African Development Bank

THE DEVELOPMENT OF HARMONIZED MINIMUM STANDARDS FOR GUIDANCE ON HIV TESTING AND COUNSELLING AND PREVENTION OF MOTHER-TO-CHILD TRANSMISSION OF HIV IN THE SADC REGION

HTC COUNTRY REPORT

SOUTH AFRICA

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TABLE OF CONTENTS

ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
AfDB	African Development Bank
ART	Antiretroviral therapy
BCC	Behaviour Change Communication
CICT,CITC	Client Initiated Counselling and Testing
CT, C&T	Counselling and Testing
DHS	Demographic and Health Survey
HTC	HIV Testing and Counselling
HIV	Human Immunodeficiency Virus
HSRC	South African Human Sciences Research Council
MARP	Most-At-Risk Population
M&E	Monitoring and Evaluation
MOH	Ministry of Health
MS	Member State
NAC	National AIDS Council
NGO	Non Governmental Organisation
NSP	National Strategic Plan for HIV&AIDS and STI
PEP	Post-exposure Prophylaxis
PFP	Project Focal Person
PICT, PITC	Provider Initiated Counselling and Testing
PLWHA	People Living with HIV and AIDS
PMTCT	Prevention of Mother to Child Transmission (of HIV)
PSS	Psychosocial Support
SADC	Southern African Development Community
SAHARA	Social Aspects of HIV/AIDS Research Alliance
STI	Sexually Transmitted Infections
SWOT	Strengths, Weaknesses, Opportunities and Threats analysis
TAC	Technical AIDS Committee
TOT	Training of Trainers
TB	Tuberculosis
UN	United Nations
UNAIDS	United Nations Joint Programme on AIDS
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

ACKNOWLEDGEMENTS

This report is based on information and support from many sources. Our thanks to the SADC Secretariat for commissioning this project, and for supporting all its various phases Thanks also to the various partners and South African national authorities and officials who contributed to the design and successful implementation of field work. Our gratitude also to the HTC Project Focal Person for South Africa, Prof Geoff Setswe, for the substantial efforts invested in conducting the field work. This analysis was carried out by Prof. John Seager (Monitoring and Evaluation Expert for the project) and Dr. Njeri Wabiri (Project Director).

1. INTRODUCTION

1.1 HIV/AIDS and HTC in South Africa

According to the South African UNGASS report for 2006-2007[1], the international protocol on HIV testing, including rapid tests is used at South African health facilities. During 2006/2007, 1 610 775 men and women were tested at public health facilities. Approximately 578 000[2] pregnant women were tested in 2007. The majority (90%) attending VCT services receive their results the same day. Post test counselling is offered routinely and clients are offered a confirmatory rapid test where results are positive.

1.2 Aim and Objectives of the Consultancy

The main aim of this consultancy is to develop regional harmonized minimum standards for HTC policies, protocols and guidelines in the SADC region.

To achieve this, project team of the Social Aspects of HIV/AIDS Research Alliance (SAHARA) – see Appendix 1 -- is reviewing and analysing policies, protocols and guidelines for HTC in each SADC member state (MS), in collaboration with the HTC project focal person in the MS.

The specific objectives are to:

- identify and assess policies, procedures and frameworks on HTC, and come up with best practices in implementation of HTC policies;
- conduct field visits to engage in policy dialogue with policy makers and other stakeholders (including discussions of implementation strategies and challenges, opportunities and lessons learnt, gather views of the service users/providers);
- review gender issues and consider how men and women are involved in HTC; and
- review and analyse proposed minimum standards for HTC policies.

2. METHODOLOGY

The HTC project focal person (PFP) in South Africa was tasked with three key responsibilities:

2.1: Identify policies, procedures and frameworks on HTC
2.2: Participate in the assessment of the policies, procedures and frameworks on HTC
2.3: Facilitate dialogues and stakeholder consultations on policies relating to HTC, including policy discussions on the development and implementation of policies, procedures and frameworks on HTC in the country.

A field guide, consisting of relevant tools and instructions for each of the tasks, was provided to the PFP by the SAHARA project team, and included tables for data collection and key questions to guide policy discussions with key HTC stakeholders in the country. The field guide was implemented in Botswana in collaboration with the SADC Secretariat. Lessons learnt were used to enrich fieldwork in the other MSs.

