



Regional Minimum Standards for the Harmonised Guidance on HIV Testing and Counselling in the SADC Region



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ACRONYMS AND ABBREVIATIONS

AIDS	Acquired immune deficiency syndrome
HTC	HIV testing and counselling
HIV	Human immunodeficiency virus
PITC	Provider-initiated testing and counselling
PLWHA	People living with HIV and AIDS
PMTCT	Prevention of mother-to-child transmission (of HIV)
SADC	Southern African Development Community
STI	Sexually transmitted infection
TB	Tuberculosis
UN	United Nations
UNAIDS	United Nations Joint Programme on AIDS
VCT	Voluntary counselling and testing
WHO	World Health Organization



1. BACKGROUND

The SADC region bears the brunt of the global AIDS epidemic. The epidemics in the region are diverse, with varying levels of adult HIV prevalence fuelled by behavioural, social, cultural, biomedical and economic factors. HIV is the leading cause of morbidity and mortality in the region.

SADC Heads of State and Government have made several commitments to fight the AIDS epidemic and other communicable diseases. They include the *Maseru Declaration* (2003) as well as other commitments such as the *Abuja Declaration* (2001 and 2006), the *Maputo Declaration* (2005), the *Brazzaville Commitment* (2006) and the Millennium Development Goals.

In order to implement some of those commitments, the SADC region developed the SADC Regional Prevention Strategy and Action plan to support Member States' efforts to significantly reduce the incidence of new HIV infections. The review notes modest achievements in the priority areas of prevention of mother-to-child transmission of HIV (PMTCT), condom use, management of sexually transmitted infections (STIs), HIV testing and counselling (HTC), and behaviour change. Unfortunately, the progress has not been sufficient to reduce HIV incidence to an extent that would reverse the AIDS epidemic.

A systematic review of the impact of VCT in developing contexts shows that evidence exists for VCT as an effective behaviour change strategy, but that weak study designs and limited replication mitigate the strength of that evidence. Several studies indicate that VCT is most effective in promoting behaviour change (such as reports of less unprotected sex, fewer multiple sex partners, and fewer casual partners) between couples tested together and among HIV-positive individuals, particularly with their non-primary partners. The efficacy of VCT as a primary prevention strategy for HIV-negative people, as well as the long-term effects of VCT for HIV-negative and HIV-positive individuals is less certain.

HTC is a vital entry point for PMTCT services, and there is evidence of considerable success in reducing mother-to-child transmission of HIV in some SADC Member States. In Botswana, for example, mother-to-child transmission has been reduced from about 40% to about 3%. All Member States should scale up this very effective intervention.

In order to successfully implement the prevention agenda, it is vital that as many people as possible test for HIV and know their status so that they can initiate appropriate prevention, support or care and treatment.

However, surveys in sub-Saharan Africa have shown that very few people test for HIV. Knowledge of one's HIV status may be a significant tool for prevention of HIV and AIDS (if supported with strong links to prevention services) and can help in ensuring timely access to treatment, care and support.

2. RATIONALE

The *SADC Protocol on Health* ranks the fight against HIV and AIDS among its priorities. Article 10 of the *Protocol* states that Member States shall:

- Harmonise policies aimed at disease prevention and control, including co-operation and identification of mechanisms to reduce the transmission of STIs and HIV infection;
- Develop approaches for the prevention and management of HIV and AIDS, as well as STIs, which are to be implemented in a coherent, comparable, harmonised and standardised manner; and
- Develop regional policies and plans that recognise the intersectoral impact of HIV and AIDS, and STIs and the need for an intersectoral approach to these infections.

HIV testing and counselling is an important entry point for prevention, treatment and care, and can be especially effective when provider-initiated services are used. Couple counselling and testing for HIV has also been shown to have a strong impact for short-term behaviour change. Similarly, there is some evidence that persons who test HIV-positive adopt safer behaviour. Identifying discordant couples and engaging them and people living with HIV in prevention efforts is particularly important.

The development of regional minimum standards for harmonised approaches to HIV testing and counselling is therefore a significant milestone towards operationalising the *SADC Protocol on Health*.

