



Republic of Botswana

# NATIONAL GUIDELINES

## HIV TESTING AND COUNSELLING

MINISTRY OF HEALTH  
BOTSWANA

# 2009





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## Foreword

Botswana is experiencing one of the most severe and devastating HIV epidemics in the world. This epidemic has slowed economic development and reversed years of gains in health and social welfare. HIV testing and counselling is one of the most important services in HIV prevention and care strategies, as people are better equipped to make informed decisions when they know their HIV status. It also serves as an entry point for accessing treatment, care and support services.

The HIV prevention strategy reduces infection rates between mothers and their unborn babies and in young couples who intend to marry. More importantly, people living with or affected by HIV and AIDS need to be cared for and supported in an open society where there is no stigmatization and discrimination.

These guidelines on HIV testing and counselling will help define the legislative framework for the management and control of sexually transmitted infections (STIs), HIV and AIDS in Botswana. They will create a conducive environment for all stakeholders to engage in the national response. Employers and other members of the society will be encouraged to have a positive attitude towards HIV-infected people, emphasizing the need to ensure that they lead a high quality, productive life.

The Government of Botswana is committed to ensuring that this policy document is translated into action for the benefit of all Botswana. Civil society, the private sector and institutions of learning all have a role to play. It is expected that the participatory nature of the policy document will foster a spirit of ownership among stakeholders to ensure success. It is therefore my sincere hope that we all adhere to the provision of high quality client-initiated and provider-initiated HIV testing and counselling services in both the private and public sectors in Botswana.

May I take this opportunity to express the gratitude of the Ministry of Health to all individuals and institutions listed in the acknowledgement for the selfless work they put into producing these guidelines.



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Special appreciation goes to Dr Buhle Ncube (VCT Technical Officer - WHO AFRO) for her valuable technical guidance to the working team, patience and perseverance during this process; to Kgoreletso Molosiwa, (WHO Office – Botswana) and Mary Grace Alwano (BOTUSA Counselling Technical Advisor) for always being there for the team.

Finally, appreciation goes to the editorial team and all those who contributed in many ways, especially in reviewing the document and giving valuable comments towards the finalization of these guidelines.



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## Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ACHAP	African Comprehensive HIV/AIDS Partnerships
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARVs	Antiretroviral Drugs
BONELA	Botswana Network of Ethics, Law and HIV/AIDS
BOTUSA	Botswana/United States of America Partnership
CBOs	Community Based Organizations
CDC	Centers for Disease Control and Prevention
DBS	Dry Blood Spot
DHT	District Health Team
DMSAC	District Multisectoral AIDS Committee
DNA	Deoxyribonucleic acid
ELISA	Enzyme-Linked Immunosorbent Assay
FBOs	Faith-Based Organizations
HIV	Human Immune Deficiency Virus
HTC	HIV Testing and Counselling
IDM	Institute of Development Management
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illnesses
MOH	Ministry of Health
NACA	National AIDS Coordinating Agency
NGO	Non-Governmental Organization
OPD	Outpatient Department
PCR	Polymerase Chain Reaction
PEP	Post-Exposure Prophylaxis
PLWH	People Living with HIV
PMTCT	Prevention of Mother-To-Child Transmission of HIV
RHT	Routine HIV testing
RNA	Ribonucleic Acid
SDP	Service Delivery Point
SOPs	Standard Operational Procedures
STI(s)	Sexually Transmitted Infection(s)
TB	Tuberculosis
VCT	Voluntary Counselling and Testing
WHO AFRO	World Health Organization Regional Office for Africa
WHO	World Health Organization

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## Chapter 1: Introduction

### Background

Botswana is one of the countries with the highest HIV prevalence rates in Sub-Saharan Africa, with the first case of AIDS reported in 1985. Although the estimated HIV prevalence in the general population is 17.1%, it is as high as 25% among the sexually active population and an estimated 270,000 adults and children are living with HIV(1). In 2007, HIV prevalence among pregnant women was 33.7%, having declined from 37.4% in 2003 especially among young women aged 15 to 24 years (2). In February 2008 the number of orphans in the country was estimated at 137,805 with the majority being due to HIV and AIDS(3).

The Government of Botswana has demonstrated a high level of commitment to fighting the HIV epidemic. Botswana has been a pioneer in Africa in a number of programmes aimed at addressing the HIV epidemic in the country. These include the national Prevention of Mother to Child Transmission of HIV (PMTCT) programme, the *Masa* (Setswana for “dawn”) Antiretroviral Therapy programme and the Routine HIV Testing (RHT) programme.

### Evolution of HIV Testing and Counselling in Botswana

The HIV Testing and Counselling programme was established in 1989 as a component of the National AIDS Control Programme. Its emphasis is on HIV prevention and psychosocial support. The programme aims to meet the emotional, psychological, social and spiritual needs of HIV affected and infected individuals and families. Prior to the establishment of the programme, the Botswana Red Cross Society provided Voluntary Counselling and Testing (VCT) services at the Blood Donation Centre in Gaborone. On average, about 100 clients were counseled and tested every month. By then the services could not be expanded to other towns and villages due to limited human resource capacity. VCT was also provided to a limited extent in hospitals and clinics.

In 2000, the Government of Botswana and the United States Government established the Tebelopele VCT programme which was scaled up to a network of 16 centers nationwide. In order to increase access to HIV testing and counselling and maximize prevention and treatment opportunities, Botswana introduced Routine HIV Testing (RHT) in clinical settings in January 2004. Routine HIV Testing was implemented in health facilities so that HIV positive patients could be identified early and those needing treatment could access it promptly. Lay counselors were hired and trained to scale up HIV testing and counselling services, initially in the PMTCT programme and later to cover programmes such as Community Home Based Care and *Masa* antiretroviral therapy programmes. The RHT initiative complemented the VCT programme. It is now estimated that the proportion of Botswana who know their HIV status stood at 53.2% at the end of December 2007(4).



## Rationale for HIV Testing and Counselling guidelines

Despite the availability of HIV Testing and Counselling services through a network of public and private health facilities and non-governmental organization (NGO) sites, Botswana does not have comprehensive national guidelines for HIV testing and counselling which encompass both VCT and RHT. The Ministry of Health issued guidelines for RHT service provision in clinical settings in October 2003.

In view of the above situation, in 2007, the Ministry of Health decided to develop comprehensive guidelines which would incorporate lessons learnt to date in the country and international guidance for provider-initiated and client-initiated HIV testing and counselling. This document endorses both RHT which is Provider-Initiated Testing and Counselling (PITC) mostly practiced in health facilities, and VCT which is Client-Initiated HIV Testing and Counselling mostly provided in community-based settings. The guidance provided in this document will assist in standardizing HIV testing and counselling service provision. The document is intended for policy makers, HIV and AIDS programme managers and health care providers in the public, private and civil society settings.

These guidelines provide national standards that must be adhered to by all organizations and individuals for the provision of high quality HIV testing and counselling services in Botswana.

## Chapter 2: Ethical and Legal Considerations

### 2.1 HIV Testing and Counselling (HTC) and human rights

The guiding principle in the provision of HIV Testing and Counselling (HTC) services in Botswana is that it is every Motswana's right to know his or her HIV status. HIV Testing and Counselling services should be provided in an environment where human rights are respected. This reduces vulnerability for people living with HIV (PLWH) and those who are affected.

The human rights principles most relevant to HTC include the following:

- o The right to informed consent before a medical procedure is carried out
- o The right to information for making choices about one's health and well being
- o The right to education
- o The right to confidentiality and privacy
- o The right to non-discrimination, equal protection and equality before the law
- o The right to marry and found a family
- o The right to the highest attainable standard of physical and mental health
- o The right to access the highest quality of health care services.

In Botswana, service providers are bound by an ethical principle to provide the highest quality of HTC, treatment, care, support and follow-up services.

#### 2.1.1 Stigma and discrimination

In the context of HIV and AIDS, stigma and discrimination\* refer to actions taken against individuals solely on the basis of their HIV status or perceived HIV status. It has been shown that programmes that allow more people to know their HIV status can actually reduce stigma and discrimination and foster normalization of HIV testing. Therefore, service providers interacting with patients or clients should receive specific training and ongoing supervision to address the needs of PLWH and those who are at risk of acquiring HIV.

A person's HIV status should not be used to deny them employment or educational opportunities. Where an individual already in employment becomes ill with HIV-related conditions, the case should be treated in the usual manner of determining fitness for work(5). Institutions should raise awareness about HIV and AIDS and human rights issues among their workers and reinforce their adherence to appropriate standards of practice. It should be standard practice to treat all workers with respect and without discrimination on the basis of HIV status.

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\***Stigma** - Refers to the negatively perceived characteristics used to set individual or groups apart from the normalized social order. In other words there are those who are regarded as normal and those who are regarded as 'not normal', hence they are treated differently.

\***Discrimination** – occurs when a distinction is made that results in a person being treated unfairly and unjustly on the basis of his/her belonging or being perceived to belong to a particular group.