Policy discussions, facilitated by the PFP, were held with various key stakeholders in the country, including:

- government official(s) responsible for HTC policies, protocols and guidelines;
- civil society official(s) dealing with HTC policies, protocols and guidelines;
- representative(s) of international organizations involved in HTC;

[1] Republic of South Africa, 2008. Progress report on declaration of commitment on HIV and AIDS. Reporting period: January 2006-December 2007. Prepared for UNGASS.
[2] *District Health Barometer 2006/07*; Pg.130 http://www.hst.org.za/publications/717 Accessed 23/03/09

- representative(s) of private or informal sector involved in HTC policies, protocols and guidelines; and
- others as appropriate.

The policy discussions were scheduled at the convenience of the respondents, and conducted in the community or at an office where there was an undisturbed atmosphere. The PFP received direction and guidance from the SAHARA project team on how to conduct policy discussions. Selected respondents were invited by letter or email to participate in the discussions, and included officials from the national AIDS council and national AIDS coordination programmes, HTC programme and administrative staff, primary stakeholders (such as technical partners, donors and implementing agencies), and civil society.

3. FINDINGS

3.1 SWOT analysis of HTC in South Africa

An analysis of collected data revealed the following strengths, weaknesses, opportunities and threats regarding HTC programming in South Africa (see details in Appendices 2, 3, 4 and 5)

STRENGTHS	WEAKNESSES
• HTC guidelines prepared 2007 • Recent HTC campaigns used male role models to encourages males to test • Broad consultation (national and international stakeholders)	• Policy still in draft form • Current policy is limited to VCT (no PITC) • Inadequate infrastructure and human resources • Shortage of testers and counsellors • Poor M&E (incomplete and late) • Insufficient post-test support for positives • Limited male involvement • No minimum counselling standards • "Fairly adequate" involvement of PLWHA
OPPORTUNITIES	**THREATS**
• Recent renewed political commitment	• Cultural issues may prevent voluntary testing (for women)

3.2 Assessment of HTC policies in South Africa

- According to respondents, service providers follow the policies, protocols and guidelines where services are provided e.g.:
    - Nurses who are not trained in rapid HIV testing will not conduct the test. Lay counsellors are also trained in counselling and testing techniques.
    - Pre-test and post-test counselling are always done.
    - Confidentiality is maintained in the testing process.
    - Consent is always obtained before the testing is done.

- HIV testing has been adopted as an HIV prevention measure. Key prevention targets of the National Strategic Plan (NSP) for 2008 were to:
    - Expand access to HIV testing to five community and non-health care settings per district
    - Ensure 85% of pregnant women to be tested through provider-initiated testing (95% by 2011)
    - Increase to 35% the number of adults who have ever had an HIV test (with a focus on men)

3.3 HTC policy gaps in South Africa

- The current HIV testing policy is limited to VCT. There is no policy on provider initiated counselling and testing.
- Women don't return for test results for fear of stigma and discrimination from partners and the health care system.

3.4 HTC situation analysis in South Africa

The country has undertaken:

- Development of National HTC guidelines and training manuals
- Development of HTC guidelines and training manuals for counselling children
- Training and use of lay counsellors to provide counselling services
- Media campaigns (National Radio and TV) and national newspapers
- Development of an HTC communication strategy to facilitate roll out.

- The approximate number of delivery points was 4,172, by end of 2006

- HTC is available at hospitals, clinics, stand alone and outreach services.
- The majority of clients are women (±70%) between 20 and 59 years of age
- HIV testing is done on site with results provided to clients on the same day.
- Public clinics are open 6 days a week 08:00-16:00 on weekdays and shorter hours if they operate over weekends.

But the following implementation challenges remain:

- Inadequate infrastructure and human resources
- Shortage of testers and counsellors. Thus, lay counsellors and nursing assistants need to be allowed to test if we are to increase coverage. There is a proposal to request the SA Nursing Council to relax the scope of practice to allow enrolled nurses and assistant nurses to do counselling and testing.
- Inadequate space for confidential counselling and for on-site rapid HIV testing within clinic setting
- Monitoring and Evaluation unsatisfactory
    - Incomplete reporting & untimely submission of reports
- Failure to report by H/Ws due to competing priorities
- Resistance to change or new approaches by health workers
- Lack of incentives for added workload
- Overburdening patients with HIV test result
- Inadequate psycho-social support structures
- Availability of adequate care, treatment and support services
- Limitation for some women to make independent decisions without consulting spouse or relative
- Limited follow up care and support for those with positive HIV test
- Limited meaningful male involvement

