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REGIONAL MINIMUM STANDARDS FOR GUIDANCE ON HIV TESTING AND COUNSELLING (HTC) IN THE SADC REGION

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ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
AfDB	African Development Bank
BAIS	Botswana AIDS Impact Survey
BCC	Behaviour Change Communication
CBO	Community Based Organisation
DART	Demonstration of Antiretroviral Therapy
FBO	Faith Based Organisation
HTC	HIV Testing and Counselling
HIV	Human Immunodeficiency Virus
HSRC	Human Sciences Research Council (of South Africa)
IDU	Injecting Drug User
IPT	Isoniazid Prophylaxis Therapy
KCTT	Kara Counselling and Training Trust
KYS	Know Your Status
MARP	Most-At-Risk Population
M&E	Monitoring and Evaluation
MS	Member State
MSM	Men who have Sex with Men
NAA	National AIDS Authorities
NAC	National AIDS Council
NDP	Ndola Demonstration Project
NGO	Non Governmental Organisation
OI	Opportunistic Infection
PC	Primary Counsellor
PFP	Project Focal Person
PITC	Provider Initiated Testing and Counselling
PLWHA	People Living with HIV and AIDS
PMTCT	Prevention of Mother to Child Transmission (of HIV)
QA	Quality Assurance
RHT	Routine HIV Testing
RISDP	Regional Indicative Strategic Development Plan
SADC	Southern African Development Community
SAHARA	Social Aspects of HIV/AIDS Research Alliance
STI	Sexually Transmitted Infections
TAC	Technical AIDS Committee
TB	Tuberculosis
UN	United Nations
UNAIDS	United Nations Joint Program on AIDS
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

GLOSSARY OF TERMS

Confidentiality	Right of every person to have their medical information, including HIV status, kept private.
Counselling	A confidential dialogue between a client and a trained counsellor aimed at enabling the client to cope with stress and take personal decisions related to HIV and AIDS. Counselling may be provided by a professional or a lay counsellor.
ELISA	Enzyme-linked Immunosorbent Assay - the test used to identify the presence or absence of HIV antibodies.
Epidemic	A sudden unusual increase in cases that exceeds the number expected on the basis of experience.
Endemic	Usually prevalent; persistent at relatively constant levels.
Concentrated epidemic	An HIV epidemic in a country in which 5% or more of individuals in groups with high-risk behaviour, but less than 5% of women attending urban antenatal clinics, are infected.
Generalised epidemic	An HIV epidemic in a country in which 5% or more of women attending urban antenatal clinics are infected; infection rates among individuals in groups with high-risk behaviour are also likely exceed 5% in Member States with a generalized HIV epidemic.
High risk behaviour	Unprotected sexual intercourse (i.e., without a condom) with many partners, or sharing of unsterilized injecting equipment.
Hyper-endemic	A situation where 15% or more adults aged 15 years and older are living with HIV.
Incidence of HIV	The number of new cases of HIV in a given time period, often expressed as a percentage for a given number of the susceptible population.
Pre-test counselling	Counselling given to an individual before an HIV test, to make sure that the individual has sufficient information to make an informed decision about having an HIV test.
Post-test counselling	The counselling provided when an individual receives his or her HIV test result. Post-test counselling involves one or more sessions.
Policy	Written document that aims at setting out a country's position and practices on HIV/AIDS.
HIV Testing	The obtaining of a bodily sample for the specific purpose of performing one or more medical tests to determine the HIV status of a person.
Trained HIV counsellor	A person trained in HIV counselling skills, preferably on a course which meets the agreed standards.
Window period	The incubation period between infection and detection of HIV antibodies.
Minimum standard	A statement of the lowest acceptable level of performance. In this report, it is the most basic activities that must be provided to a client presenting for an HIV testing and counselling session.

EXECUTIVE SUMMARY

The main aim of this project was to develop regional harmonized minimum standards for policies, protocols and guidelines for HIV testing and counselling (HTC) in the SADC region. This is consistent with Article 10 of the SADC Protocol on Health, which calls for the harmonization of policies on disease prevention and control.