## 2.2 Ethical issues relating to informed consent

The term “informed consent” refers to a patient or client being given information on knowing one’s status, the benefits and potential challenges associated with having access to information regarding their HIV status, having an understanding of the HIV testing procedure, and then taking the decision to be tested for HIV. The patient or client should be able to consider the implications of a positive diagnosis on their personal and professional lives.

HIV testing must be voluntary, with patients or clients making an informed decision about accepting an HIV test. The service provider should explain the procedure and make sure that the patient or client is requesting or undergoing HIV testing without coercion. While approaches to obtaining informed consent can be flexible, the fundamental value to be applied is respecting the choices and decisions of individuals. All those offered the test should receive sufficient information and should be helped to reach an adequate understanding of what is involved.

The three crucial elements in obtaining truly informed consent in HIV testing are:

- o providing pre-test information on the purpose of testing
- o providing information on prevention, treatment, care and support services available once the result is known
- o ensuring understanding of the procedure and respecting the individual’s autonomy.

Only when these elements are in place will individuals be able to make a fully informed decision on whether or not to be tested. The actual process of obtaining informed consent can be adapted to suit the different settings under which expanded HTC services are provided. Facilities providing VCT services must document that all persons being tested have voluntarily and freely consented to being tested. It should be borne in mind that patients or clients attending health facilities have a right to decline HIV testing if they do not think that it is in their best interest or if they need more time to consider the implications of the test.

## 2.3 Mandatory testing

Mandatory HIV testing is neither effective for public health interventions nor ethical, because it denies individuals choice and violates principles such as the right to health and the right to privacy. However mandatory testing can be considered in special circumstances such as rape. Rape suspects must be tested for HIV after being counseled.

Properly evaluating the need for post-exposure prophylaxis (PEP) for needle-stick and related injuries when the HIV status of the source patient is unknown, is another instance in which patient rights to refuse HIV testing must be weighed carefully. According to the 2008 HIV/AIDS Treatment Guidelines, if the source patient’s HIV status is unknown, and if the source patient refuses HIV testing, then an HIV rapid test will be carried out on the source patient, but the results will not be shared with the source patient. If the source patient physically hinders or obstructs performance of HIV rapid testing, then it is necessary to initiate PEP for the health care worker.

## **2.4 Legal issues relating to informed consent**

### **2.4.1 Minimum age for HIV testing**

Anyone aged 16 years or above should be considered able to give full informed consent for HIV testing. A parent's or legal guardian's consent is required for testing young people below 16 years of age. Those below 16 years of age and are married or are operating their own business, should be considered "emancipated minors" who can give consent for HIV testing. Service providers should make an assessment of the minor's maturity to receive HTC services. In all situations, service providers should ensure the availability of follow-up post-test support services. Those providing services to adolescents and minors should receive additional training on the unique issues relating to HTC for youth.

### **2.4.2 HIV testing and counselling of children**

The welfare of the child must be the primary concern when considering testing a child for HIV. When children are brought to a facility providing HTC services, the counsellor should discuss with the parents or guardians and the child, if mature, to determine the reason for testing. If the counsellor feels that testing is not in the best interest of the child then the counsellor reserves the right not to test the child. In such a situation, counselling should be provided to both the child and the parent or legal guardian and HIV testing recommended at an appropriate time or referral made to an appropriate institution.

### **2.4.3 Testing of individuals with hearing and visual impairment or who are mentally challenged**

The welfare of individuals with hearing and visual impairment or those who are mentally challenged should be the primary concern of the HTC service provider. The service provider reserves the right not to test the individual for HIV if the test is not in the individual's best interest. HTC, however, can be provided in the company of a legal guardian or interpreter as necessary.

### **2.4.4 Testing of persons under the influence of drugs**

HIV Testing and Counselling services must not be provided to persons who cannot give informed consent for HIV testing because they are under the influence of alcohol or illicit drugs. The service should be withheld until they have recovered from the effects of the drugs.

### **2.4.5 Testing on clinical grounds**

A medical practitioner responsible for the treatment of a person may conduct an HIV test without the consent of that person if that person is unconscious and unable to give consent and the practitioner believes that such a test is clinically necessary or desirable in the interest of that person(6).

## **2.5 Blood donation and informed consent**

It is important that before their blood is taken, all blood that is donated for transfusion must be screened for HIV. All blood donors should be informed that their blood will be tested for HIV as well as other infections before their blood is taken. Individual pre-test education for blood donors should be provided at all times. Blood donors who would like to know their HIV status should be referred to a trained counsellor for post test counselling.

## **2.6 Issues relating to confidentiality**

### **2.6.1 Confidentiality**

Confidentiality is the right of the individual to privacy and dignity. It pertains to the individual's disclosure of personal information in a relationship of trust and with the expectation that it will not be divulged to others in ways that are contrary to the rights of the patient or client to privacy and dignity. Confidentiality must be maintained for people who will receive HIV counselling, HIV testing and referral services.

Confidentiality is one of the guiding principles for provision of HTC services and must be protected at all times. It requires that access to information on the patient's or client's HIV status should be restricted and only shared between professionals (e.g. nurse, doctor, social worker) who are directly involved in providing services to the client. The information can also be shared with primary care givers at home after client's consent, for their mutual benefit, thereby allowing for optimum care for the patient and prevention of HIV transmission to care givers.

### **2.6.2 Confidential record keeping**

All medical records, including those with HIV-related information, must be managed in accordance with Records Management Procedures Manual (Botswana National Archives and Records Services.) Only persons with a direct role in the management of the client should have access to these records.

### **2.6.3 Anonymity**

Anonymity is practised when only code numbers instead of client's names are used in an HTC facility. However, confidentiality must still be maintained.

### **2.6.4 Written results**

Written results should be provided to those who wish to have their HIV test results. The date when the test was conducted must be stated in all cases. However, HTC service providers should focus mainly on helping clients to make better decisions about their sexual behaviour and reducing the risk of HIV transmission.

## **2.7 Issues relating to ethical disclosure**

### **2.7.1 Issuing of test results**

HIV test results should be disclosed in person only to the patient or client, unless the patient or client is a minor or is mentally challenged or consents to a third party being present at the time of disclosure. Disclosure of the results to anyone else should only be done with the patient's or client's consent, which should be documented. Disclosure of HIV status to children should be informed by a thorough assessment of the child's knowledge level of HIV and AIDS issues and level of maturity.

### **2.7.2 Partner disclosure**

All patients or clients - regardless of their HIV status - should be empowered and encouraged to inform their sexual partner/s about their HIV test results. For HIV positive clients who are reluctant or fearful to disclose their results, the service provider should offer additional, on-going counselling to help the client inform the partner. The service provider may inform the client's sexual partner/s about the HIV test results in the presence of the client and only upon the client's request. Sexual networks can be uncovered through contact tracing and partner notification, resulting in more people obtaining knowledge of their HIV status and accessing HIV prevention, treatment, care and support services.

## **2.8 Issues relating to rape**

Anyone who has been raped should undergo HTC and access PEP - optimally within 4 hours but within 72 hours of exposure. It is essential that police officers dealing with victims of sexual abuse are educated on the importance of these victims starting PEP as soon as possible.

Mandatory testing and counselling for the rapist should only be performed with a court order, and the results disclosed to the magistrate or judge handling the case.

## CHAPTER 3 Approaches To HIV Testing and Counselling Service Delivery In Botswana

In Botswana, two approaches are employed in providing HTC services, namely:

- o Routine HIV Testing (RHT) - which is provider-initiated HIV testing and counselling; and
- o Voluntary Counselling and Testing (VCT)-which is client-initiated HIV testing and counselling

In both RHT and VCT, universal human rights requirements of the “3Cs” of confidentiality, counselling and informed consent with voluntarism are respected.

### 3.1 Routine HIV Testing (RHT)

#### 3.1.1 Definition and Background

RHT refers to a provider-initiated service where HIV testing is an integral part of the clinical services provided at the health facilities or is part of the services of other organizations providing health-related services. It implies a default (opt-out) policy of HIV testing whereby the patient or client may decline such testing. In the clinical setting, RHT is a standard clinical activity that is similar to having one's blood taken for various tests, with the patient's informed consent.

RHT is mostly practiced in health facilities but can also be expanded to other settings, such as Botswana Family Welfare Association centers. The approach requires health care providers to recommend and perform HIV testing on all patients or clients attending health facilities as a standard component of medical care. This will be part of the normal standard of care, irrespective of whether or not the patient or client:

- i) has signs and symptoms of underlying HIV infection
- ii) has other reasons for presenting to the health facility.

This guidance applies to all public, private and NGO settings. RHT is a process which entails provision of simplified pre-test education, HIV testing and post-test counselling. The approach is consistent with the WHO policy developed in 2003 – “WHO/UNAIDS policy statement on HIV testing” as well as the 2007 “WHO/UNAIDS Guidance on Provider-Initiated HIV Testing and Counselling In Health Facilities”. RHT does not endorse mandatory or coercive HIV testing.