3.5 HTC approaches South Africa

- The predominant HIV testing model is VCT
- There is no policy on provider initiated testing at health services although some services have started implementing it.
- Focus is on good group education at health institutions – for outpatients, ANC, TB etc.
- One-on-one is used for patients who come in after the group education.
- Couple counselling and partner counselling is done where applicable

3.6 HTC policy discussion: Success, Challenges, Best practice views of stakeholders

A summary report on the policy discussions is provided in Appendix 6

- A public media campaign is being organized by the SANAC Communication Technical Task Team. This involves promotions on special calendar days, e.g. Valentine's Day, mothers' and fathers' day etc.
- Counselling and testing initiatives should reach more men at workplaces and in public health services.
- HTC campaigns e.g. (HIV testing week – used role models and sports personalities in 2008 to encourage men to get tested)

4. RECOMMENDATIONS FOR MINIMUM STANDARDS

Further details are provided in Appendix 6

a) Age of Consent in testing

a. Usually anyone 12 or older can give consent to test for HIV or other STIs.

b) Standards for service provision

- Protection of human rights and the importance of counselling
    - Standards for counselling and related care services should be determined and monitored for quality and consistent service
    - Minimum standards for counselling are necessary;
    - Standards for counselling need to be flexible to allow counsellors to modify the time and information provided according to the assessment of a person's needs
    - Counselling must be done in a manner that encourages, instead of discouraging, HIV testing.

- HIV rapid testing staff and counsellors need to be readily available, to reduce waiting time for clients
- Regular support and supervisory visits by Lab scientist to trained non lab staff, e.g. nurses or lay counsellors
- Resources including consumables, e.g. gloves, bins etc. to be readily available, not just test kits
- Selection of HIV Testing algorithms (Parallel or serial)
- Staff motivation and stress management programmes (Caring for the carer)

- Counselling and testing sites should meet standards for privacy and confidentiality
    - There should be adequate space for HIV testing
    - Professional staff to be available (with adequate support from management)
    - Registers and stationery to be available; train staff to compile data and analyze it and submit to next level

c) Training of providers

- Standardize training at all levels (for health professionals and non health professionals). Propose standard training duration for the two groups.
- Include practicals for both counselling and Rapid HIV testing training
- Attachment to laboratory scientist or regular support and supervision, especially for non medical staff

- Support and supervision for counsellors
- Use of videos and role plays for training
- Non medical staff should be trained on rapid HIV testing to have a longer period for training and include microbiology
- Pre- and post-course assessments to be standard and by target group.
- Use variety of trained, experienced facilitators
- Payment of registration and renewal fees for rapid HIV testing to be the government responsibility and not the service provider.
- Periodic refresher courses

d) Accreditation of HTC sites

- Accreditation forms have been designed by the Department of Health to accredit ARV and VCT sites.
- Team of technical experts to visit HTC sites (includes lab scientist, counsellor and administrator)
- Based on standards of service provision (e.g. adequate space, trained staff and resources)

e) Quality assurance of HTC services

Counselling QA

- Mystery client surveys to assess different cadres' roles and responsibility: e.g. Counsellors, Receptionist Ancillary staff, etc.
- Client and provider satisfaction surveys (staff support assessment and client exit interview surveys)
- Staff motivation and stress management

Rapid HIV Testing

- Regular support and supervision by trained laboratory scientists
- Internal and external quality assurance
- Workplace wellness and provider safety assurance (PEP availability including follow up care and support)

f) Monitoring and evaluation of HTC policies

- Good reporting form
- Effective data submission mechanism
- Computers from institution to national level
- Feedback provided through different methods

g) Comprehensive HTC approaches

- Integrated into heath institutions
- Stand alone
- Mobile/ Outreach
- Private sector
- Periodic Campaigns e.g. at church gatherings, door-to-door etc

h) Referral system

- Strengthen and standardize referral system. e.g. Basic 1 (Group education), Basic 2 (Individual counselling), Preparation for Cotrimoxazole prophylaxis / ART.
- Follow up counselling before initiating ART

- Nutrition counselling accompanied with therapeutic feeding where necessary.