Several approaches were followed in developing these minimum standards. Firstly, an extensive literature review of both published and unpublished literature on HTC in the SADC region and globally was conducted as well as analysis of HTC policies, protocols and guidelines. Secondly, a technical meeting was held in Gaborone from 15-16 December 2008 with HTC experts and implementers from the region. The objective of the meeting was to discuss and share experiences on current national policies and programmes for HTC, and to give guidance on the approach for developing minimum standards. Thirdly, policy discussions were held in 14 SADC Member States with representatives of Ministries of Health and National AIDS authorities, and local and international stakeholders, to gain more understanding on how the programmes work, and to identify major achievements, challenges and best practices. Based on information collected from the Member States, individual HTC reports were developed for each of the Member States. These were subsequently sent back to the Member States for verification.

Based on a review and assessment of current HTC policies, protocols and guidelines in the Member States and global recommendations, the following HTC minimum standards are proposed:

1. **Availability and regulation of HIV testing:** Member States must ensure that HIV testing facilities are available and accessible free of charge to the population. The responsible government department must also ensure that laboratory facilities providing tests such as CD4 count, viral load test and pap smear are available and accessible to all.
2. **Routine offer of testing at health facilities:** Member States must encourage providers to offer testing at all health facilities because of the magnitude of the HIV epidemic in the SADC region, and in order to ensure timely access to prevention, care and treatment.
3. **Age of consent in HIV testing:** Persons aged 12 years and above requesting HTC services are considered able to give full, informed consent.
4. **Standards for service provision:** To offer high-quality HTC services at any site, HTC programmes need to be guided by key principles of consent, confidentiality and counselling.
5. **Capacity building for providers and task shifting:** MS must decide must decide on what cadre of HTC service providers to have at institution and community levels. They must also employ culturally acceptable service providers and must explore the possibility of absorbing lay counsellors into the country's formal health care systems.
6. **Accreditation of HTC sites:** Accreditation must be done by a team of technical experts (including laboratory scientists/technologists, counsellors and administrators). Minimum requirements for accreditation are staff, space, equipment and supplies.
7. **Quality assurance of HTC services:** Strategies for quality counselling must address staff competency, follow-up training, supervision, monitoring of sessions, stress management, exchange visits and formation of a counsellor support network. Quality assurance for HIV testing must include adherence to laboratory protocol, quality control of samples and quality control of testing kits and supplies.
8. **Handling of test results and referrals:** In consultation with the client, appropriate referrals must be made to additional services as needed. These may include medical, social, legal, economical, spiritual and psychological support. Emphasis must be on simple-to-use referral forms and links must be established among the referring units.
9. **Comprehensive HTC approaches**: Comprehensive HTC approaches must be introduced, including stand-alone, mobile/outreach, private sector, periodic campaigns, door to door, integrated services, etc.

10. **Involvement of men and people living with HIV/AIDS:** Men and people living with HIV/AIDS have been acknowledged as an important and missing link in HTC programmes and their involvement will increase uptake. The involvement of men will increase their support for female partners.

1. PROCESS FOR DEVELOPMENT OF SADC HTC MINIMUM STANDARDS

1.1. Rationale

The rationale for this project is to develop regional harmonized minimum standards for policies, protocols and guidelines for HTC in the SADC region. This is in keeping with Article 10 of the SADC protocol on health.

The objective of developing the minimum standards for HTC in SADC is to ensure coherent, comparable, harmonised and standardised approaches to HTC in the region.

The recommendations for minimum standards address the following issues:

- The value-adds for SADC regional standards;
- What is different and specific to the region about the minimum standards;
- How SADC standards are different from the already - available UN standards (to avoid duplication);
- Clearly identified regional best practices that should guide the harmonization; and
- The needs and challenges of implementation of HTC programmes in the region.

1.2. Process for developing regional HTC minimum standards

The following approaches were used in developing regional minimum standards for guidance on HTC.

Firstly, an extensive literature review and analysis of HTC policies, protocols and guidelines, as well as a review of both published and unpublished literature on HTC in the SADC region, were conducted. This was supplemented by a review of global literature.

Secondly, a technical meeting was held in Gaborone from 15-16 December 2008 with HTC experts from the region. The objective of the meeting was to discuss and share experiences on current national policies and programs for HTC, and to give guidance on the approach to this project.