### **3.1.2 Rationale for RHT**

Many people in Botswana still do not know their HIV status, despite HTC services being available countrywide. Not knowing one's HIV status makes it difficult for one to access prevention, treatment, care and support services. For example, although the government is offering antiretroviral therapy (ART) to patients with AIDS in the public health facilities, many patients first present for care during the late stages of the disease when it is too late for ART to make a meaningful difference in their lives. RHT makes it possible for as many people as possible to have knowledge of their HIV status early enough to benefit from preventive, treatment, care and support services. Following routine testing, specific remedial actions can be taken on the basis of the HIV test result. Above all, making HIV testing routine is also meant to normalize HIV infection so that it can be regarded as a chronic, manageable disease as is the case with such diseases as hypertension or diabetes.

### **3.1.3 Indications for RHT**

Health care workers should recommend and deliver routine HIV testing to the following:

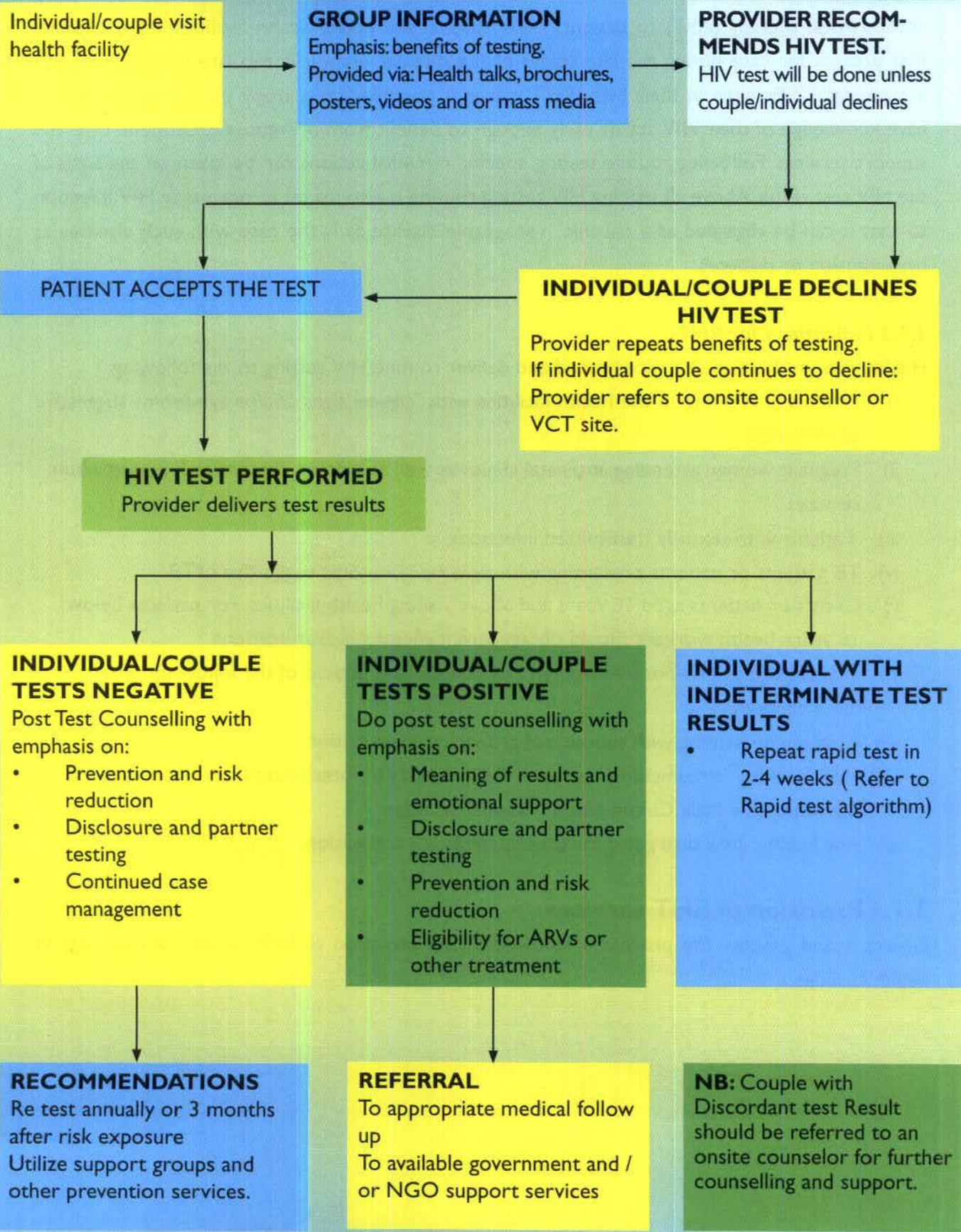
- i) Patients presenting to the health facilities with clinical signs and/or symptoms suggestive of HIV/AIDS
- ii) Pregnant women attending antenatal clinics as well as women presenting for postpartum services
- iii) Patients with sexually transmitted infections
- iv) TB patients or patients presenting with signs or symptoms suggestive of TB
- v) Clients or patients aged 16 years and above visiting health facilities. For patients below 16 years, health workers should obtain parental/legal guardian consent
- vi) Infants born to HIV-positive women as a routine component of the follow-up care for these children
- vii) Children presenting with suboptimal growth or malnutrition
- viii) Men seeking circumcision as an HIV prevention intervention, in accordance with Botswana Safe Male Circumcision National Strategy
- ix) Any healthy individual going for general medical examination.

### **3.1.4 Provision of RHT services**

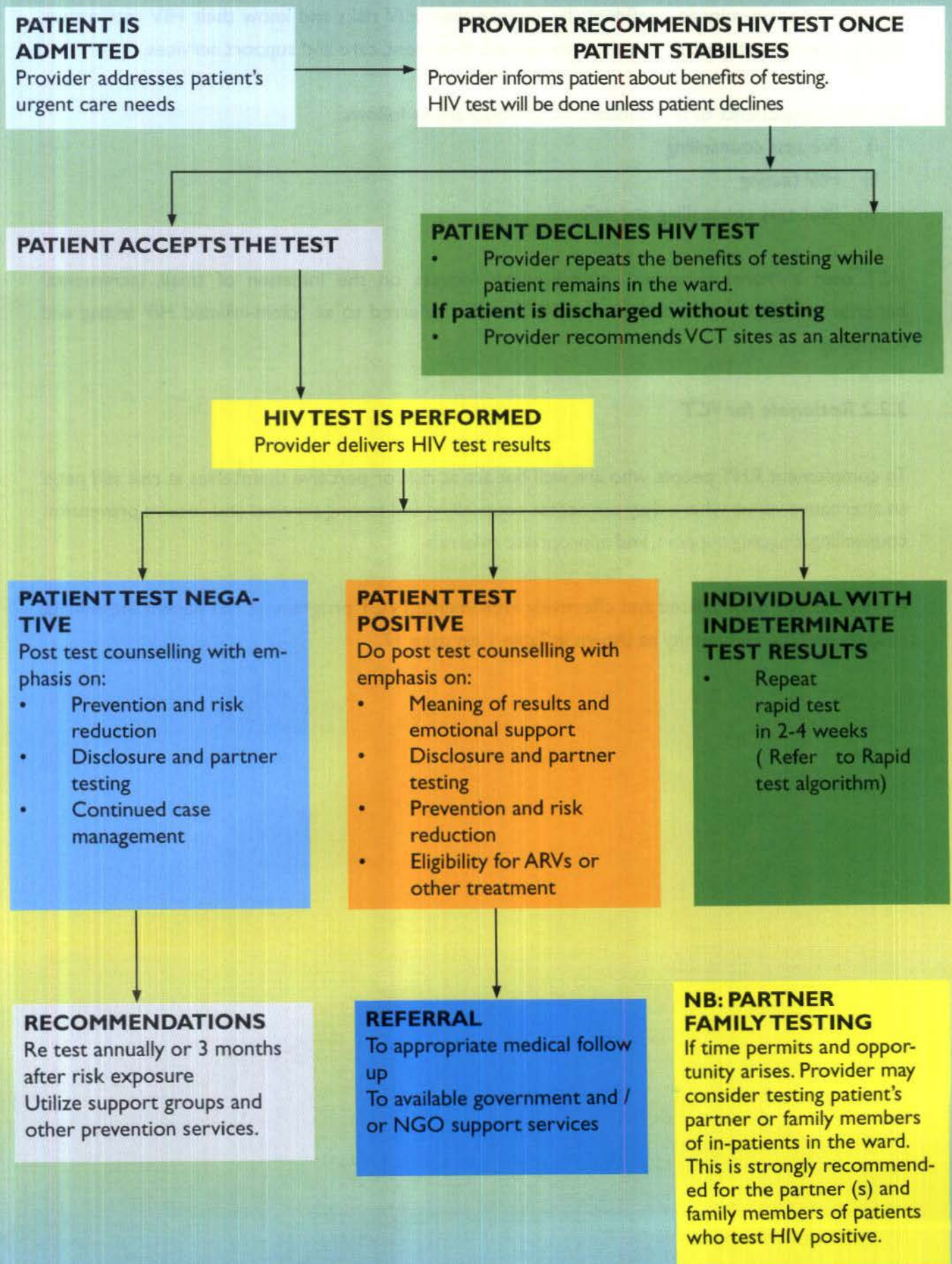
Figures 1 and 2 show the processes followed in the provision of RHT in different settings in health facilities.