The SADC region is signatory to several continental and global declarations which highlight the need to know one's HIV status as a gateway to accessing appropriate prevention, treatment, care and support services. Those declarations include:

- The *Maseru Declaration on HIV and AIDS* (2003), which emphasises the importance of prevention and social mobilisation;



- The *UN General Assembly Special Session on HIV/AIDS Declaration* (2001), which positions prevention as the mainstay of HIV responses;
- The *Abuja Declaration* (2001 and 2006) which consolidates the foundations for HIV prevention and control;
- The *Maputo Declaration* (2005), which calls for strengthened national responses to accelerate prevention; and
- The *Brazzaville Commitment* (2006), which calls for scaling up towards universal access to prevention, treatment, care and support.

Building on these commitments, the regional minimum standards will serve as a framework for regional harmonisation of approaches to HTC.

3. PROCESS FOR DEVELOPING REGIONAL HIV TESTING AND COUNSELLING MINIMUM STANDARDS

The process for the development of these regional minimum standards for HIV testing and counselling was participatory including Member States, the SADC Secretariat and various stakeholders. The process was also informed by internationally-recognised best practices.

Firstly, a desk review of the current national, regional and global policies relevant to HIV Testing and Counselling was conducted. This was followed by individual country assessments in each Member State. During the assessment, key informants within the respective programs, including development partners, civil society organizations and the private sector were consulted to provide information on the state of programmes and policies. The respondents also shed light on some challenges and best practices. Each visit culminated in a country level assessment report which was reviewed and validated by officials from Ministry of Health of each Member State.

The country reports were then compiled to inform a regional picture of the situation and response analysis. The draft regional assessment report was used as a basis for Regional Minimum Standards. Both the draft Regional assessment report and the draft regional minimum standards were then reviewed by a technical team for technical soundness on 15 – 16 December 2008 in Gaborone, Botswana. The team comprised 7 Member States, Technical Partners (WHO), and the

SADC Secretariat. The purpose of the review team was to strengthen the quality of the documents.

Following the technical review and the incorporation of the comments, the documents were then presented to a regional workshop for validation of the situation and response analysis report and consensus building on the proposed regional minimum standards. All Member States and major stakeholders including regional partners and civil society organisations were invited to the validation and consensus building workshop. The workshop was held on 25 – 27 May 2009 at Victoria Falls, Zimbabwe. The meeting recommended the draft reports for approval through the SADC structures subject to the incorporation of suggested changes.

Accordingly, the revised reports were reviewed by the SADC National AIDS Authorities in their meeting of 12 – 16 October 2009 in Kinshasa, DRC for technical soundness and recommendation for approval by Ministers. Finally, the document was reviewed by Senior Officials in Ministries of Health and those responsible for HIV and AIDS before being submitted for approval by the joint ministerial committee of Ministers of Health and those responsible for HIV and AIDS. Ministers approved the minimum standards at their meeting held on 9 – 13 November at Ezulwini, Swaziland.

4. GUIDING PRINCIPLES

The provision of HTC should be undertaken in an evidence-informed way to maximise the benefits for both treatment access and HIV prevention. The HTC minimum standards are guided by the following principles. These principles combine the UNAIDS Principles of Effective HIV Prevention with values governing regional action:

- **Human rights.** Human rights, including the rights of men, women, children and youth, must be promoted, protected and respected. These minimum standards endorse the SADC Model Law on HIV and AIDS pertaining to the protection of human rights and prevention of criminalising HIV transmission;
- **Gender equity promotion.** It is important to integrate strategies for empowering women and engendering equality in access for males and females, participation and control over resources for HIV testing and counselling;
- **Evidence-based.** The design of more effective HTC initiatives should rely on evidence of ‘what works’ and use sound local data;



- **Complementarity.** It is vital that the support and enhancement of national efforts through regional action be harmonised with Member State priorities and responses;
- **Participatory.** Inputs from all Member States, all sectors and all segments of citizenries, particularly members of marginalised groups, are essential for ensuring effective HTC responses;
- **Greater and meaningful involvement of PLWHA.** It is imperative that people living with HIV and AIDS are involved in policy development and programme delivery for HTC;
- **Contextual relevance.** The design of regional interventions should fit the social, economic and cultural contexts of targeted communities, and should be implemented at the levels at which they can be most effective;
- **Partnerships.** It is important to act in partnership with regional civil society organisations and institutions, utilising their comparative advantage to facilitate stronger Member State responses.

- HTC service delivery must be made accessible to all citizens by using a range of models (for example, integrated, stand-alone, mobile, and home-to-home). In addition, more effort must be made to integrate HTC with other services. In all instances, the HTC services must have strong links to prevention and treatment services.
- The ‘3Cs’ guiding principles of confidentiality, counselling, and informed consent with voluntarism must be adhered to in both PITC and VCT.

