initiation of antiretroviral therapy. Achieving MDG 4 (reduction in the under 5 mortality) is dependent on mitigating the effect HIV has on young children and hence this section of testing of 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**

Circumstances in which a child may be tested for HIV

- 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 is in order to find out whether a health care worker may have contracted HIV from the child in a situation where the health care worker must have been exposed to the child's body fluids in a manner which potentially puts the HCW at risk of contracting HIV
- When the test is 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:

HIV testing facilities that offer HIV testing services to children should:

- Be staffed with persons who should be able (through experience and/or training) to:
  - Assess the developmental capacity of children to ensure that they are of sufficient maturity to understand the benefits, risks and social implications of such a test in terms of the Children's Act no 38 of 2005 as amended (S132 (1) (a))
- Ensure that both pre and post-test counselling are offered in every instance.
- Before a child is offered pre- or post-test counselling it should be established whether they have the maturity (as outlined in section 7.1.3) to understand the benefits, risks and social implications of the counselling.
- Children who are mature enough to understand the implications of the HIV test should be counselled.

- Children who are not mature enough to understand the implications of the HIV test should be informed that their parents or care-givers need to be involved in the counselling process to assist them
- Where appropriate, children with the maturity to undergo counselling on their own should be advised 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 certain 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 they can demonstrate that they understand information given to them 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; and
- *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 Social Development
- A designated child protection organization 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 caregiver 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.

#### **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 -
  - Consent is unreasonably withheld; and
  - Disclosure is in the best interests of the child; or if
  - The child or the parent or caregiver 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; 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 HIV testing of infants**

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

### **7.2.1 Testing for HIV exposed infants**

HIV exposed infants are born to an HIV positive mother. HIV exposure occurs during pregnancy and birth as well as during breast feeding. Without any intervention, MTCT occurs in about 30% of infants of HIV positive mothers. If followed correctly, the South African National PMTCT dual therapy to mother and child aims to reduce MTCT to 3% by 2011. The following should be observed when testing HIV exposed infants:

- All HIV-exposed infants should be tested for HIV at six weeks of age and 6 weeks post weaning, if under 18 months, using HIV DNA PCR testing as well as having a rapid antibody test at 18 months if the exposed infant had a prior negative PCR test
- ALL HIV-exposed infants who are awaiting confirmation of their HIV status at six weeks should be started on CTX prophylaxis whilst awaiting their HIV test results
- All infants identified as being HIV positive by early testing should be investigated further as soon as possible by checking HI viral load, CD4 cell count, CD4 cell percent, and by undertaking a baseline immunological and clinical staging as part of their overall baseline assessment.