**Figure 1: Routine HIV Testing in Health Facilities**  
**Out patient clinic or department**



**Figure 2: ROUTINE HIV TESTING IN HEALTH FACILITIES IN PATIENT WARD**



## **3.2 Voluntary Counselling and Testing (VCT)**

### **3.2.1 Definition**

VCT is a client-initiated HIV prevention intervention that gives the individual or couple the necessary opportunity to confidentially explore their HIV risks and know their HIV test results. VCT is the key entry point to other prevention, treatment, care and support services.

The key components of the standard VCT model are as follows:

- i) Pre-test counselling
- ii) HIV testing
- iii) Post-test counselling and referral.

VCT uses a “harm-reduction” model which focuses on the initiation of small, incremental behavior change steps to reduce risk. VCT is also referred to as “*client-initiated HIV testing and counselling*”.

### **3.2.2 Rationale for VCT**

To complement RHT, people who are well but are at risk, or perceive themselves at risk still need an alternative venue where they can access counselling and testing services and receive prevention counselling, ongoing support, and appropriate referrals.

A well planned, coordinated and effectively implemented VCT programme can benefit individuals, couples and the community as shown in Table 1 on page 17.

**Table 1: Benefits of VCT to the Individual, Couple and Community**

Individual benefits	Couple Benefits	Community benefits
<p>1. Empowers the uninfected person to protect himself or herself from HIV</p> <p>2. Empowers infected persons to protect themselves and others and to live positively</p> <p>3. Knowledge of HIV status enables infected persons to seek prevention, treatment, care and support services such as PMTCT, ART, treatment of opportunistic infections and psychosocial support</p>	<p>1. Supports safer sexual relationships</p> <p>2. For couples with discordant HIV test results, knowledge of HIV status can help protect the uninfected partner through condom use, abstinence or other safer sex practices</p> <p>3. Can prevent mother-to-child transmission of HIV if couples learn that they are HIV positive</p> <p>4. Guides couples in making informed decisions about future plans including HIV prevention, family planning, treatment, care and support</p>	<p>1. Generates optimism when large numbers of persons test HIV negative</p> <p>2. Increases community support for those who test HIV positive</p> <p>3. Influences community norms regarding HIV testing, risk-reduction, discussion of HIV status and condom use</p> <p>4. Reduces stigma, denial and discrimination as more persons go public about their HIV status</p> <p>5. Promotes awareness and community support for appropriate interventions</p> <p>6. Supports human rights</p>

**3.2.3 Indications for VCT**

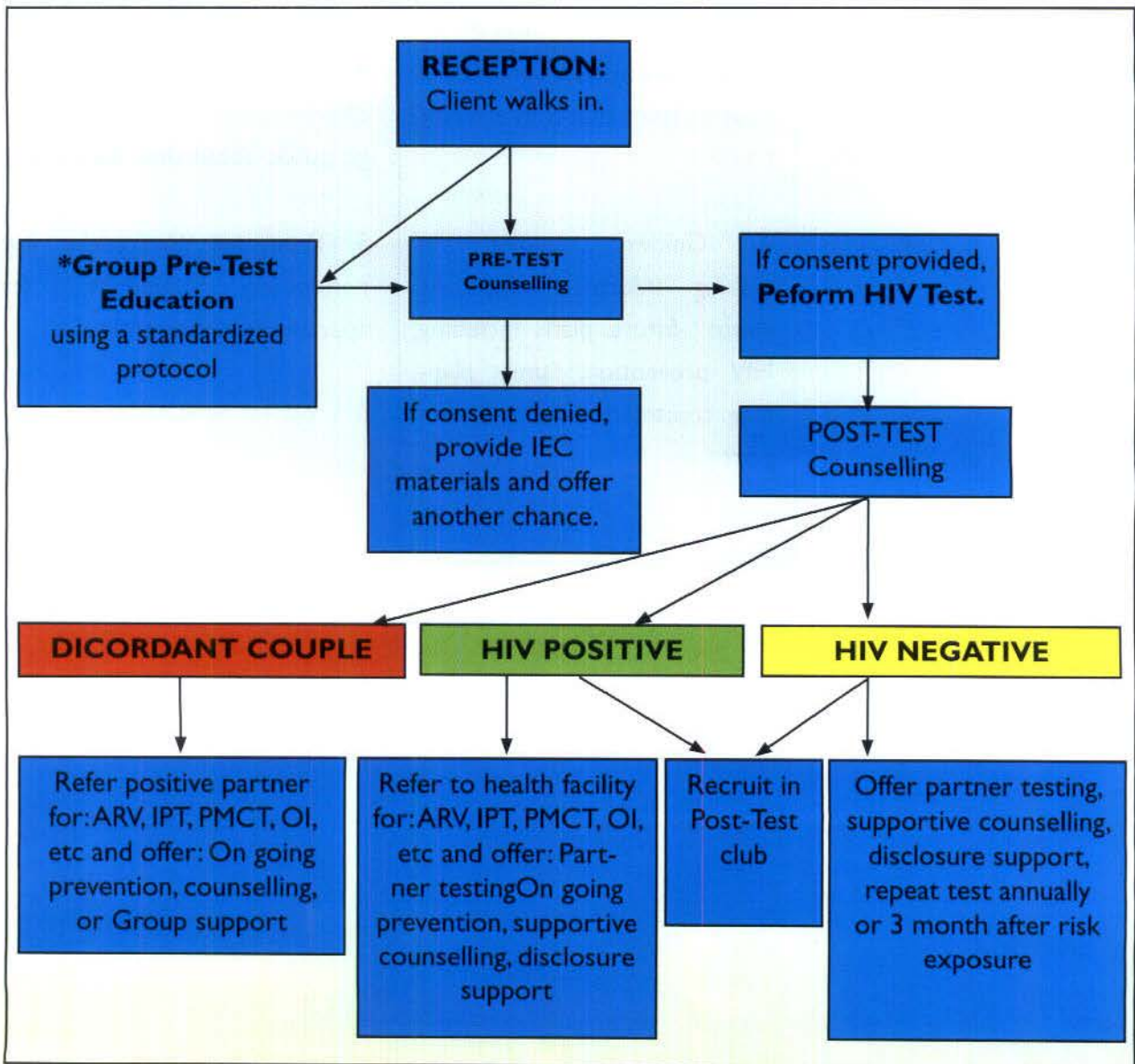
Anyone may seek and receive VCT services on a walk-in basis. These include:

- o Adult men and women who may be at risk of HIV infection
- o Couples contemplating engaging in a sexual relationship, marriage, re-union or having a baby
- o Youth aged 16 years and above who fall in the above categories may consent to HIV testing on their own
- o Minors below the age of 16 years may receive VCT with consent of parents or legal guardian.

**3.2.4 Provision of VCT services**

Figure 3 below shows the process that is followed in provision of VCT services in Botswana.

**Figure 3:VCT Flow Chart**



\*Group pre test education in VCT is not mandatory, but may shorten the time clients spend in the pre-test counselling session. However, pre-test education does not replace pre-test counselling in VCT.

### **3.3 HTC service delivery models**

Botswana has two models of HTC service delivery:

- a) Health facility-based HTC services
- b) Community-based HTC services

#### **3.3.1 Health facility-based HTC services**

Health facilities provide integrated services where HTC and other services such as out-patient and in-patient services, STI and TB management, antenatal and post-natal care are available. The facility staff recommends HTC to all patients visiting health facilities using the provider-initiated approach. However, client-initiated HIV testing and counselling (VCT) is also provided in health facilities to clients who come seeking such services.

#### **3.3.2 Community-based HTC services**

HTC services in the community can be provided through free-standing sites, outreach services, mobile services and workplace programmes.

##### **3.3.2.1 Free-standing HTC services**

Free-standing HTC services are provided in sites that are situated outside health facilities and almost entirely dedicated to VCT. The services provided may or may not be anonymous. The services are mainly provided by civil society organizations but other sectors, such as the private sector, can also provide these services.

##### **3.3.2.2 Outreach HTC services**

These services are offered as an extension of existing static HTC sites, targeting hard-to-reach populations. Approaches may include door-to-door and other community HIV testing activities. Both RHT and VCT services can be provided through outreach services. Premises such as community halls, school halls, youth facilities and other structures such as tents and caravans can be temporarily utilized for HTC service provision.

##### **3.3.2.3 Mobile HTC services**

Mobile services are provided from a fully equipped mobile HTC unit. Both RHT and VCT can be provided from these units.

##### **3.3.2.4 Workplace HTC services**

These services are offered to employees, with the support of the employer, at places of work and may be integrated into other wellness programmes. Both RHT and VCT services can be provided to employees at the workplace.