Thirdly, policy discussions were held in 14 SADC Member States (Angola, Botswana, DRC, Lesotho, Malawi, Mauritius, Namibia, Mozambique, Seychelles, South Africa, Swaziland, Tanzania, Zambia, and Zimbabwe) with representatives from Ministries of Health, National AIDS authorities, and local and international stakeholders to gain more understanding on how the programs work, and to identify major achievements, challenges and best practices.

It was not possible at the time of the project to conduct policy discussions in Madagascar for reasons ranging from riots and political instability to difficulty in identifying a project focal person to assist with policy discussions.

Based on information collected from the Member States (MS), individual HTC reports were developed for each. These were subsequently sent back to the MS for verification.

1.3. Guiding principles

The HTC minimum standards are guided by the following principles[1]:

- **Human rights** - promotion, protection and respect for human rights, including women's rights;
- **Gender equity promotion** - integration of 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** - reliance on evidence of what works and on sound local data for designing more effective HTC initiatives;
- **Complementarity** - support and enhancement of national efforts through regional action in harmony with MS priorities and responses;
- **Participatory** - input of all MS, all sectors and all segments of citizenry, particularly members of marginalised groups, is essential for ensuring effective HTC responses;
- **Greater and meaningful involvement of People Living with HIV and AIDS (PLWHA)** - PLWHA involvement in policy development and programme delivery for HTC is imperative;
- **Contextual relevance** - designing regional interventions to fit the social, economic and cultural contexts of the communities targeted, and to be implemented at the level at which they can be most effective;
- **Partnerships** - acting in partnership with regional civil society organizations and institutions, utilising their comparative advantage to facilitate stronger MS responses.

[1] These principles combine the UNAIDS Principles of Effective HIV Prevention with values governing regional action

2. REGIONAL MINIMUM STANDARDS FOR HTC

Regional minimum standards were developed following an assessment of the current HIV counselling and testing policies, guidelines and programmes in SADC and two consultation meetings in 2008 and 2009, involving officials managing the implementation of HTC services in SADC Member States. The recommended minimum standards for HTC are described below.

2.1. Availability and regulation of HIV testing

i) Member States must ensure that HIV testing facilities are available and accessible free of charge to the population. The Ministry of health must also ensure that laboratory facilities providing services such as CD4 count and viral load test are available and accessible to all.

ii) HIV testing must be voluntary, anonymous and confidential.

iii) However, there are circumstances in which mandatory testing could be conducted. In such situations, Member States must develop mandatory testing guidelines for legal and diagnostic purposes. Mandatory testing for the military services are addressed by another regional forum.

iv) No public or private health institution or non-governmental organization may carry out HIV testing unless it is registered with the relevant government institution.

v) All HIV testing centres must comply with national regulations and guidelines related to the conduct of HIV testing and counselling.

vi) No prisoner must be subjected to compulsory HIV testing. The rules relating to informed consent, pre-test information and post-test counselling apply equally to prisoners[2].

2.2. Provider-initiated testing and counselling (PITC) at health facilities

i) An offer of HIV testing by health care providers must be made to all clients being seen at health services.

ii) Explicit mechanisms are necessary in provider-initiated HIV testing to promote referral to post-test counselling services emphasizing prevention, for all those being tested, and to medical and psychosocial support, for those testing positive.

iii) The basic conditions of confidentiality, consent and counselling apply but the standard pre-test counselling used in VCT services is adapted to simply ensure informed consent, without a full education and counselling session for groups of clients who are offered PITC.

[2] SADC Parliamentary Forum (2008) Model law on HIV in southern Africa

iv) The minimum amount of information that clients require in order to be able to provide informed consent is the following:

a. the clinical benefit and the prevention benefits of testing;
b. the window period;
c. the right to refuse;
d. the follow-up services that will be offered

v) For provider-initiated testing, whether for purposes of diagnosis, offer of antiretroviral treatment, prevention of mother-to-child transmission (PMTCT) or encouragement to learn HIV status, patients or clients retain the right to refuse testing, i.e. to 'opt out' of a systematic offer of testing.