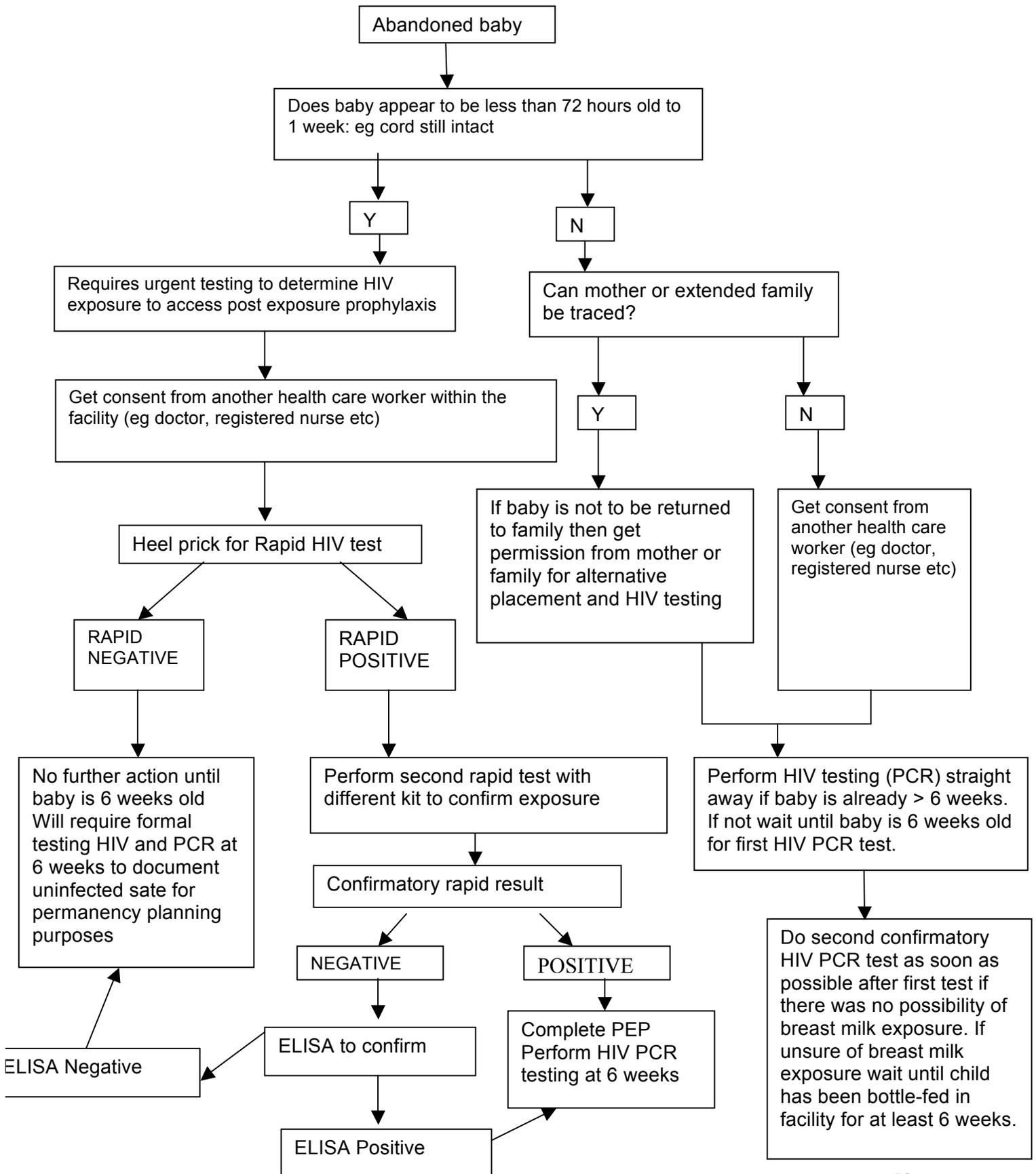
### **7.2.2 Testing abandoned babies**

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 rapid test/ heel prick to determine their HIV status exposure.
- If a rapid is negative in an abandoned baby, then the likelihood of HIV-exposure is small and so will not require PEP.

- If a rapid test RESULT cannot be OBTAINED within 2 hours of taking the baby to a place where PEP can be provided, then PEP must be instituted without any further delay.
- This imperative of providing PEP prior to testing is informed by the fact that these infants have HIV exposure rates as well as the need to provide PEP within 12 hours for improved efficacy (note PEP can be given up to 72 hours) as well as the safety profile of these ARV drugs. The rapid HIV test can then be done at the earliest convenience and PEP stopped if the HIV rapid test is negative.
- If the rapid antibody test is positive, DNA-PCR should be conducted to confirm the positive result and the infant should be started on the PEP. If PCR comes back as positive then the infant needs to access ART as soon as possible.
- A positive rapid antibody test expedites access to PEP for abandoned babies who are excluded from PMTCT as the mother's status is unknown.
- If a rapid test is positive in an abandoned baby less than 72 hours old, it would be in the best interests of the child to start PEP to avoid being negligent in view of the fact that the best time to receive PEP is within the first 12 hours of life and, abandoned babies have HIV exposure rates that are much higher than ANC prevalence rates.
- In a baby younger than 72 hrs, a negative PCR would not exclude infection and therefore should be repeated at the recommended six weeks to establish HIV status and access to treatment if necessary.
- PCR testing needs to be included for all abandoned babies, if under 18 months, in order to exclude HIV. This facilitates permanent placement and the adoption process.

**Figure 3: Recommended algorithm for testing abandoned children**



### **7.2.3 Testing infants younger than 18 months**

Early infant diagnosis of HIV is essential for child survival. In testing infants younger than 18 months, the following steps are recommended:

- Virological testing using HIV DNA PCR is the test of choice.
- Either liquid blood or dried blood spot samples can be used depending on site-specific circumstances, e.g. the skill of healthcare personnel in venesection of young babies.
- Consumables should be available in all facilities for collecting liquid blood and/or dried blood spots for DNA PCR testing in infants younger than 18 months.
- ALL HIV-exposed infants must be tested at six weeks of age using PCR.
- Positive HIV antibody tests (positive ELISA) must not be used to diagnose or confirm HIV infection in asymptomatic infants younger than 18 months (positive antibody tests in these infants could reflect maternal antibodies and therefore HIV exposure). HIV infection could only be confirmed with an HIV DNA PCR test.