APPENDICES

APPENDIX 1: SAHARA PROJECT TEAM

NAME	TITLE
Dr. Vincent Agu	Team Leader
Prof. Karl Peltzer	PMTCT Expert
Prof. John Seager	Monitoring and Evaluation Expert
Prof. Geoffrey Setswe	HTC Expert
Dr. Njeri Wabiri	Project Director
Ms. Mercy Banyini	Researcher

APPENDIX 2: ASSESSMENT OF HTC POLICIES, PROTOCOLS AND GUIDELINES

	Yes, No, N/A and Additional comments
Is HTC policy available?	Yes in draft form
Has HTC policy been approved? Indicate year	Draft since 2007
Are there HTC guidelines? (indicate the year of the operational guidelines)	Draft since 2007
When were the guidelines published?	
Please list the stakeholders involved in the consultation process for developing HTC policy?	Department of Health Society for Family Health Centers for Disease Control Right to Care AIDS Consortium Treatment Action Campaign
Are policies/guidelines easily available?	Yes. The draft guideline is available
Is there an HTC implementation plan?	Yes.
Which CT methods/approaches are used?	- integrated into family planning (FP), PMTCT, sexually transmitted infection (STI) and TB services in public clinics or hospitals. - NGO providers in their own facilities, alongside other community services - free-standing sites, strategically located and managed by an NGO - private commercial enterprises such as mines, farms, and factories
Which types of staff do the counselling?	Doctors, nurses, professional counsellors such as psychologists and social workers and lay counsellors
Other relevant documents	

APPENDIX 3: HTC INDICATORS

Please provide the extent of the following HTC indicators in your country (in numbers or Percentage, specify the year and the source of information

Indicator	
HIV testing and counselling	25% of men have ever been tested for HIV at public health services. This increased to 52% at Society for Family Health
Retesting at a later stage	
HIV pre-test counselling	
Post-HIV test counselling	
Male involvement in HTC	Very poor involvement. Male role models were used in the 2008 HIV testing week
Involvement of PLWHA	Fairly adequate

APPENDIX 4: SUMMARY OF HTC IMPLEMENTATION CHALLENGES IN SOUTH AFRICA

Implementation Challenges	Yes, No, N/A Additional comments
Inadequate financial resources, which are often narrowly earmarked by donors	Y
Inadequate human resources; problems with lay counsellors	
Poor partner and sectoral coordination and donor support resulting in verticalisation of programmes and poor implementation of national policies	Y
Stigma and discrimination	Y
Inadequate support for infant feeding which remains a complex issue, requiring further research	
Unequal emphasis on the needs of women, their children, partners and families, and insufficient follow up within a continuum of care and assurance of adequate care, treatment and diagnosis of exposed infants	
Insufficient integration of HTC services and insufficient linkages with other health and social services;	
The need to decentralize implementation and service delivery, and focus on developing and strengthening of community structures and systems to include HTC;	Y
Programme monitoring, recording and reporting	Y
Quality assurance and impact assessment;	Y
Inadequate efforts to ensure male engagement in HTC;	Y
Impact of gender inequality and of gender-based violence	Y
Lack of capacity to cost plans	Y
Slow scale-up of provider-initiated testing and counselling services, where appropriate, and the limited creation of demand for these services.	Y
Other: Please include other challenges not covered above	

APPENDIX 5: HTC IMPLEMENTATION NEEDS IN SOUTH AFRICA

Implementation Needs	Yes, No, N/A Additional comments
Need to speed up development of HTC policies and guidelines	Y
Need to improve M & E (HTC indicators, registers)	Y
Need to improve C & T (quality)	Y
Appropriate use of lay counsellors in the health care setting	
Improve integration of HTC into AIDS treatment and care activities	
Effective communication on HTC	Y
Improve community support for HTC	Y
Strengthen quality assurance for HTC services	Y
Best practice/models in HTC	
Other: Please include any other needs not captured in the table	

APPENDIX 6: SUMMARY OF DIFFERENT POLICY DISCUSSIONS

Date (day, month, year): 5 February 2009
Name of country: South Africa

Participants/Stakeholders

Participants /Stakeholders:

Representatives of the following organizations: Department of Health, AIDS Consortium, Society for Family Health, Right to Care, South African Medical Association (SAMA).

DISCUSSION QUESTIONS

Please tell me about the Country's HTC programme, what have been its great achievements or strengths, and where you think it could be improved?"

- Development of National HTC guidelines and training manuals
- Development of HTC guidelines and training manuals for counselling children
- Training and use of lay counsellors to provide counselling services
- Media campaigns (National Radio and TV) and national newspapers
- HTC strategy to facilitate roll out.