Box 1: Recommendations on when to consider HIV testing

- Individuals presenting to a health facility must be offered an HIV test regardless of signs or symptoms of disease or risk factors for infection.
- Pre-test and post-test discussions are necessary and the principles of consent, counselling and confidentiality must be clearly observed during HIV testing.
- In the case of inability to comply with the recommendation to test all individuals presenting to a health facility, after clinical examination and pre-test discussion, priority should be given to most at risk groups such as men who have sex with men (MSM), injecting drug users (IDUs), commercial sex workers (CSWs) and mobile populations.
- HIV testing should not be restricted to newly presented patients only, but all previously HIV negative patients should be offered and encouraged to have HIV testing following possible re-exposure.
- HTC should be encouraged to those people who do not know their HIV status.

2.3. Age of consent for HIV testing

i) People aged 12 years and above requesting HTC are considered able to give full, informed consent.

ii) People under 12 years who are married, pregnant, parents, heads of households, engaged in behaviour that puts them at risk of acquiring HIV or are child sex workers are considered 'mature minors' who can give full, informed consent for HTC.

iii) HIV tests performed on a child under 12 or a mentally incapacitated person must be conducted with the consent of the parents or the legal guardian of the child. When the best interest of the child requires otherwise or if the child is a 'mature minor', the absence of parental or guardian's consent shall not constitute an obstacle to testing and counselling. In the event of a dispute, the relevant court has jurisdiction to decide[3].

[3] SADC Parliamentary Forum (2008) Model law on HIV in southern Africa

Box 2: Recommendations for informed consent

- Testing for HIV at all health facilities must be carried out with informed consent, which includes pre- and post-test counselling.
- In the context of HIV and AIDS, testing with informed consent implies that the individual understands what the test is, why it is necessary and the benefits, risks, alternatives and possible social implications of the outcome.
- Informed consent further implies the giving of express agreement to HIV testing in a situation without coercion, in which the individual should feel equally free to grant or withhold consent. Written consent should be obtained where possible.
- Where a person is unable to consent to an HIV test due to their incapacity or age, another person may consent to the test on their behalf. In such circumstances proxy consent must be given in accordance with common law and legislative provisions.

2.4. Standards for counselling and service provision

To offer high-quality HTC services, Member States need to address the following key issues:

i) Standards for pre-test counselling

Counselling must precede every HIV test. Pre-test counselling must include, at a minimum, information on the following:

- the nature of HIV and of AIDS;
- the nature and purpose of an HIV test;
- the clinical and prevention benefits of testing, and the potential risks, such as discrimination, abandonment or violence;
- the services that are available in the case of either an negative or a positive test result, including whether antiretroviral treatment is available;
- the fact that the test result will be treated confidentially and will not be disclosed;
- the fact that the patient has the right to decline the test;
- the fact that declining an HIV test will not affect the patient's access to services that do not depend upon knowledge of HIV status;
- in the event of an HIV-positive test result, encouragement of disclosure to other persons who may be at risk of exposure to HIV; and
- an opportunity to ask the health care provider questions.

ii) Standards for group pre-test education

The same basic information provided in individual sessions must be offered during the group session, although the individual session does offer an opportunity to discuss more in-depth personal issues.

iii) Standards for post-HIV test counselling

Counselling must be provided after every HIV test. Where the test is positive, the person providing treatment, care or counselling service:

a. must counsel the tested person or in the case of a child under 12 or a mentally incapacitated person, the parents or the legal guardian of that child or that person, on appropriate matters including the:

   - medical consequences of living with HIV and AIDS;
   - modes of prevention and transmission of HIV and other opportunistic infections;
   - importance of disclosing his or her status to his or her spouse or sexual partner(s);
   - medical treatment and social benefits available.

b. must refer the tested person to such centre as may be prescribed for follow-up or treatment.

c. When a patient is referred to another health professional, the patient must be encouraged to inform the attending health professional of their HIV status and whether he/she is on ARV treatment or not.

iv) Post-test counselling for HIV-positive persons

Post-test counselling for people with an HIV-positive test result must focus on psychosocial support to cope with the emotional impact of the test result, and must facilitate access to treatment, care and prevention services, prevention of transmission and disclosure to sexual and injecting partners. Health care providers must:

- Inform the patient of the result simply and clearly, and give the patient time to consider it;
- Ensure that the patient understands the result;
- Allow the patient to ask questions;
- Help the patient to cope with emotions arising from the test result;
- Discuss any immediate concerns and assist the patient to determine who in her/his social network may be available and acceptable to offer immediate support;
- Describe follow-up services that are available in the health facility and in the community, with special attention on the available treatment, PMTCT and care and support services;
- Provide information on how to prevent transmission of HIV, including provision of male and female condoms and guidance on their use;
- Provide information on other relevant preventive health measures such as good nutrition, use of co-trimoxazole and, in malaria-endemic areas, insecticide-treated bed nets;
- Discuss possible disclosure of the result, when and how this may happen and to whom;
- Encourage and offer referral for testing and counselling of partners and children;
- Assess the risk of violence or suicide and discuss possible steps to ensure the physical safety of patients, particularly women; and
- Arrange a specific date and time for follow-up visits or referrals for treatment, care, counselling, support and other services as appropriate (e.g. tuberculosis screening and

treatment, prophylaxis for opportunistic infections, STI treatment, family planning, antenatal care, opioid substitution therapy, and access to sterile needles and syringes)[4].

2.5. HIV testing following occupational exposure to HIV

i) If a health worker has medical accidental exposure to blood or blood products from a patient, preferably both the health worker and patient must be tested for HIV. Even if the patient refuses to be tested for HIV, the health worker should get tested. Post-exposure prophylaxis guidelines must apply. If the health worker tests positive he/she should be put on treatment as per treatment guidelines.

ii) MS must arrange post-test counselling for HIV-negative persons. Counselling for individuals with HIV-negative test results must include the following minimum information:

- An explanation of the test result, including information about the window period for the appearance of HIV-antibodies and a recommendation to re-test in case of a recent exposure;
- Basic advice on methods to prevent HIV transmission;
- Provision of male and female condoms and guidance on their use.

iii) The health care provider must assess whether the patient needs referral to more extensive post-test counselling or additional prevention support, for example, through community-based services.

2.6. Capacity building of service providers

i) MS must decide on what cadre of HTC service providers to have at institution and community levels.

ii) MS must consider culturally acceptable service providers.

iii) MS must explore the possibility of absorbing lay counsellors into the country's formal health care systems.

iv) MS must consider documenting experiences on the use of non-health personnel for HTC.

v) All HTC service providers must be trained by qualified trainers using curricula approved by the Ministry of Health, and must be certified.

2.7. Accreditation of HTC sites

i) Member States must consider accreditation of HTC sites as part of minimum standards for HTC. This should be done by a team of technical experts (including laboratory scientists/technologists, counsellors, and administrators) who visit the HTC services. Minimum requirements for accreditation are staff, space, equipment and supplies.

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[4] WHO, 2007

ii) Member States must develop minimum standards or adapt minimum requirements to accommodate mobile HTC/VCT services

2.8. Quality assurance of HIV counselling and HIV testing

i) MS must ensure that the counselling provided to clients and patients is of high quality at all sites. Strategies to maintain quality counselling must address:

- staff competency;
- follow-up training;
- supervision;
- monitoring sessions;
- counsellor reflection;
- stress management; and
- exchange visits and formation of a counsellor support network.

Quality assurance of HIV counselling must be evaluated through client exit surveys and mystery client surveys.

ii) MS must ensure that all components of quality assurance (QA) for HIV testing are strictly adhered to. These components must include:

- adherence to laboratory protocol;
- quality control of samples;
- internal quality control such as checking the expiry date and integrity of test kits;
- external quality control such as using known positive and negative reference specimens;
- quality control of test kits and supplies; and
- proper calibration of equipment.

Box 4: Recommendations on how to test for HIV

- Capillary blood specimen is preferred for community rapid HIV testing. Venous blood is used in health settings with access to a laboratory.
- In HIV testing, MS must use the most sensitive test as the first screening test and confirm reactive results with a more specific test which preferably uses different method/antigen.
- All HIV testing procedures must be performed to the highest quality standard to ensure consistency and reliability of results.
- ELISA test is used for screening HIV antibodies.
- Western blot (WB) is preferred for final confirmation assay.
- If possible, a second blood sample should be tested for confirmation of HIV infection to exclude mislabelling, misidentification and clinic/laboratory mix-ups.
- The patient can be told after confirmation of the first blood that he/she is HIV infected but final assurances can only be given after a second confirmatory blood.
- There should be active encouragement to destigmatise HIV and there should be a system in place to provide anonymous testing should a patient want it.

iii) HIV self-testing

- Due to the illegal status of HIV self-tests in some SADC Member States and several concerns (accuracy, the inability of people to provide adequate samples for testing, possibility of abuse, lack of pre-test and post-test counselling) the use of HIV self-test cannot be recommended, at present.
- People who want to be tested must be referred to an accredited testing centre or staff, to ensure that pre- and post-testing counselling are conducted.