### **7.2.4 Testing infants older than 18 months**

In testing infants older than 18 months, the following steps are recommended:

- 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.

### **7.2.5 Breast feeding and infant HIV testing**

- At 5 to 6 months, it is strongly recommended that an HIV PCR test should be performed on all exposed infants.

- Infants should be re-tested six weeks after cessation of breast feeding using PCR if <18 months or HIV rapid test if >18 months.

#### **7.2.6 Children not identified by PMTCT programme (Active Case Finding)**

- All infants should have their HIV exposure status assessed at their six week immunization visit to ensure improved early infant testing rates with PCR by asking the mother's status. In addition, the mother should also be offered HIV testing at the well baby clinic as a way of screening her and her infant for HIV infection and exposure respectively if her status is unknown.
- Immunization visits up to 14 weeks of age should be used to identify babies' status.
- All opportunities should be used to diagnose HIV in infants who display attributable signs and symptoms.
- HIV negative Mothers should always be encouraged to take up an HIV test and to have their child tested for HIV.

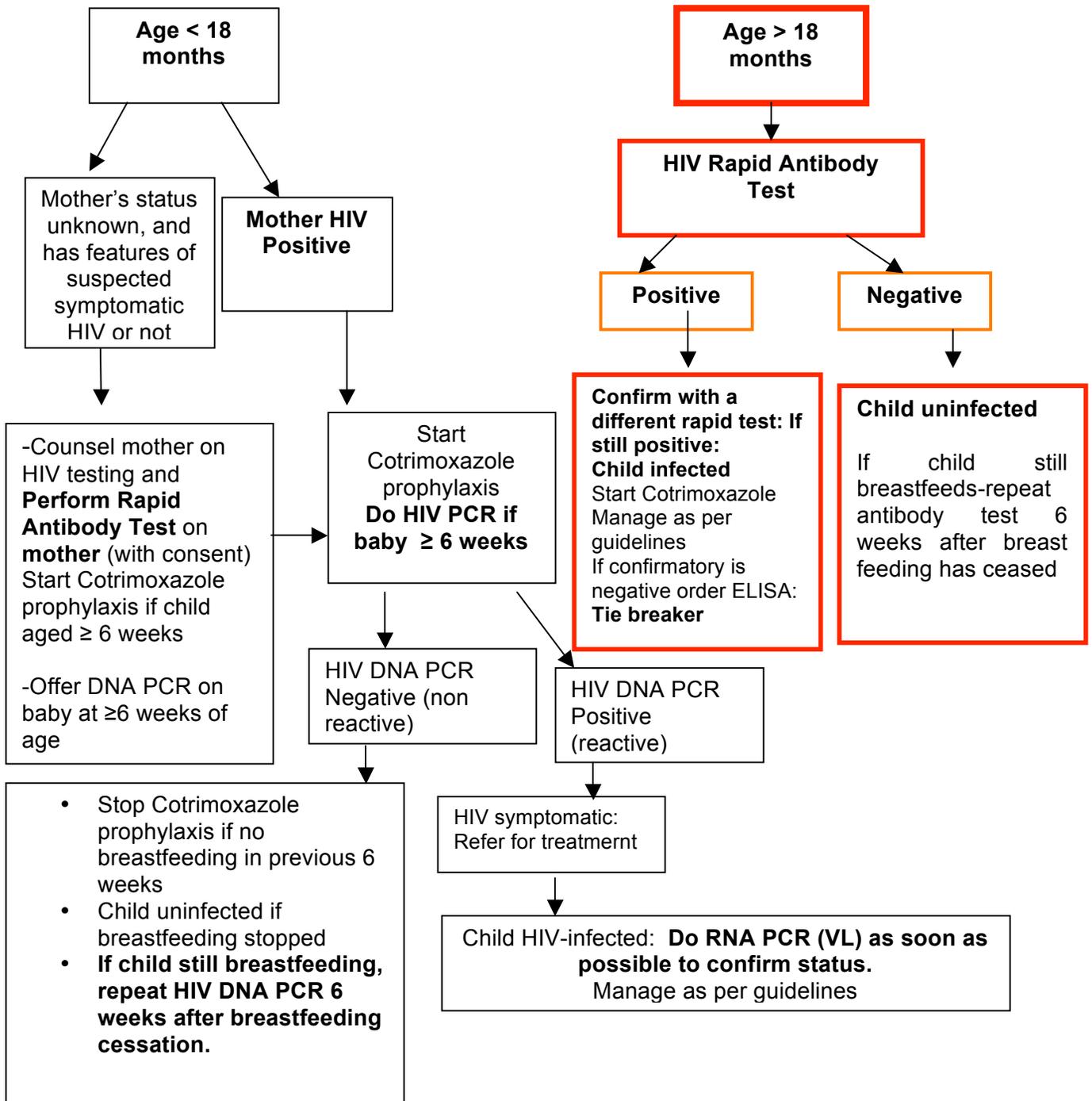
#### **Clinical features and HIV test results**