## Chapter 4 : Operational Requirements For HIV Testing And Counselling

### 4.1 Coordination of HIV testing and counselling (HTC) services

#### 4.1.1 National Level

The National AIDS Coordinating Agency (NACA) has the mandate to coordinate the overall multisectoral response to HIV and AIDS.

The Department of HIV and AIDS Prevention and Care (DHAPC) in the Ministry of Health (MOH) coordinates the health sector response to HIV and AIDS. It also sets health sector HIV and AIDS policies, standards and operational guidelines including HTC. The Counselling and Testing Unit of the Department of HIV and AIDS Prevention and Care coordinates all HIV counselling and testing activities in public, private and civil society organizations. In order to carry out the coordination role, the DHAPC has set up a HTC Technical Advisory Committee to provide technical support for all HTC activities in the country. MOH will register all HTC sites to ensure that they meet the stipulated minimum requirements for operation of HTC services. All registered HTC sites will be assessed annually to ensure that they maintain the minimum required standards.

#### 4.1.2 District Level

At the district level, the District AIDS Coordinating (DAC) office coordinates all sector response to HIV and AIDS.

The District Health Team (DHT) coordinates and supervises the implementation of HTC services in the public, private and civil society settings. In order to carry out the coordination role, DHTs should assign one of their staff to be an HTC focal person.

The HTC focal person should set up a technical advisory committee to provide technical support for all HTC activities in the district.

#### 4.1.3 Community/Village Level

The officer in charge of the clinic should set up a technical advisory sub committee to provide technical support for all HTC activities in the village. The technical advisory sub committee should have representatives from the public, private and civil society organizations.

#### 4.1.4 Site/Facility Level

The officer in charge of the site or facility should be responsible for the day to day coordination and supervision of HTC services.

## 4.2. Minimum requirements for HTC service delivery

### 4.2.1 Community –based HTC services

These services can be provided from free-standing, outreach, mobile and workplace HTC services.

#### 4.2.1.1 Free-standing Facilities

##### a) Space and equipment requirements

The following are the minimum space and equipment requirements:

- *Reception area* equipped with desk and chair, fan, computer for data entry and communication equipment e.g. telephone. IEC materials should also be available.
- *Waiting area* equipped with audiovisual equipment and IEC materials, including those that explain the HIV testing procedure.
- *Counselling rooms* in which rapid HIV tests can be conducted. The rooms should have 3 chairs, small table with a washable surface, fan, water supply and wash basin, soap, disinfectants, hand drying towels, sharps disposal container, clinical waste bins, HIV test kits and consumables, stationery, male and female condoms and demonstration models, cue cards for counselling, HIV testing algorithm, timer and medical consumables. It is important for these rooms to have enough space to allow for the desk and chairs to be placed in a way which does not create a barrier between the counsellor and the client/patient.
- *HIV testing area* with a desk; chair, washable work counter, storage space for medical consumables, HIV test kits and consumables, lockable storage for test kits that do not need refrigeration, refrigerator for test kits and/or reagents needing refrigeration, standard contaminated waste disposal containers, sink with elbow taps and running water (both hot and cold), soap, disinfectants, hand drying towel, HIV testing algorithm, a timer and Standard Operating Procedures for HIV testing.
- *Exit* - Where possible a separate door for exit of clients following receipt of test results should be created
- *Toilets* - there must be an adequate number of toilets, in accordance with the number of clients visiting the site with separate ones for males, females, staff and those for the physically challenged.

##### b) Staffing

Key staff is required for the following positions:

- *Site Manager* responsible for planning and coordination of services, supervising and supporting staff at the site and ensuring adequate and consistent supplies.



- *Personnel to perform HIV counselling* – HTC staff should be trained according to the MOH approved curriculum for HTC. The staff could be full or part-time staff who provide services even during weekends and special events.

These staff includes:

- Professional counselors
  - Health workers
  - Lay counselor
  - Peer counselors
  - Volunteers
- c) Personnel to perform rapid HIV testing – these include Laboratory Technicians or any staff that have been trained and certified to provide rapid HIV testing according to MOH approved curriculum - e.g. counsellors with or without a medical background.
- d) Data entry personnel – data entry can be done by data entry clerk or/and any other staff who is trained and assigned.
- e) Receptionist/s to welcome and register clients, collect user fees if applicable, explain site procedures, and do any other duties as assigned.
- f) Ancillary staff (e.g. cleaners, security guards and drivers) are responsible for general upkeep and other duties at the site.

#### **4.2.1.2 Outreach HTC services**

Space may be provided by a suitable institution in the area where services are to be provided e.g. community halls, churches, tents.

#### **4.2.1.3 Mobile HTC services**

Mobile HTC services are provided from fully equipped vehicles with the required rooms for counselling and for carrying out rapid HIV testing.

#### **4.2.1.4 Workplace HTC services**

Workplace HTC sites should use existing rooms for service provision, provided the rooms offer both auditory and visual privacy for the employees.

#### **NOTE:**

**The principles used in determining space, equipment and staff requirements are the same for all modes of HTC service delivery.**

The section below highlights the key issues that need to be taken into consideration for each mode of HTC service delivery.

#### **4.2.2 Health Facility-Based HTC Services**

These services can be provided from public and private sectors.

##### **4.2.2.1 Public Health Facilities**

###### *a) Space and equipment requirements*

- Although all health facilities have consulting rooms, there is need to ensure privacy during counselling sessions. This may require that additional rooms are set aside for HTC.
- Areas where rapid HIV testing is to be conducted must be equipped according to the National Policy on Rapid HIV Testing. There may also be need for additional rooms. Equipment requirements are the same as for free-standing sites.

###### *b) Staffing*

- In addition to providing clinical services, existing staff should recommend and perform HTC using the RHT (provider-initiated) approach. VCT services may also be provided by the staff.
- Additional staffing should be provided through the continued deployment of lay counsellors in health facilities.

###### *c) Personnel to perform rapid HIV testing*

- Will be the same as in free standing sites. In situations where HIV testing cannot be conducted in the consulting rooms, service providers should conduct HIV tests in other rooms including the laboratory.

###### *d) Data entry staff*

- Should enter data in accordance with the prevailing practice for data management for patients and clients attending the facility.

##### **4.2.2.2 Private Health Facilities**

While there may be some insurance-related issues for private sector health facilities in providing HTC services, these facilities are still expected to comply with the standards for HTC as outlined in this document. Counselling is not restricted to lay counselors, but can be provided by any health care provider including nurses, doctors, etc.

### **4.3 Minimum supplies for all service delivery models**

The quantity and type of supplies needed for HTC will depend on the volume of clients expected. Additionally, if it is envisaged that other medical services will be provided - e.g. TB or STI screening - then supply lists will need to be appropriately modified. Some of the critical supplies include the following:

- HIV test kits
- Medical consumables, such as needles and syringes or lancets, swabs, methylated spirit, disinfectants
- Protective clothing, gloves and other medical supplies, including those for universal precautions
- Drugs for Post Exposure Prophylaxis [PEP]
- Sharps disposal containers
- Contaminated waste disposal containers
- Stationery
- Condoms - both male and female

### **4.4 Training of personnel to provide HIV counselling**

The selection criteria for counsellors will include having a minimum of Cambridge "O" level education and interest in providing HIV counselling services.

All counsellors must be trained by qualified trainers and approved institutions - using national training manuals approved by the MOH -and certified following successful completion of an HTC course.

Refresher training should be provided as necessary to maintain a high quality of HIV counselling and testing services, help counsellors cope with complex cases and augment and update their skills. Volunteers including community based service providers should also be provided with refresher training as appropriate.

Nurses, doctors and other professionals selected by MOH should receive pre-service training in HTC.

### **4.5 Training of personnel to perform rapid HIV testing**

Laboratory Technicians should train personnel to perform rapid HIV testing using curricula approved by MOH. They should also provide follow up support and supervision to ensure quality of services.

## Chapter 5 HIV Counselling

HIV counselling takes into account the universal human rights requirements of the “3Cs” of confidentiality, counselling and informed consent with voluntarism.

### 5.1 Definition of HIV counselling

Counselling for HIV is a confidential dialogue between a client(s) or patient(s) and a service provider aimed at enabling the client or patient to make informed decisions about HIV testing cope with the outcome of the test and, make personal decisions related to HIV and AIDS including accessing relevant prevention, care and support services.

### 5.2 Pre-test education

Pre-test education is information given to an individual, couple, family or groups prior to undergoing an HIV test. It aims at enabling them to make an informed decision about HIV testing. This can be done by both counsellors and other health care providers. Service providers must ensure that patients or clients have basic pre-test information and provide informed consent for testing before the HIV test is performed.

In RHT, the service provider provides focused pre-test information to patients, with risk reduction being covered in post-test counselling. If a patient declines the HIV test they can still access the services that do not depend upon knowledge of their HIV status. The patient may be provided with pre-test counselling and encouraged to return for testing when they are ready.