2.9. Disclosure, handling of HIV test results and referrals

i) The results of an HIV test shall be confidentially and directly communicated to the person concerned.

ii) A person providing treatment, care or counselling services to a person living with HIV may encourage that person to inform his or her sexual partner(s) of his or her HIV status. That person shall, upon request, receive or be referred for psychological, social or legal support to facilitate disclosure.

iii) A person providing treatment, care or counselling services to a person living with HIV may notify a third party of the HIV status of that person only where:

a. the notifying person is requested by the person living with HIV to do so; or
b. all the following circumstances exist:
   - the third party to be notified is at immediate risk of HIV transmission;
   - the person living with HIV, after appropriate counselling, does not personally inform the third party at risk of HIV transmission; and
   - the person providing treatment, care or counselling services has properly and clearly informed the patient that he or she intends to notify the third party under the circumstances; and ensured that the person living with HIV is not at risk of physical violence resulting from the notification; or
c. all the following circumstances exist:
   - the person living with HIV is dead, unconscious or otherwise unable to give consent to the notification; and is unlikely to regain consciousness or the ability to give consent; and
   - in the opinion of the health care provider, there is or was a significant risk of transmission of HIV by the person living with HIV to the sexual partner(s).

iv) In the case of notification provided under (iii) above, the person providing treatment, care or counselling services shall ensure that follow-up services in the form of counselling are provided to those involved, as necessary[5].

v) In consultation with the client, appropriate referrals must be made to additional services as needed. These may include medical, social, legal, economic, spiritual and psychological support. For clients who are HIV positive, post-test support services should include referral to ART, PMTCT, treatment services for TB, STI and other opportunistic infections (OIs). Other post-test support services include:

a. Strengthening or standardizing group education and individual counselling.

[5] SADC Parliamentary Forum (2008) Model law on HIV in southern Africa.

b. Preparation for cotrimoxazole prophylaxis and/or ART.
c. Following up counselling before initiating ART;
d. Nutrition counselling accompanied by therapeutic feeding where necessary.
e. Outreach support, for example home visits and psychosocial support (PSS) groups.

2.10. Comprehensive HTC service delivery for different target groups

i) HTC service delivery must be accessible to different target groups. This can be achieved by providing HTC services through:
- Stand alone sites;
- Mobile or outreach services;
- Private sector; and
- Periodic campaigns such as HIV testing weeks, World AIDS Day, at community gatherings, door-to-door campaigns etc.

ii) Comprehensive interventions must be complemented by periodic HTC campaigns at special occasions such as church or sports gatherings. The comprehensive HTC interventions must be integrated into the activities of public heath institutions.

2.11. Involvement of men and people living with HIV and AIDS (PLWHA)

i) Male involvement

- MS must encourage couples counselling and mutual disclosure. This will benefit adherence, and improve uptake and family-centred care and treatment.
- Male partners who are diagnosed as being HIV-positive must be referred to appropriate treatment and care services.
- MS must promote and support male-friendly models for delivering HIV services and the participation of male partners in interventions involving HIV prevention in general[6].
- HIV testing and counselling is recommended to all men seeking circumcision as an HIV prevention intervention.

ii) Involvement of PLWHA

- MS must emphasize the participation of people living with HIV and AIDS (PLWHA) and communities;
- MS must encourage the participation of people living with HIV in peer support groups; and
- Lay counsellors should provide opportunities to engage male partners, families and communities as a whole in implementing programmes[6].

[6] WHO (2007) Guidance on provider-initiated HIV testing and counselling in health facilities. Geneva: WHO. http://www.who.int/mediacentre/news/releases/2007/pr24/en/index.html , accessed 13 November 2008).