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

**The Figure 4 below illustrates the algorithm for testing children.**

At 18 months all HIV exposed infants should receive a rapid HIV test to confirm the HIV status previously assigned by DNA PCR testing

**Figure 4: Algorithm for HIV testing of children**



### **7.3 HIV counseling and testing for child survivors of rape**

Child survivors of sexual abuse are entitled to access the full package of services as above with a child friendly child centered approach including:

- An experienced counsellor providing age appropriate counselling.
- 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 who do not have sufficient maturity to understand the benefits of HIV testing, and mentally ill or disabled survivors, pre- and post test counseling should be given to the parent, care giver or legal guardian of the child who should give consent for HIV testing.
- An HIV test must be performed on all child survivors of sexual assault before commencing PEP.
- If the test results are not available, the child should be started on PEP dosages appropriate for the child's weight with a three-day starter pack while waiting for results.
- If the results are negative, the full course of PEP treatment should be provided.
- If the results are confirmed positive, the parents/caregiver and child (if of sufficient maturity) should be counselled and referred to appropriate services for management and support.
- If the results are discordant, blood should be sent to the laboratory for an ELISA test which will be the tie breaker.
- Child survivors receiving PEP should be encouraged to test again at six weeks, 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 in 7.1.5 for all child survivors of rape.
- The parents/caregivers of children who have experienced sexual assault, or the children themselves may apply for the testing of the alleged offender if The application is made within 60 days of the assault

- The offender is identified
- The procedure laid down in the SOA is followed

Results may be disclosed to the child (if of sufficient maturity) and to the caregiver/parent.

The parents and child must be counseled on the implications of the results and encouraged to continue with PEP regardless of the outcome of the alleged offender's HIV test

### **7.3.1 Mandatory reporting of abuse**

The law states that 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, or
- 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 (2007). It says that 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 a sexual offence has been committed against them must report this information to the police or social workers. Failure to report is a criminal offence (S54 of the Criminal Law (Sexual

Offences and Related Matters) Amendment Act no 32 of 2007). 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, in this document a child is referred to as anyone under the age of 18. The NSP also specifically targets the 15-49 age groups. Subsumed under these two broad categories are "young people" i.e. those who fall in the 10 to 24 year old 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, 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 actually 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 of adolescent development, and of appropriate medical, psychosocial and developmental options according to age and maturity.

## **SECTION 8: COUNSELLING and TESTING of SPECIAL POPULATIONS**

The HCT policy 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 discussed until currently.

### **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. Rhesus Factor, haemoglobin, RPR (syphilis) and HIV should be done during antenatal care (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.

Women who test HIV-negative should receive post-test counselling and counselling on risk reduction interventions, focusing mainly on how to maintain their HIV-negative status while continuing to receive routine antenatal care.

- Women who test HIV-negative should be offered a repeat HIV test at or around 32 - 34 weeks to detect late seroconversion and to allow time for PMTCT prophylaxis.
- 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 and offered a PMTCT intervention if positive for HIV and their infants be offered PEP.
- 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 antenatal care
  - Receive ARV regimens prescribed by a registered health professional including registered midwives and professional nurses (in line with the relevant legislation and regulations) for PMTCT short course or HAART.