5.3 Informed consent

- HIV testing must be routinely offered to all young people and adults accessing health services. Persons should undergo HTC once they have given informed consent.
- Where a person is unable to consent to HIV test, for example children and mentally disturbed adults consent must be obtained from an appropriate adult in accordance with legal provisions of the country.
- The minimum amount of information that persons require in order to be able to provide informed consent include:
 - The clinical benefit and the prevention benefits of testing;
 - The ‘window period’ after infection and before HIV antibodies can be detected;
 - The right to refuse; and
 - The follow-up services that are available for prevention and for treatment.

- At a minimum, consent should be verbal, except in special circumstances where written consent is required.
- For PITC, persons retain the right to refuse testing, i.e. to ‘opt out’ of a systematic offer of testing, without any penalty, real or threatened, to ongoing care and treatment or prevention services.

5.4 Pre-test and post-test counselling

- All clients or patients must be provided with pre-test information.

5. REGIONAL MINIMUM STANDARDS FOR HIV TESTING AND COUNSELLING

5.1 Conducive environment for HIV testing and counselling

- Member States must ensure availability of HTC policy guidelines, protocols or standard operating procedures to guide implementation and ensure all groups are represented, including vulnerable groups.

5.2 HIV testing and counselling approaches

- Member States must ensure provision of HTC through both provider-initiated testing and counselling (PITC) and VCT. PITC refers to a practice whereby healthcare providers recommend HTC to persons attending healthcare facilities as a standard component of medical care. By contrast, with VCT individuals seek out and request HIV counselling and testing services.



- They must be provided with post-test counselling.
- All persons who test HIV-positive must be referred to appropriate prevention, treatment care and support services to ensure continuum of care.
- All persons who test HIV-negative must be provided with appropriate education and support (including condom provision) to help ensure that they do not become HIV-infected.
- Member States must ensure appropriate linkages of HTC services to services such as treatment for STIs, family planning, TB, as well as pertinent legal and other HIV prevention or treatment services.
- HTC services must be gender-sensitive and youth-friendly.
- Member States must ensure access to HTC services for marginalised groups, with health staff trained in positive, non-judgmental attitudes.
- Member States must ensure the meaningful involvement of people living with HIV and AIDS.

5.5 Age of consent

- Member States must adhere to national legal frameworks on the minimum age and mature minors, but efforts are needed to reduce those ages, taking into consideration the average age of sexual debut.
- Young people whose age's falls under the country's stipulated age of consent and who are married, pregnant or parents should be considered mature minors who can give consent for HTC in accordance with the legal provisions of the country.

5.6 HIV testing and counselling

- Member States must use HIV test kits recommended by WHO for adults and children, and utilise a WHO-approved protocol for quality assurance.
- Selected test kits must be used to determine the specimen to be collected for HIV testing.

- Laboratory Scientists Councils must be responsible for training, monitoring and supervision of HIV testing at all levels.
- Member States must select either serial or parallel testing algorithms, taking into account the type of epidemic and available resources.
- Member States must have a quality assurance system in place for HIV testing, which meets agreed WHO standards.
- Member States must ensure the availability of post-exposure prophylaxis for personnel providing HIV testing services, in line with national post-exposure prophylaxis standards.

5.7 HIV testing and counselling for children

- Member states must ensure that HTC services are accessible to children.
- All HTC services provided to children must be in the best interest of the child.
- Member states must ensure that psychosocial services are available for children and their families in the case of positive test results. The services should be available at schools, hostels, churches and other sites where children spend a lot of time.

5.8 Capacity building for HIV testing and counselling service providers

- All HTC service providers must undergo training by qualified trainers using training approved and/ or certified by Ministries of Health.
- Member states must consider utilising non-health personnel in HIV testing and counselling service provision.
- Task shifting of HIV testing to non-laboratory personnel should be considered.

5.9 Accreditation of sites

- All sites providing HTC services must be approved by the Member State's Ministry of Health.
- All sites must meet the minimum staff, space, equipment and supplies requirements, as stipulated in the national HTC guidelines.



5.10 Care for HIV testing and counselling service providers

- Member States must ensure that post-exposure prophylaxis is accessible to all service providers within 72 hours of exposure and in line with national post-exposure treatment standards. Post-exposure prophylaxis must also be accessible and available to all others who may need it including survivors of sexual assault.
- Member States must have counsellor support strategies in place.