In VCT, pre-test education may be provided to a group of clients while they wait to see a counsellor. This must be followed by pre-test counselling which can be carried out in individual or couple sessions before HIV testing.

### 5.3 Pre-test counselling

Pre-test counselling is a confidential dialogue between the client/s and service provider aimed at assisting him/her to make an informed decision about taking an HIV test.

Minimum information for pre test counselling session

- o Correcting misconceptions and filling gaps in information about HIV and AIDS
- o Discussion of benefits and potential challenges of HIV testing
- o Discussion of implications of a positive or negative HIV test result.
- o Explanation of HIV rapid test process and meaning of HIV test results
- o Exploration of personal HIV risk behaviour and options for reducing risk
- o Assessment of clients' readiness for HIV testing
- o Exploration of support system and discussion of disclosure mechanisms
- o Obtaining consent for HIV testing

## 5.4 Informed consent

Informed consent should be provided individually and in private. Verbal communication is adequate in obtaining consent for either RHT or VCT. Service providers should ensure that client/s are not coerced to take an HIV test.

### 5.4.1 RHT and informed consent

The minimum information to be provided to patients by service providers for informed consent includes:

- o Reasons why HTC is being recommended
- o Clinical and prevention benefits and potential risks of testing e.g. discrimination, abandonment or violence
- o Services available in case of an HIV negative or HIV positive result, including availability of ARVs
- o That HIV test result will be treated confidentially and will only be shared with health care providers directly involved in providing services to the patient
- o That the patient has a right to decline the HIV test and that testing will be performed unless the patient exercises that right
- o That declining the test will not affect the patient's access to services that do not depend on knowledge of HIV status
- o That in the event of a positive HIV result, the patient will be encouraged to disclose to other persons who may be at risk
- o That the patient will be afforded an opportunity to ask the health care provider questions

## 5.5 Post-test counselling

Post-test counselling is a confidential dialogue between a client or patient and a service provider aimed at helping him/her to cope with the HIV test result and providing appropriate referral and support.

HIV test results can be given in individual or couple sessions. Patients/Clients may specifically request that a family member, friend, or other supportive person be present when they receive results. The service provider, however, should make sure that this is truly desired by the patient/client.

*Minimum information for post-test counselling session includes:*

- o Provision of HIV test results
- o Discussion of window period and repeat testing as appropriate
- o Reviewing and/or developing risk reduction plan including abstinence, faithfulness, condom use, partner reduction, substance abuse etc.
- o Discussion of positive living
- o Discussion of disclosure of HIV test results
- o Discussion of partner referral for HIV testing
- o Discussion on family planning
- o Discussion and provision of referral for prevention, treatment, care and support services

## 5.6 Referral and follow up

Referral services are available for all patients or clients who need ongoing medical or psychosocial care and support. All HIV positive patients or clients should be assessed or referred for assessment for ARV eligibility and/or treatment for HIV-related illnesses. Service providers should have basic knowledge of HIV prevention, treatment, care and support services, including information on availability and accessibility of antiretroviral therapy (ARVs). Service providers should have a directory of HIV-related referral services available within the catchment area of the site. When such services are not available within the site, HTC service providers should refer patients or clients to other accessible service providers. Patients/ Client's name, national identity number (Oman) and HIV test results are among the key variables to be documented for all such referrals. The standardized referral form should be used for referrals to and from health facilities.

In health facility settings all patients who have undergone HTC may still need comprehensive clinical management based on their clinical presentation and therefore should be referred back to the clinician for further management.

## 5.7 On-going supportive counselling

Supportive counselling is a confidential dialogue between a counselor and the patient or client after pre- and post-test counselling. Supportive counselling aims at empowering the individual, couple or family to maintain control over the situation and develop positive coping skills. Both HIV positive and HIV negative patients or clients should be encouraged to return for additional counselling and prevention education. HTC sites should have an open door policy for their patients or clients for on-going supportive counselling.

The following are examples of categories of patients or clients who need ongoing supportive counselling:

- Many patients or clients need time to adjust to and start coping with their HIV test results and thus, additional counselling sessions may be beneficial for them.
- A number of HIV positive patients or clients are not yet eligible for ARVs and therefore need on-going support for prevention and psychosocial support.
- High risk HIV negative patients or clients need on-going support for risk-reduction.
- Discordant couples need on-going support for prevention to protect the HIV negative partner from HIV infection and helping the HIV positive partner in accessing treatment, care and support.
- Some clients or patients need additional support for disclosure to partner/s and loved ones.

On-going supportive counselling sessions should be guided by standardized protocols approved by MOH and service providers should be trained on the use of these protocols. The additional counselling should include health issues and such non-health issues as legal and workplace problems that the patients or clients may encounter. Privacy and confidentiality for all patients/clients should be ensured at all times.

Issues that may need to be addressed in on-going supportive counselling sessions include:

- Coping with HIV infection
- Accessing prevention, care, treatment and support services
- Adherence issues
- Positive living
- Risk-reduction
- Disclosure
- Partner or family testing
- Substance use or abuse
- Referral, as appropriate.

## **5.8 Special Counselling Situations**

### **5.8.1 Children**

Service providers should receive training in child counselling using curricula approved by MOH. Services should be provided using MOH approved protocols for counselling children.

HTC for children should be guided by the following considerations:

- The best interests of the child should be the guiding principle in any decision to test a child
- Children infected with HIV may have delayed milestones and therefore their level of maturity may not always match their chronological age. This has an impact on the conduct of counselling sessions and the stage at which the HIV status of the child is disclosed to him/her.
- Service providers should ensure that the parents or legal guardian are intimately involved in all issues pertaining to the child's illness, including the disclosure process.

In cases of a positive HIV test result or suspected HIV infection for children under 5 years of age, the counsellor should refer the child to a clinician for assessment utilizing a protocol for *Integrated Management of Childhood Infections (IMCI)*.

Parents and guardians of HIV positive children should be counseled about HIV so that they develop better understanding of the child's circumstances and emotional needs. In many cases, parents and caregivers should also be provided supportive counselling services to help them accept and cope with the child's diagnosis.

### **5.8.2 Adolescents and Youths**

The number and coverage of “adolescent-friendly” and “youth-friendly” services should be increased to cater for the needs of adolescents and youths who might be reluctant or have problems with accessing conventional HTC services.

Service providers should receive training in adolescent-friendly and youth-friendly approaches and should offer flexible hours of service.

Adolescents and youths should be strongly encouraged to abstain from sex through intensified and targeted information, education and communication (IEC) campaigns and materials.

In addition to encouraging abstinence, condom use should be promoted as a back-up strategy for those who fail to abstain. Youths and adolescents should be encouraged to know their HIV status, and that of their partners.

### **5.8.3 Couple Counselling**

Couple counselling is a dialogue between a counsellor and individuals in a pre-sexual or sexual relationship. It is recognized as an important and effective intervention in which the two individuals are counselled and provided with HIV test results as a couple. This encourages the couple to plan for their future and discuss a realistic risk reduction plan that they can implement together. Counsellors should follow Botswana's couple counselling protocol which highlights the importance of the couple agreeing or accepting to receive couple HTC together, instead of receiving HTC services individually. Counsellors should note that there may be situations where there may be more than two individuals in a sexual relationship. In such cases, the couple should be counselled about disclosure and testing of those other partners and about other risk reduction measures.

In some cases, the HIV test results can be discordant i.e. when one partner is HIV positive while the other is HIV negative. In such a situation, the need for protecting the uninfected partner/s from HIV infection and helping the infected partner access care, treatment and support should be emphasized and the necessary emotional support and counselling provided to both individuals.

### **5.8.4 Prevention of Mother to Child Transmission of HIV (PMTCT)**

The MOH has adopted RHT in the provision of PMTCT services. By this approach, HTC is recommended as part of the “standard of care” for antenatal care (ANC) clients and their partners. However, HIV testing is still voluntary and a pregnant woman has a right to consent or decline HIV testing should she choose to do so. The National Guidelines for PMTCT and the 2008 HIV/AIDS Treatment Guideline should be adhered to by all service providers.

Women who are HIV negative should be tested as early as possible in each new pregnancy. Pregnant women who test HIV-negative must receive ongoing counselling regarding safe sex, in order to avoid undetected HIV infection during pregnancy, which could be transmitted to the baby. Such women should be advised to have repeat HIV testing if they have possible exposure to HIV infection during pregnancy.



For pregnant women who initially test negative early in pregnancy, repeat HIV testing should be performed routinely at either 36 weeks gestation or at onset of labor, whichever occurs first, in order to detect new HIV infection that occurred during pregnancy.

#### **5.8.5 HIV and TB**

TB is the most common serious infectious complication associated with HIV infection in Botswana. Up to 80% of TB patients are co-infected with HIV in the country. The high rates of HIV infection among patients with active TB provide one efficient approach for identifying individuals with HIV among TB patients. HTC is strongly recommended as part of the standard of care for all TB patients. However, HIV testing is still voluntary and the patient has a right to consent or refuse HIV testing should she or he choose to do so.