What are the gaps in HTC policies? Give examples.

- The current HIV testing policy is limited to VCT. There is no policy on provider initiated counselling and testing.
- Women don't return for test results for fear of stigma and discrimination from partners and the health care system.

What are the HTC implementation challenges?

- Inadequate infrastructure and human resources
- Inadequate space for confidential counselling and for on-site rapid HIV testing within clinic setting
- Monitoring and Evaluation
- Incomplete reporting & untimely submission of reports
- Failure to report by H/Ws due to competing priorities
- Resistance to change to new approaches by health workers
- Lack of incentives for added workload
- Overburdening patients with HIV test result, Inadequate psycho-social support structures
- Availability of adequate care, treatment and support services
- Failure by some women to make independent decisions without consulting spouse or relative
- Limited follow up care and support for those with positive HIV test results who may require these services
- Limited meaningful male involvement

Describe the characteristics of HTC service users?

Which groups of people does the CT service mainly target? What is the age and gender of the clients who used your counselling and testing services during the past year?

- 20 – 59 years age group.
- ±70% women

HIV Counselling & Testing (CT) Services

Is HIV testing done on site? If YES, is rapid HIV testing available with clients being given their HIV test result on the day of testing? If NO, how long do clients have to wait for a HIV test result? _5_ days

- HIV testing is done on site with results provided to clients on the same day.
- The only challenge is shortage of testers and counsellors. Thus lay counsellors and nursing assistants need to be allowed to test if we need to increase coverage.

Are you familiar with the CT methods/approaches used in the country?

Do you use traditional one-one-one HTC, or is CT is part of a prevention of mother-to-child transmission (PMTCT) programme, Provider-initiated CT, Group counselling (pre-test), Couples counselling, Family counselling, Partner counselling (partners of HIV-positive people), Home-based CT or any other method of CT?

- The predominant HIV testing model is VCT
- There is no policy on provider initiated testing at health services although some services have started implementing it.
- Focus is on good group education at health institutions – for OPD patients, ANC, TB etc.
- One on one is used for patients who come in after the group education.
- Couple counselling and partner counselling is done where applicable

Which types of staff do the counselling?

Is it Health workers, professional counsellors (registered with the Health Professions Council of South Africa -HPCSA) or Lay counsellors.

- Trained health workers and lay counsellors do the counselling in health services
- There is a proposal to request the SA Nursing Council to relax the scope of practice to allow enrolled nurses and assistant nurses to do counselling and testing

Do you know of HTC policies in this country?

How closely do the HTC policies, protocols and guidelines match practice?

- Service providers do follow the policies, protocols and guidelines where services are provided e.g.:
    - Nurses who are not trained in rapid HIV testing will not conduct the test. Lay counsellors are also trained in counselling and testing techniques.
    - Pretest and post-test counselling are always done.
    - Confidentiality is maintained in the testing process.
    - Consent is always obtained before the testing is done.

- HIV testing has been adopted as an HIV prevention measure. Key prevention targets of the National Strategic Plan (NSP) for 2008 are to:
    - Expand access to HIV testing to five community and non-health care settings per district
    - Ensure 85% of pregnant women to be tested through provider-initiated testing (95% by 2011)
    - Increase to 35% the number of adults who have ever had an HIV test (with a focus on men)

Where are HIV Counselling & Testing (CT) services provided in this country?

Is it nationally (all provinces), provincially (services spread throughout one or more provinces in the country), district (services spread throughout a health district or a municipality) or local (services spread over an area smaller than a health district or municipality)?

- National roll out of HTC at the moment. In all the institutions with trained staff.

Service Load

How many HIV counselling and testing CT service delivery points?
4,172 VCT points by November 2006.

How many HIV counselling sessions were conducted (across all service delivery points combined) in the past year?

How many HIV tests were done (across all CT service delivery points combined) in the past year?
+/- 578,000[3] among pregnant women in 2007

Hours of Operation of HIV Counselling & Testing (CT) Services

How many days per week are counselling and testing services available at service delivery points in this country?

- 6 days per week (Monday to Saturday) in most clinics and 7 days in institutions which are open Sundays.
- Public health service points operate from 08:00 to about 16:00 on weekdays and shorter hours if they operate over weekends.

What are the service delivery points for providing HIV Counselling & Testing (CT) in this country?