- Member States shall identify challenges to implementation of each standard, identify the specific shortcomings that prevent the standards from being met, and identify the barriers and opportunities for each standard.
- Member States shall develop a detailed financial plan and avail resources for supporting the implementation of the harmonised minimum standard.

6.1.2 SADC Secretariat

The SADC Secretariat will coordinate the overall implementation and monitoring of these minimum standards on behalf of the Ministers of Health. Specific responsibilities will include:

- Advocating for implementation of effective HTC programmes in the region in relation to the commitments made by Member States (such as the *SADC Protocol on Health*, and the *Maseru Declaration on HIV and AIDS*);
- Facilitating the harmonisation of policy guidelines and protocols for the prevention of mother to child transmission of HIV;
- Facilitating skills transfer and sharing of good/innovative practices, benchmarking of Member States among each other and provide a platform of sharing of good practices;
- Coordinating partners for resources mobilisation and technical support in the region; and
- Coordinating regional training programmes on HIV testing and counselling.

6.1.3 Other stakeholders

Other stakeholders include UN Agencies, bilateral donors and development partners, local and international NGOs, community-based organisations and communities, the private sector and research and training institutions. All are essential for the successful implementation of the Minimum Standards.

UN Agencies and other development partners

Their roles will vary but will include:

- Assisting in updating and developing new programmatic/clinical guidelines.
- Linking Member States with new technologies and tools for diagnostics.

6. Implementation Mechanisms for the Regional minimum standards

The implementation mechanism defines the key stakeholders and their roles in the implementation of the Regional Standards. Furthermore, it provides guidance on how the agreed Standards will be financed. Lastly, it identifies the critical indicators to be monitored to ensure that the Standards fully integrated in the work of the Member States. To this end, this section is intended to map out the path to the domestication of the minimum standards, including how it will be financed and monitored.

6.1 Stakeholder roles and responsibilities

The successful implementation of the regional Minimum Standards for harmonised guidance on HIV Testing and counselling programme requires the involvement of all key stakeholders at both national and regional levels. It is thus important to provide an outline on their roles.

6.1.1 Member States

- The SADC Health Ministers will oversee and monitor the implementation of this Minimum standards.
- Member States shall take a lead role in ensuring that the minimum standards are integrated to the annual work plans of their national HTC programmes.
- Member States shall ensure that national HTC programmes involve various departments in the Ministries of Health and key stakeholders in the public and private sectors (for example, donors, WHO, partners, community-based organisations, Private Sector and training institutions) to identify their roles in the implementation of the various activities articulated in the minimum standards.



- Supporting resource mobilisation to assist in implementing HTC activities.
- Assisting with inputs in harmonising the management protocols to support implementation, including routine reporting and recording HTC data.

Local and international donors and NGOs shall:

- Assist in implementation of agreed on minimum standards.
- Advocate for strengthening of HTC.
- Augment resources to ensure implementation of the minimum standards.
- Assist in disseminating best practices within the region.
- Provide additional human resources as needed to support implementation of minimum standards.
- Support integration of HTC in the overall primary health care services.
- Provide feedback to MS on the progress or otherwise in the implementation of the minimum standards.

6.2 Financing mechanisms

Implementation of these minimum standards may require additional financial resource allocation by each Member State. Funding for the activities required to meet the minimum standards will be allocated within the national budget of each Member State, if these activities are not currently provided for in the HTC budgets.

Member States shall ensure that:

- Areas that need additional financial resources are identified, with the participation of all relevant stakeholders, including UN agencies, donors, development partners, and NGOs.
- Each area that needs improvement is costed. Examples could include the costing of implementing the advocacy, communications and social mobilisation strategy.
- National HTC programmes receive endorsement from their Ministries of Health where additional finances are required.

6.3 Monitoring and evaluation

6.3.1 Role of Monitoring and Evaluation in Implementation of Minimum Standards

These minimum standards need to be monitored in order to enable both Member States and the SADC Secretariat to objectively assess progress in implementing the regionally agreed on Minimum Standards for Harmonised Guidance on HIV Testing and Counselling (HTC). Monitoring is an important management tool that helps to identify implementation progress, challenges and bottlenecks that should be addressed for enhanced impacts. Effective monitoring shows programme managers the extent to which they are making progress in institutionalising the minimum standards into the national health programme. Furthermore, results from monitoring implementation of the minimum standards will inform management decisions aimed at fine-tuning the response to HTC at the MS level. At the same time, results from monitoring will show progress that the region is making in the implementation of the SADC Protocol on Health as it relates to HTC.

