GUIDANCE NOTE ON

STRENGTHENING THE HCT UPTAKE

IN THE SOUTH AFRICAN MINING INDUSTRY

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MINE HEALTH AND SAFETY INSPECTORATE

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DEPARTMENT OF MINERAL RESOURCES

MINE HEALTH AND SAFETY INSPECTORATE

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STENGTHENING THE HCT (COUNSELLING AND TESTING) UPTAKE IN THE SOUTH AFRICAN MINING INDUSTRY

CHIEF INSPECTOR OF MINES

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PART A: THE GUIDANCE NOTE

1. FOREWORD

1.1. The guidance note on the strengthening of **HCT** has been developed to provide a framework in promoting and implementing the **HCT** uptake.

1.2. The mining industry **MITHAC** established a task team to facilitate the development of the guidance note on strengthening the **HCT** uptake.

1.3. This guidance note has been developed based on the **HATOLD** policy, South African mining industry strategy on reducing TB and **HIV**, and **HIV** self-screening guidance note, amongst others.

1.4. The guidance note will be reviewed based on emerging developments pertaining to **HCT** programmes.

2. STATUS OF THE GUIDANCE NOTE

2.1. The guidance note has been compiled specifically with the view to provide guidance to the relevant stakeholders regarding their roles and responsibilities with regard to strengthening the **HCT** uptake in the South African mining industry.

2.2. The guidance note sets out good practice and must be read and interpreted within the existing legal framework on South African Constitution, 1996 (Act 108 of 1996), the Employment Equity Act and other relevant legislation.

2.3. The guidance note presents an opportunity for the South African mining industry to strengthen the employee **HCT** uptake through legally acceptable workplace initiatives.

3. THE OBJECTIVES OF THE GUIDANCE NOTE

The objectives of this guidance note are to:

3.1. Assist the South African mining industry in achieving the first 90% of the UNAIDS 90/90/90 strategy by strengthening the **HCT** uptake;

3.2. Assist the South African mining industry in having a holistic approach on strengthening the **HCT** uptake through multiple interventions;

3.3. Reach the first and second 90 of the 90:90:90 strategy through targeted testing and linkage to care in line with the **WHO** test and treat policy;

3.4. Provide an enabling environment to increase health seeking behaviour by strengthening and implementing linkages to care, treatment and support;

3.5. Strengthen **HIV** Prevention interventions aligned to **NSP** 2017-2022 Goal 1;

3.6. Promote the reduction of the number of medical incapacity/deaths linked to complications of **HIV**; and

3.7. Promote leadership and shared accountability for a sustainable response to **HIV**.

4. DEFINITIONS AND ACRONYMS

4.1. **"Counselling"** means an interpersonal, dynamic communication process between a client and a trained counsellor (who is bound by a code of ethics and practice) that tries to resolve personal, social or psychological problems and difficulties. In the context of an **HIV** diagnosis, counselling aims to encourage the client to explore important personal issues, identify ways of coping with anxiety and stress, and plan for the future (such as keeping healthy, adhering to treatment and preventing transmission). When counselling in the context of a negative **HIV** test result, the focus is exploring the client's motivation, options and skills to stay **HIV**-negative.

4.2. **"CITC"** means client-initiated testing and counselling.

4.3. **"DMR"** means Department of Mineral Resources.

4.4. **"DoH"** means the Department of Health.

4.5. **"HATOLD"** means **HIV**/AIDS, TB and occupational lung diseases.

4.6. **"HCT"** means **HIV** counselling and testing.

4.7. **"HIV"** means Human Immunodeficiency Virus.

4.8. **"HTS"** means **HIV** testing and services.

4.9. **"IPT"** means isoniazid preventive therapy.

4.10. **"MITHAC"** means TB and **HIV** advisory committee

4.11. **"NSP"** means National Strategic Plan.

4.12. **"PICT"** means provider-initiated testing and counselling.

4.13. **"SADC"** means Southern African Development Community.

4.14. **"WHO"** means World Health Organisation.

5. MEMBERS OF THE TASK TEAM

This guidance note was prepared by members of the task team, which comprised of:

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6. BACKGROUND

With respect to **HIV**, South Africa aims to achieve the adopted 90-90-90 targets which provide that by 2020:

- 90% of all people living with **HIV** will know their **HIV** status;
- 90% of all people with diagnosed **HIV** infection will receive sustained antiretroviral therapy (ART), and
- 90% of all people receiving ART will be virally suppressed.

According to the **WHO** more than 19% of adults in South Africa are living with **HIV**. The **HIV** burden varies widely by geography, age and gender and for key and vulnerable populations. Key and vulnerable populations including mine workers remain most heavily affected by the epidemic.