Is it HTC clinics, hospitals, community health centres, clinics, (stand-alone) counselling and testing facilities or other fixed HTC service points? What is the approximate number of service delivery points in urban/rural areas?

- Hospitals, Clinics, Stand alone, Outreach services
- Approximate number of delivery points = 4,172 by end of 2006

3 *District Health Barometer 2006/07*; Pg.130

What are the strategies to promote HTC uptake in the country?

- Communication strategy to increase access to and uptake of HTC is in the process of development
- A public media campaign is being organized by the SANAC Communication Technical Task Team. Promotions on special calendar days e.g. Valentine's Day, mothers' and fathers' day etc.
- Counselling and testing initiatives should reach more men at workplaces and in public health services. Importance of counselling:
    - Standards for counselling and related care services should be determined and monitored for quality and consistent service
    - Minimum standards for counselling are necessary;
    - Standards for counselling need to be flexible to allow counsellors to modify the time and information provided according to the assessment of a person's needs
    - Counselling must be done in a manner that encourages, instead of discouraging, HIV testing.
- HTC campaigns e.g. (HIV testing week – used role models and sports personalities in 2008 to encourage men to get tested)

In your view what issues should proposed minimum standards for HTC in SADC critically consider under each of the following themes?

i) Age of Consent in testing

a. Usually anyone 12 or older can give consent to test for HIV or other STIs.

j) Standards for service provision

- Protection of human rights and the importance of counselling
    - Standards for counselling and related care services should be determined and monitored for quality and consistent service
    - Minimum standards for counselling are necessary;
    - Standards for counselling need to be flexible to allow counsellors to modify the time and information provided according to the assessment of a person's needs
    - Counselling must be done in a manner that encourages, instead of discouraging, HIV testing.

- HIV rapid testing staff to be readily available, same as counsellors to reduce turn around/ waiting time for clients
    - Regular support and supervisory visits by Lab scientist to trained non lab staff e.g. nurses or lay counsellors
    - Resources including consumables e.g. gloves, bins etc to be readily available, not just test kits
    - Selection of HIV Testing algorithms (Parallel or serial)
    - Staff motivation and stress management programmes (Caring for the carer)

- Counselling and testing sites should meet standards for privacy and confidentiality
    - There should be adequate space for HIV testing
    - Professional staff to be available (with adequate support from management)
    - Registers and stationery to be available and train staff to compile data and analyze then submit to next levels

k) Training of providers

- Standardize training at all levels (for health professionals and non health professionals). Propose standard training duration for the two groups.
- Include practicals for both counselling and Rapid HIV testing training
- Attachment to laboratory scientist or regular support and supervision especially for non medical staff
- Support and supervision for counsellors
- Use of videos and role plays for training
- Non medical staff should be trained on rapid HIV testing to have a longer period for training and include microbiology.
- Pre and post course assessments to be standard and by target group.
- Use variety of trained, experienced facilitators
- Payment of registration and renewal fees for rapid HIV testing to be the government responsibility and not the service provider.
- Periodic refresher courses

l) Accreditation of HTC sites

- Accreditation forms have been designed by the Department of Health to accredit ARV and VCT sites.
- Team of technical experts to visit HTC sites (includes lab scientist, counsellor and administrator)
- Based on standards of service provision (e.g. adequate space, trained staff and resources)

m) Quality assurance of HTC services

Counselling QA

- Mystery client surveys to assess different cadres roles and responsibility: Counsellors, Receptionist Ancillary staff, etc)
- Client and provider satisfaction surveys (Staff support assessment and client Exit interview surveys)
- Staff motivation and stress management

Rapid HIV Testing

- Regular support and supervision by trained laboratory scientists
- Internal and external quality assurance
- Workplace wellness and provider safety assurance (PEP availability including follow up care and support)

n) Monitoring and evaluation of HTC policies

- Good reporting form
- Effective data submission mechanism
- Computers from institution to national level
- Feedback provided through different methods

o) Comprehensive HTC approaches

- Integrated into heath institutions
- Stand alone
- Mobile/ Outreach
- Private sector

- Periodic Campaigns e.g. at church gatherings, Door to door etc

p) Referral system

- Strengthen/ standardize e.g. Basic 1 (Group education, Basic 2 (Individual counselling) Preparation for Cotrimoxazole prophylaxis / ART.
- Follow up counselling before initiating ART
- Nutrition counselling accompanied with therapeutic feeding where necessary.
- Outreach support – home visits, support groups.