3. IMPLEMENTATION MECHANISMS

The SADC Secretariat, through the HIV and AIDS Unit, will drive the implementation of the *Minimum Standards for Guidance on HTC* in collaboration with the HIV response machinery in Member States – the National AIDS Authorities (NAA), Regional partners and international partners (IP). The success of the implementation of the minimum standards is therefore predicated on the various stakeholders playing their roles.

3.1. Principles for the implementation of the minimum standards

The implementation of the SADC *Minimum Standards for Guidance on HTC* will be aligned to the general principles of the Regional Indicative Strategic Development Plan (RISDP) and the Strategic Framework on HIV and AIDS. Specifically the following will apply:

Value addition – the minimum standards to be spearheaded at the regional level will be limited to those that clearly add value or generate solutions to the regional problem.

Broad participation and consultation – the implementation of the minimum standards must be based on broad participation and consultation to ensure ownership.

Suitability of implementation level – the implementation of the minimum standards will also recognize the need to ensure that HTC programmes and activities are delivered at levels where they can be best handled. To this end, the Secretariat will promote partnership with other regional institutions outside SADC structures to facilitate the implementation of the minimum standards.

Pilot testing – the Secretariat will also give consideration to the implementation of minimum standards within a limited number of Member States in order to draw lessons for replication.

3.2. Institutional Arrangements

The key structures in the implementation of the *Minimum Standards for Guidance on HTC* would include the following:

- The HIV Unit of the SADC Secretariat;
- International cooperating partners;
- Regional NGOs and research institutions;
- The SADC Technical Advisory Committee on HIV and AIDS; and
- National AIDS authorities.

The HIV and AIDS Unit of the SADC Secretariat will play the lead role for the implementation of the *Minimum Standards for Guidance on HTC*. The key activities will be integrated with the annual business plan of the Unit. The Unit will strengthen its capacity to make the strategy more visible by employing a team leader to drive the HTC agenda. In addition, the Unit will facilitate the coordination of various activities among different stakeholders. The Unit will also mobilise resources to ensure that all critical activities are undertaken.

International partners, especially the UN system, will be expected to play a key role in providing technical assistance to drive the implementation of the minimum standards. Other international partners will also play an important role.

Regional NGOs and research institutions will serve a dual role as both implementing partners and in some cases technical advisors. Comparative advantage of the individual institution will be considered in assigning responsibilities.

The SADC Technical Advisory Committee on HIV and AIDS will monitor the implementation of the *Minimum Standards for Guidance on HTC*. The Committee will provide technical guidance, direction and quality control. In addition, it will approve the annual plans and advise on policy matters. The Committee may also establish ad hoc technical committees to assist in fast-tracking and guiding implementation.

National AIDS authorities (NAA) will remain the pillars to ensure the success of the programme and to ensure that regional initiatives are fully integrated into national plans. The NAA will monitor the implementation of programmes at national level and provide the necessary feedback to the SADC Secretariat. In addition, they will identify and document any emerging best practices to fast-track the response.

4. RESOURCES FOR IMPLEMENTATION OF MINIMUM STANDARDS

The *SADC Minimum Standards for Guidance on HTC* will be implemented through support from 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 pooled to support the minimum standards.

5. SYSTEMS FOR MONITORING IMPLEMENTATION

The SADC Secretariat, NAA, civil society organisations, development partners and external experts will monitor implementation of the SADC *Minimum Standards for Guidance on HTC* through periodic reviews.

The annual forum for NAA and the partnership forums will be used to assess progress in implementation. The Technical Advisory Committee will monitor the implementation of the Strategy more closely.

The monitoring and evaluation component of the SADC *Minimum Standards for Guidance on HTC* defines key activities that will be facilitated by the SADC Secretariat to create a conducive environment for the implementation of effective HIV prevention interventions at Member State level. While the SADC Secretariat has control over the implementation of activities at the regional level, these activities will no doubt have down-stream effects at the Member State level. Thus, over and above measuring process and output indicators resulting from implementation of regional minimum standards, it is important to have outcome and impact indicators that will be measured at the country level. The assumption is that effective implementation of the minimum standards will contribute to increased uptake of HIV testing and counselling in the Member States.

The outcome indicators will be integrated into the overall SADC Monitoring and Evaluation Framework. Progress on the implementation of the minimum standards will be documented annually in the SADC Epidemic Response Report.

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APPENDICES

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