6.3.2 Monitoring and Evaluation at MS Level

There are broad areas that are articulated in the Minimum Standards for HTC that if fully implemented, will lead to realization of HTC commitments and harmonisation of HTC response across MS. These are the areas that MS are expected to collect data on as a way of systematically assessing progress in each of the areas articulated in the minimum standards. Member States will collect information to track progress on the following areas:

- Development of HTC policy guidelines, protocols or standard operating procedures to guide implementation of HTC interventions;
- Adoption of multiple HIV testing approaches;
- Routine provision of HIV testing and counseling to people accessing health services;
- Provision of pre-test and post-test counseling;
- Adherence to national legal frameworks on the minimum age and mature minors;
- Use of internationally recognized HIV Test Kits for adults and children;
- Accessibility of HTC services to children;



- Developing and implementing plans to strengthen the human resource capacity for HIV testing and counseling services;
- Accreditation of testing sites;
- Care for HIV testing and counseling service providers; and
- Development and implementation of monitoring and evaluation frameworks

Member States will collect information on the broad areas above on an annual basis and prepare an annual report. The detailed variables on which information will be collected are in a separate document “Framework for monitoring progress in implementing Regional Policies and Frameworks”.

6.3.3 Monitoring and Evaluation at the SADC Regional Level

At the SADC regional level, tracking implementation progress for the minimum standards for HTC will focus on issues relevant at that level. It should be noted that the aspects of HTC monitored are exactly the same with those monitored at the MS level. The difference is that at the regional level, interest will be to know the number of MS that are implementing each of the aspects of HTC that are articulated in the Minimum Standards. Thus, more specifically, at the regional level monitoring will focus on the number of MS implementing the following:

- Development of HTC policy guidelines, protocols or standard operating procedures to guide implementation of HTC interventions;
- Adoption of multiple HIV testing approaches;
- Routine provision of HIV testing and counseling to people accessing health services;
- Provision of pre-test and post-test counseling;
- Adherence to national legal frameworks on the minimum age and mature minors;
- Use of internationally recognized HIV Test Kits for adults and children;
- Accessibility of HTC services to children;
- Developing and implementing plans to strengthen the human resource capacity for HIV testing and counseling services;

- Accreditation of testing sites;
- Care for HIV testing and counseling service providers; and
- Development and implementation of monitoring and evaluation frameworks

Specific details on the information to be collected are contained in the “Framework for monitoring progress in implementing regional Policies and Frameworks” document.

6.3.4 Reporting Mechanisms

Member States will prepare national reports on the implementation of HTC Minimum Standards based on the information on the areas to be monitored at the MS level. These national reports will be submitted to the SADC Secretariat annually by 30 April. The reports that will be submitted by MS will also describe challenges that MS are experiencing in the implementation of Minimum Standards for HTC. On the basis of MS reports, the SADC Secretariat will compile an annual regional report detailing progress in the implementation of minimum standards for HTC. This report will be a section in the annual regional HIV and AIDS Epidemic Report. Thus, the submission timelines of MS reports on the implementation of minimum standards for HTC will be in line with submission of national HIV and AIDS Epidemic Reports as detailed in the “SADC Harmonised Surveillance Framework for HIV and AIDS, TB and Malaria”.

The SADC Secretariat will share the report with HIV and AIDS Managers, HTC Programme Managers from MS and HTC Experts from partner organisations for their review and comments in mid-June every year. MS HTC Managers at MS level will compile comments from stakeholders in their country and share them with the SADC Secretariat by mid-July. The SADC Secretariat will incorporate the comments and present the Draft Regional Report as a section in the SADC HIV and AIDS Epidemic Report to Senior Officials from the Ministries of Health and Ministries responsible for HIV and AIDS for comments and recommendations to Ministers of Health and Ministers responsible for HIV and AIDS for final review, comments and approval at their annual meeting.

The HTC component of the SADC HIV and AIDS Epidemic Report will be analysed to identify implementation challenges and recommend concrete solutions to the identified bottlenecks. Thus, the HTC report will be used for decision making and policy reviews at both the national and regional levels.



7. RESOURCES FOR IMPLEMENTATION OF MINIMUM STANDARDS

The *SADC Minimum Standards for Guidance on HTC* will be implemented with the support of Member States.

The resources will be sourced mainly from the SADC Regional Trust Fund. Additional resources will be sought from development partners. Resource mobilisation will be aimed at securing technical assistance and funds that will be pooled to support the minimum standards.





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