7. CURRENT SITUATION

The **DMR** Annual Report for the year 2017/2018 indicated that of the 329 562 South African mining industry employees counselled for **HIV**, 62.5% opted to get tested. Despite the implementation of **DMR** 164 TB and **HIV** reporting form, **IPT** policy, and **HATOLD** policy, there is still a need for the South African mining industry to strengthen **HCT** uptake in order to achieve the 90-90-90 strategy by 2020.

7.1. Identified gaps and challenges

The following gaps and challenges have been identified as causes to the South African mining industry not being able to close the testing gap.

7.1.1. Offering (promotion)

a) Non-allocation of budget for **HIV** programmes by employers.

b) Lack of engagement of key stakeholders, which results in lack of capacitation and participation.

c) Lack of on-site facilities offering **HCT**.

d) Lack of well spread wellness programme throughout the year - World AIDS Day (WAD) commemoration being held once a year with incentive driven participation.

e) Inadequate **HIV** content during induction programmes.

f) Lack of interventions targeting office personnel.

g) Insufficient number of **HIV** and TB peer educators.

7.1.2. Counselling

a) Inadequate counselling skills for training and capacitation.

b) Non-conducive environment for privacy and confidentiality.

7.1.3. Testing

a) Limited testing methods.

b) Fear of testing due to fear of job loss.

7.1.4. Treatment

a) Inadequate provision of **HIV** treatment by employer.

b) Non-satisfactory implementation of **IPT** Guideline.

c) Lack of harmonised **HIV** treatment across the **SADC**.

d) Stigma and discrimination leading to non-compliance and defaulting on treatment.

e) Inadequate implementation of the Universal Test and Treat Policy.

f) Non-availability of a tracking system of those who tested **HIV** positive using outsourced services.

8. ASPECTS TO BE ADDRESSED IN THE GUIDANCE NOTE

The **HCT** programme should cover the following:

8.1. Policy issues related to **HIV**

a) Implementation of the **HATOLD** policy.

b) Implementation of the **WHO** test and treat policy.

c) Implementation of **HTS** policy - optimise **PICT** and **CITC**.

8.2. Resource allocation

a) Budgeting for **HIV** programmes.

b) Human resource, training and upskilling.

c) Promoting quality standards in recording, reporting and tracking patient transfer between facilities and services.

d) Introduction of new innovative testing methods (i.e. **HIV** Self-screening).

8.3. Governance and ownership

a) Advocacy, education, communication and social mobilisation for the **HIV** programmes.

b) Inclusion of adequate **HIV** content on induction programmes.

8.4. Leadership and shared accountability

a) Diverse leadership and accountability in strengthening of **HCT** uptake.

b) Sustainable programme - well spread wellness programme throughout the year.

c) Participation and engagement of all relevant stakeholders through tripartism.

8.5. Stakeholder buy-in

a) Engagement of key stakeholders to ensure full participation (multi-sectoral approach).

9. MONITORING, EVALUATION AND REPORTING

9.1. Periodical monitoring of number of employees:

a) Offered **HCT**.

b) Counselled.

c) Tested.

d) Linked to treatment.

e) Encourage those who opted out to explore other available options.

9.2. Regular audits of the **HCT** Programme:

a) Internal auditing (by the employer).

b) Conducted by the Regulator (**DMR**) and State (**DoH**).

c) External auditing by the Council (every five years).

9.3. The data needs to be collected and collated in a manner that will inform the data that goes into the **DMR** 164 **HIV** and TB reporting form and assist with other reporting requirements.

9.3.1. Applicability of the indicator for the first 90 (90% of people living with **HIV** knowing their status) to apply it as 90% of the mining workforce knowing their **HIV** status.

9.3.2. The use of a unique identifier is recommended to eliminate duplication e.g. a person counselled and tested more than once should be counted once within a reporting period.

9.3.3. Companies to explore opportunities of adopting the TIER.net combined TB and **HIV** module.

9.4. Mining employers are encouraged to keep data at mine level to demonstrate the impact of the **HIV** uptake in relation to closing the testing gap.

10. REFERENCES

a. **DMR** 164 reporting on **HIV** and TB.

b. Draft concept paper on **HIV** (**HTS**) health screening campaign and TB index tracing.

c. Guidance note for the implementation of **HIV** self-testing in the South African mining industry.

d. Southern African **HIV** Clinicians Society: Guideline for South African **HIV** self-testing policy and guidance considerations.

e. South Africa's **NSP** for **HIV**, TB and STIs 2017-2022.

f. **WHO** test and treat policy.