#### **5.8.6 Sexually Transmitted Infections (STIs)**

The presence of an STI can increase the risk of HIV acquisition and transmission. As such, service providers should recommend HTC for all patients presenting with STIs as well as for their partner (s) and other sexual contacts.

#### **5.8.7 Safe Male Circumcision (SMC)**

Safe Male Circumcision has been shown to reduce the risks of acquiring HIV significantly among men. In Botswana SMC is recommended as an additional strategy for HIV prevention. HTC services are the most important entry point for SMC. All men who test negative for HIV should be counseled and referred for SMC. Service providers should emphasize that SMC does not provide complete protection against HIV prevention and that clients/patients should use other risk reduction strategies to prevent themselves and their partners from HIV infection.

#### **5.8.8 Adherence**

Once treatment with an effective drug regimen has been commenced, the most important determinant of success is adherence to the regimen. Therefore, adherence should be addressed and discussed throughout the counselling continuum – before the patient starts ART and at every follow up visit after commencement of treatment.

The service provider should:

- identify and address actual and potential barriers to adherence
- address adherence-related decisions drawing on the patient's own strength
- help patients draw on the support of family, adherence buddies, support groups and significant others
- educate appropriate family members and significant others regarding the importance of adherence and solicit their support and involvement.

### 5.8.9 Occupational Exposure

In cases of occupational exposure - such as cuts and needle-stick injuries - post-exposure prophylaxis (PEP) must be made available immediately (optimally within 4 hours) but within 72 hours of exposure. National guidelines on procedures to be followed for PEP must be displayed and adhered to at all time. Adherence Counselling must accompany the administration of PEP.

### 5.10 Service provider self-care and support

“Burn-out” has been described as a physical, emotional, psychological and spiritual phenomenon characterized by progressive loss of idealism, energy and purpose, and is experienced by people working in helping professions. All service providers need formal support, stress management and mentoring strategies to prevent or mitigate the effects of burnout.

Counselling support strategies include the following:

- Ensuring that service providers have clear roles and responsibilities.
- All service providers are encouraged to go through the process of HTC so that they can access prevention, treatment, care and support services. Knowledge of their own HIV status will also help service providers to be more empathetic when providing services.
- Ensuring periodic medical screening for all service providers as they may be exposed to other diseases, (e.g. TB) in the course of their work. All areas used for counselling must be well ventilated.
- Every measure must be taken to reduce the risk of occupational transmission of blood-borne diseases therefore it is strongly recommended that service providers receive hepatitis B immunization to protect them against hepatitis B infection.
- Counselling should be made available on a regular basis.
- An experienced service provider must act as a mentor for a less experienced service provider. The mentor must be readily available and accessible for support at all times.
- Periodic counselling review meetings and debriefing sessions should be held at least once a week. During these meetings the counsellors/service providers can discuss challenging cases, share experiences and be updated on new developments in HIV and AIDS.
- Counsellors/service providers should be encouraged to form support groups in order to support and assist each other in an informal environment where both social and work-related activities should be discussed.

### 5.11 Quality Assurance for Counselling

Quality assurance is a way of monitoring and evaluating the quality of services provided in accordance with established national guidelines, policies and standards. Approaches for assessing HIV counselling services in HTC sites include mystery client surveys, client exit interviews to measure client satisfaction, counsellor self-assessment, observation of counselling sessions, regular training, supportive supervision, stress management sessions and operations research. These approaches must be used regularly to assess and monitor the quality of counselling provided at each facility.

Quality assurance is a critical responsibility of administrators and supervisors of HTC services and requires the cooperation and participation of all HTC staff.

At a minimum, the following must be routinely conducted at each HTC site:

- o Support supervision once a quarter
- o Client exit interviews at least once a year
- o Sit-in sessions for each counsellor/service provider once a quarter
- o Case conferences where counsellors review challenging cases as a group on a weekly basis

Continuous quality improvement based on the results and analysis of regular client exit interviews is also recommended.

## Chapter 6: HIV Testing

In Botswana HIV infection is usually diagnosed by testing for antibodies against HIV. However, polymerase chain reaction (PCR) using Dried Blood Spots (DBS) is becoming more widely used in the diagnosis of HIV infection in children below 18 months of age.

### 6.1 Methods of HIV testing

There are several methods used to diagnose HIV. Enzyme-linked immunosorbent assay (ELISA), rapid HIV test and polymerase chain reaction (PCR) are the methods used in Botswana. The choice of tests depends on the availability of necessary equipment and qualified personnel to operate the laboratory equipment. ELISA and rapid HIV tests utilize the same principle of detecting antibodies produced by the human body as a reaction to HIV infection. PCR, on the other hand, detects the virus's genetic material such as deoxyribonucleic acid (DNA) and ribonucleic acid (RNA).

#### 6.1.1 ELISA tests

ELISA tests are used in both public and private hospitals and clinics where there is a laboratory and a large number of HIV tests to be performed. ELISA tests were originally developed for donor blood screening and therefore are more suitable for batch testing in settings where large numbers of clients are seen. Only Laboratory Technicians can perform these tests using specialized equipment. Depending on the workload, HIV test results can be obtained on the same day or up to 2 weeks after submitting blood for testing. This long period before test results are available has resulted in greater reliance on simple, rapid HIV tests that deliver same-day results.

#### 6.1.2 Rapid HIV tests

Rapid tests are recommended for HTC services, especially where there are few samples to be tested and there is limited access to a laboratory. They are simple to perform - even in clinics without laboratories or specialized laboratory equipment and are as accurate as ELISA tests when Standard Operation Procedures (SOPs) are followed. A very small sample of blood is taken from the patient's/client's fingertip, and the result is ready within 30 minutes.

#### 6.1.3 Virology tests e.g. PCR

PCR is used for HIV testing of children less than 18 months of age. Antibodies to HIV can be passed from mothers to their babies through the placenta and breast milk and may be present in the baby's blood for up to 18 months after birth. This means that it may not be possible to determine whether a baby is HIV infected using HIV antibody tests until the baby is older than 18 months. However, there are virology tests that can be performed in this age group such as DNA or RNA PCR tests and viral culture. These tests require specialized equipment and skills and test results take a long time to be obtained, compared to rapid HIV tests and ELISA. Apart from PCR, the other tests are not widely available in Botswana.

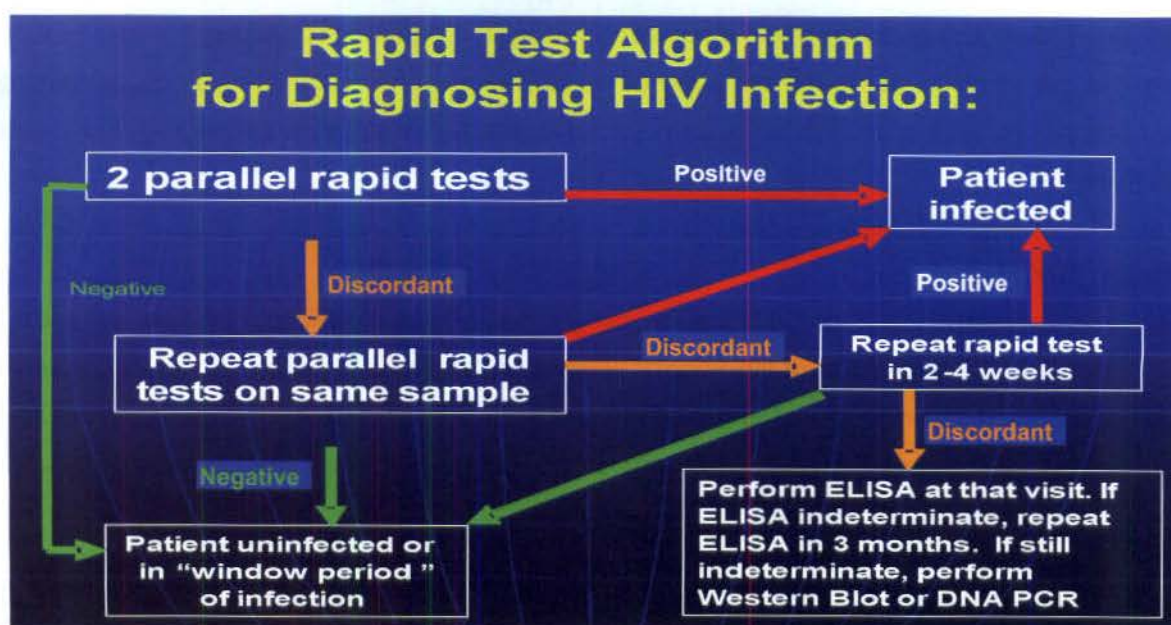
## 6.2 Window period

The 'window period' is the period from initial infection with HIV to the time when the body has produced enough antibodies to be detected with an HIV antibody test. This period is usually 3 months. The "window period" thus means that a patient/client who has been recently infected with HIV may test negative for the HIV antibody because their body has not produced enough antibodies to be detected by the test. Although testing HIV negative, such a client can still pass the virus to others. A client with a negative HIV test result and with recent high-risk exposure (unsafe sex, STI or STI exposure, pregnancy) should be cautioned about the "window period" and advised to return for a repeat HIV test in 3 months. Clients who may be in the window period should be encouraged to reduce their risk of transmitting the virus during this period and practice safer sex at all times.