Women attending postnatal clinic at six weeks who may have tested negative in early or late pregnancy may report negative status from the earlier test at a time when a recent HIV infection could have occurred should be offered HIV 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 for pregnant women**

All women attending antenatal care (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 - post exposure prophylaxis (PEP) - can be administered. PEP is given within 24 hrs and up to 72 hrs in order to minimise the risk of seroconverting to HIV following such exposure. In the case of accidental exposure, the following is recommended:

- If a client is not ready to test after pre test counselling, they will 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 is obtained before testing

### **8.3 HIV counselling and testing of survivors of sexual assault**

- Survivors of domestic violence or rape require an empathetic approach by the health care professionals
- The routine offering 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.
  - If the test results are not available, or client HIV status should never be shared with the client's employer unless the client specifically requests this.
  - Discussion about sharing confidentiality should explore the barriers faced by the client in disclosing. Where the client is in an abusive relationship, the client should not be pressurized to disclose to an abusive partner and should be referred to appropriate service providers to support the client.
  - If the client is not emotionally ready to be counseled 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 come back HIV negative, the full course of treatment should be provided.
  - If the results come back 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 recommends the following when testing sexual offenders for HIV:

- The 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 Amendment Act), 2007).
- The health care worker may only test an alleged sexual offender when presented with a court order by an investigating officer.
- The health care worker should offer the alleged sexual offender pre test counseling or ensure that such pre test counseling has been done and should provide the alleged sexual offender 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 Amendment Act), 2007).
- The survivor of the interested person who applied for the testing of the alleged sexual offender should be counseled prior to receiving the HIV results of the alleged sexual offender. The investigating officer must ensure that such counseling occurred before handing over the test results (Criminal Law (Sexual Amendment Act), 2007).

## **8.5 HIV counselling and testing of 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 followed by 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 and provide inmates with information on PEP at the time that they enter a detention facility.

On admission to a detention facility:

- Female prisoners who are accompanied by minor children in prison should be offered screening for HIV, STIs and TB as outlined above
- In addition, pregnant female prisoners should receive basic antenatal care including HIV testing and counselling according to the approved PMTCT programme by trained health professional
- Female prisoners who deliver in prison, a local maternity facility or midwife obstetric unit (MOU) 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 on counselling and testing as well as test kits used both in private and public facilities. 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 on a regular basis. 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 to ensure that the final HIV test results are correct. Several QA steps must be followed by all service providers:

- Nationally prescribed standards of practice for performing HIV tests must be followed.
- Effective linkages with the National Reference Laboratory (NICD) must be maintained to ensure that sites meet the National QA standards for HIV testing.
- HIV rapid test kits must be assessed for validity and reliability according to the National protocol.
- Procurement must ensure uninterrupted supply of all equipment and commodities.
- Good information and data management systems for performing HIV tests must be followed at all HCT sites.
- Appropriate storage requirements to ensure test kits are at their optimum and transportation of blood specimens must adhere to good laboratory practice.
- Infection control procedures should be adhered to at all times.

## **SECTION 10: 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 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 to reduce transmission and to improve early access to care through the increase of the availability, quality, provision and acceptance of care for both HIV-positive and HIV-negative people.

## **10.2 Objectives**

The social mobilization strategy in support of HCT aims to achieve the following:

- Create an enabling environment 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.
- 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 (NSP) 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.
- The Khomonani (Caring together for life) Campaign of the Government HIV AND AIDS Programme

#### **10.4 Target audience**

All South Africans are the target audience for communication about HIV testing. Within this population there may be an emphasis on sexually active men and women aged between 15-49 years, including children in this range of less than 18 years, with special efforts to reach the following:

- Men
- Couples/sexual partners.
- Pregnant women and family planning clients
- Vulnerable and marginalized groups such as commercial sex workers (CSW), men having sex with men (MSM), migrants, intra-venous drug users, alcohol and other drug users, 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

#### **10.5 Key communication areas**

In order to increase uptake of HCT, messages should address specifically what people in South Africa perceive to be the main benefits to and the main barriers of HCT. Communication should also aim to reach those who have already gone through HCT. It 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 counseling interactions confirm that they are engaging in unprotected sex. Communication should also address people who tested HIV positive to ensure that they have the information they need to access relevant services, lead healthy lifestyles and to 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 Social mobilisation through campaigns and mass media**

Key messages must include the following:

- Prevention through targeting women, men and youth, focusing on risk reduction and reduction of partners, and on using condoms consistently and correctly to encourage people who are negative to remain so.
- Increasing uptake of HCT services and encouraging regular testing for marginalised and vulnerable groups such as commercial sex workers, MSM and intravenous drug users.
- The benefits of counselling and testing for individuals and couples/sexual partners.
- Prevention, targeting HIV-positive people to reduce risk of re-infection and transmission.
- Primary prevention targeting clients testing HIV negative, strengthening the message of reducing the risk of subsequent HIV infection, and promote understanding of the window period and the need to re-test
- A continuous stress on positive living, healthy lifestyle and nutrition.
- Creating an enabling environment for HIV counselling and testing
- Combating stigma and discrimination.
- Facilitating implementation of programmes supporting voluntary disclosure of HIV status

## **10.7 Mobilisation at the service points**

Messages stressed at service points must include

- Strengthening integration of HCT services into the primary health care package by promoting communication about HCT to all clients accessing services, more especially clients accessing services such as FP, ANC, TB, PEP, IMCI and STI.
- Promotion of messages targeting health care workers to maximise HCT service delivery, e.g. to increase uptake of couple counselling and testing.
- Strengthening counselling on HIV prevention including condom use, partner reduction and family planning.
- Developing and disseminating messages at health facilities to encourage referral to relevant prevention, treatment, care and support services.
- Strengthening awareness of HCT services amongst clients attending health care facilities by making them known 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 I&E pre-test sessions may need further review and should include the following:

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

## **10.9 Organisational arrangements**

- National Department of Health: The VCT Sub-directorate will coordinate a team involving the following directorates: Government AIDS Action Plan, Khomanani, Care and Support, and the Health Promotion and Communication directorates to develop communication and social mobilization for the programme.
- Provincial Health Departments: HAST/HCT/VCT 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 counsellors with the support of the facility manager, will undertake communication activities at this level, under direction of the designated district coordinator.

## **10.10 Roles and responsibilities**

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

### **National Department of Health**

The National department, in conjunction with the Khomanani service providers:

- Coordinates and gives direction to HCT communication across provinces.
- Conducts National campaigns on HCT using National mass media and community structures created as part of the Khomanani strategy. These should 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 support messaging, which should pertain to adherence to wellness appointments, adherence to safer sex and other positive life style choices as well as treatment.

- Conducts other National campaigns on prevention, treatment, care and support that strengthen the HCT campaign.
- Develops IEC materials for use in marketing the HCT programme
- Facilitates capacity building services to provinces.
- Monitors implementation of social mobilisation at all levels.
- Monitors the impact of the communication of HCT on communities and on services.

### **Provincial health departments**

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

- Give direction to 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, either jointly with Khomanani or at their own initiative.
- 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.

### **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.
- 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 (M,E & R)**

### **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 being utilised, services are being accessed, activities are occurring in an efficient and guided manner, and the expected results are being achieved. This is for improving service quality and thus obtaining the maximum health benefit for the population served.

**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 template (e.g. 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 often indicators that are not collected through routine information systems. It also assess 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-term 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 National Strategic Plan 2007-2011.

The third phase is impact evaluation. It ensures that information on the impact of HCT is obtained from periodical population surveys such as SADHS and other such surveys. 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 for HIV and AIDS 2007-2011.

All indicators or data from public health, 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, in line with health management information system of the country. It is

important that all indicators pertaining to special groups of the population should also 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 strengthen the monitoring and evaluation of the NSP for HIV and AIDS 2007-2011. They must align with a number of the Millennium Development Goals, such as MDG 4 reduce child mortality, MDG 5 Improve maternal health (reduce maternal mortality) and MDG 6 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 (benefits fits i.e. inputs, outputs and outcomes) should be used.

] benefits

### **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 them
- Inform planning, prioritisation, allocation and management of resources for HCT
- 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 between them. 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 VCT and now the HCT programme, should be collected at the following service points offering HCT services - ANC, TB, OI, STI, PEP, PHCs and community health centres. Indicators about referral to appropriate services, e.g. TB screening, STI treatment, CD4 testing, etc 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 VCT/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.	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
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 & Facility
11.	Proportion of new pregnant women tested for HIV	Output	DHIS	Monthly	Province, District & Facility
12.	Percentage of facilities where the National VCT 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 (VCT/ 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, Province 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 in 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 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 following 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 lay counselors, 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**

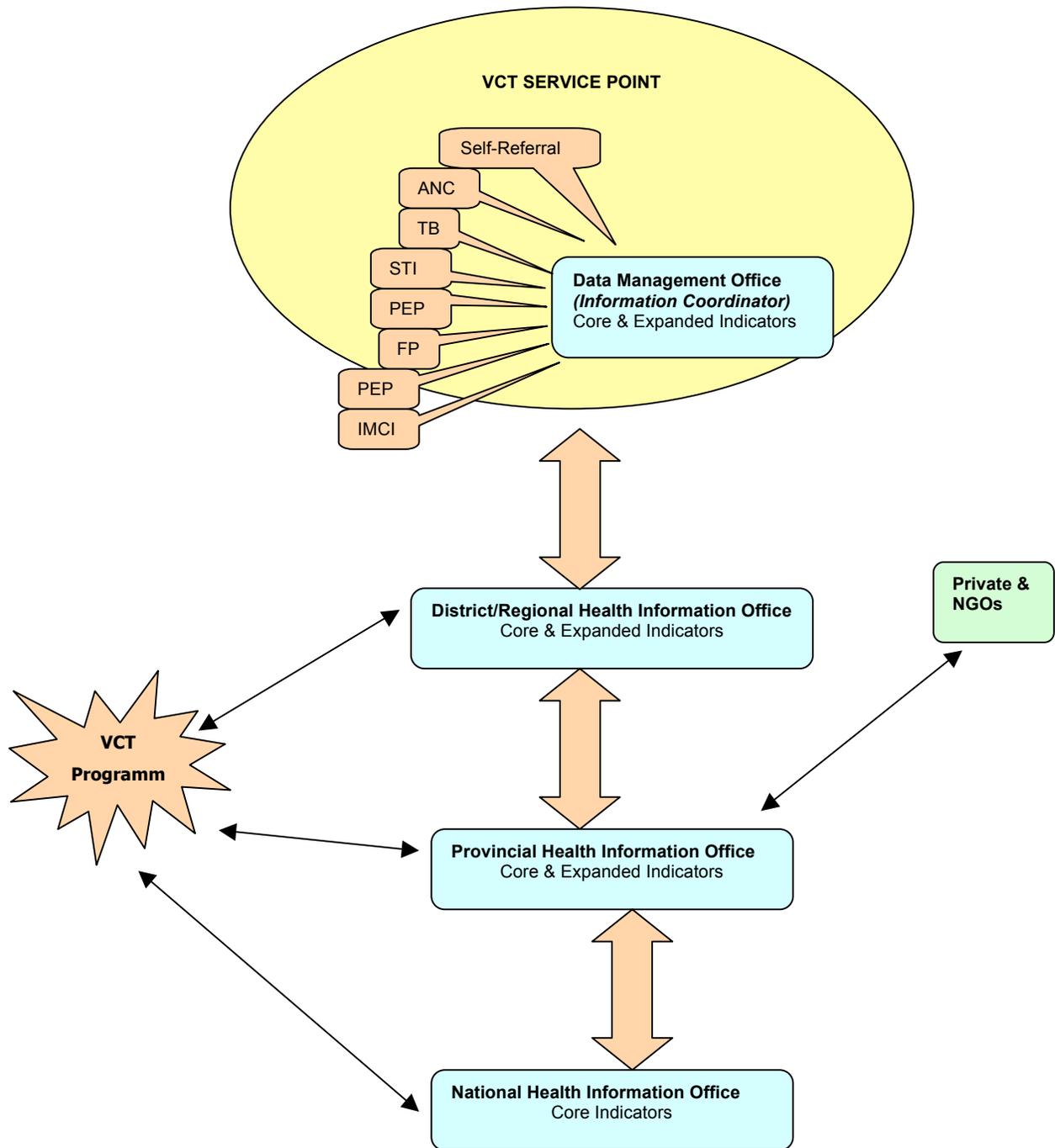
The provincial health information officer and HCT coordinator will compile all district data and report to the National Health Office.

**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 VCT manager in the HIV&AIDS and STIs cluster. The flow of information will also ensure that at each level, feedback is provided.

benefits

The typical information flow of data is illustrated in Figure 4 below.



## **SECTION 12: CONCLUSION**

The aim of the HIV counselling and testing policy guideline was to provide a National framework that would direct the provision of HIV counselling and testing services for children, youth and adults in the public and private sectors in South Africa. A key intention behind the policy guidelines is to ensure better quality and greater consistency of the delivery of many of the 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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