## 6.3 Testing algorithms

In Botswana the MOH approves all HIV test kits to be used in the country. The National Health Laboratory evaluates and recommends kits based on their sensitivity and specificity. All HTC sites must use MOH-approved test kits and HIV testing algorithms. At the time of publication of these guidelines, Botswana uses the parallel testing algorithm for both ELISA and rapid HIV tests as shown in Figure 4 below.

FIGURE 4



There are two types of testing algorithms:

- a. Parallel testing
- b. Serial Testing

### 6.3.1 *Parallel testing*

Parallel testing involves testing with two different HIV test kits simultaneously (“in parallel”) and the results given if both tests give the same result. If one test is positive and another is negative (meaning the results are “discordant”) the tests are repeated using the same test kits. A specimen that remains discordant in the repeat testing step is considered indeterminate and the following algorithm should be followed:

- The patient should be advised to return in 2-4 weeks for repeat testing by rapid test, during which time abstinence or safe sex should be practiced.
- If the repeat rapid test 2-4 weeks later is still discordant, ELISA testing is required at that visit.
- If the ELISA, as above, remains indeterminate, another ELISA should be drawn after 3 months. If at 3 months the result is still indeterminate, PCR testing or Western Blot is necessary.

Prompt and accurate HIV diagnosis in pregnant women is essential for indicated referral and interventions for PMTCT, as well as for the mother’s health. Discordant rapid test results (repeated) in a pregnant woman require priority ELISA testing at that visit, with results available within two days of testing. If the ELISA test is discordant, then repeat ELISA with Western Blot and viral load must be done immediately, with results within two days of testing. If these tests are equivocal or discordant, a physician must be consulted at once.

### 6.3.2 *Serial testing*

With ‘serial testing,’ an initial blood sample is taken and tested using one test kit. If the result is negative, the result is given to the client as HIV negative. If the result is positive, the blood sample is tested using a second, different type of rapid HIV test. If the second test is also positive, the result is given to the client as HIV positive. However, if the second test is negative, the same tests are repeated in parallel. If the results are discordant a third test (“tiebreaker”) is used. The result from the third test is the one given to the patient/client.

### 6.4. *Frequency of testing*

A patient with a negative result and with a recent high risk exposure (unsafe sex, STI, or STI exposure etc) should be cautioned about the window period and should return for repeat HIV testing in 3 months. A repeat routine test in an HIV negative individual should be recommended once a year. However, a repeat test can be carried out any time at the request of the patient or client following his/her own risk assessment, with guidance from a trained counsellor or service provider.

### 6.5 *Personnel to perform HIV tests*

Medical Laboratory Technologists may perform all the HIV tests described earlier. Trained non-laboratory personnel can perform rapid HIV tests. The training should be conducted by institutions authorized by MOH following a standard curriculum approved by MOH.

### 6.6 *Quality Assurance*

Accuracy of test results has a crucial bearing on the determination of the kind of care or treatment that needs to be afforded the patient or client.

Quality assurance includes but is not limited to the following:

- testing of specimens with pre-determined HIV status at HTC sites
- re-testing by National Health Laboratory of 5-10% of specimens previously tested at HTC sites;
- Use of Internal Quality Control (IQC) to monitor the integrity of the reagent and the testing conditions, on daily or weekly basis depending on the volume of specimens tested.
- On-site assessment by a quality assurance team.
- only trained and competent staff should perform HIV testing duties
- HIV testing carried out only at MOH-approved sites.
- All sites participating in quality assurance schemes coordinated by National Health Laboratory Quality Assurance Unit.
- Proper recording of testing procedures and HIV test results using national, standardized logbook

Quality assurance exercises should be carried out as follows:

- Quarterly for new HTC sites during their first year of operation; and
- Bi-annually for established HTC sites.

#### **6.6.1 HIV testing for research purposes**

Reference should be made to the Botswana MOH National Policy on Rapid HIV testing in relation to HIV testing for research purposes.

## Chapter 7: Scaling Up HIV Testing and Counselling Services

Many people in Botswana do not know their HIV status. In order to meet Botswana's goal of "Zero New Infections by 2016", there is need to increase access to HTC services. Also, HTC has been identified as one of the five core elements in the "minimum package" for HIV prevention as outlined in the National Operational Plan for Scaling up Prevention in Botswana (2008-2010). A number of considerations must be made to achieve this goal.

### 7.1 Promotion of HTC

The MOH has set out the following to ensure that HTC is promoted:

- IEC materials on the value and meaning of HTC should be distributed at all facilities as a means of public education and information
- MOH IEC and HTC unit should strengthen partnership with print and electronic media and other stakeholders in order to ensure wide dissemination of HTC messages to the public
- Health facilities should, at their level, strengthen partnership with the media and other stakeholders in order to ensure consistency in information disseminated to the public
- Health care workers should collaborate closely with community counselors, NGOs, community-based organizations (CBOs) and faith-based organizations (FBOs) in their community mobilization efforts.
- HTC in health facilities should be provided alongside public education about HIV and other relevant health issues
- Health care providers should give adequate information to the client to enable him/her to give informed consent before undertaking the HIV test

### 7.2 Conducive environment

There is need to improve and ensure an enabling legislative, social, medical and policy environment. Some of the areas to be addressed include those detailed below.

- The wellbeing of both clients and service providers must be ensured in order to effectively scale up HTC services. Specifically, where HTC is provided, the quality of services provided should not be compromised.
- There is need to ensure that HTC service provision observes the "3Cs" of confidentiality, counselling and informed consent with voluntarism.
- Implementation of HTC should include measures to prevent occupational acquisition of HIV, compulsory HIV testing, unauthorized disclosure of HIV status and potential negative outcomes of knowing one's HIV status.
- Service providers should ensure that a wide range of post-test services are available to meet the needs of both HIV negative and HIV positive clients as they relate to prevention, treatment care and support services.
- A system that monitors the implementation and scale-up of HTC should be developed and implemented concurrently.



### **7.3 Community mobilization**

Existing strategies such as national HIV testing month/week should be scaled up and targeted at specific individuals or groups, with special emphasis on under-served populations.

### **7.4 Convenient opening hours of HTC sites**

There is need to address the needs of the target population being served so that opening hours are convenient for them. Therefore staffing levels should address the need for opening hours that are outside the normal working hours.

### **7.5 Strategic partnerships**

Service providers must work with communities and other organizations to create awareness about HIV and HTC. This will assist in identifying existing organizations that can carry out community mobilization activities and HTC service provision. The capacity of the organizations may need to be built to address the needs of the community. Collaboration between organizations should be encouraged, especially public-private partnerships.

### **7.6 Increasing the number of service delivery points**

The number of service delivery points should be increased through outreach, mobile and other innovative approaches for delivering HTC services. Other innovative and evidence-based strategies for increasing service delivery should be considered. Geographic coverage and equitable distribution of services should be taken into account.

### **7.7 Expanding range of services provided**

HTC sites should endeavor to provide other services in addition to HTC. Wherever possible, counsellors should be equipped with skills to address a wider range of HIV-related issues that clients may present with. Both HIV positive and HIV negative clients should have their needs addressed whenever possible. The availability of these other services may also contribute to destigmatization of HTC services.

### **7.8 Supply chain management**

In order to effectively scale up HTC services, all players – e.g. Government, Central Medical Stores, private - must ensure a robust delivery system to guarantee regular, uninterrupted HIV testing supplies. This can be achieved through assessment and strengthening of the capacity of relevant institutions for planning, selection, procurement, distribution as well as use of HTC supplies.

Thus consideration should be made with regard to the following:

- Documentation of quality-assurance procedures as a primary consideration
- Existence of procurement procedures to aid timely ordering (projection: reorder levels and lead times) and distribution of supplies
- Proper storage conditions (space, security, ventilation, temperature controls, cleanliness, shelf lives)
- Keeping/maintaining daily inventory list consumables for tracking usage
- Use of MOH-approved HIV test kits

- Procurement through credible suppliers only
- Training of staff to ensure proper and appropriate use of HIV testing commodities
- Monitoring and evaluation

### **7.9 Targeting under-served populations**

Service providers should identify underserved populations (e.g. men, commercial sex workers, prisoners, refugees, children and youth etc) in their catchment areas and provide appropriate services using effective strategies.

### **7.10 Develop and adapt counselling protocols**

Service providers may develop different counselling protocols for different target groups based on such considerations as levels of knowledge of HIV and AIDS, age, gender, disability, culture and language. The protocols, however, must be approved by MOH before implementation.

### **7.11 Expand the cadres and numbers of HTC staff**

In addition to the current staff providing HTC, additional cadres should be trained to provide HTC services in the community. These may include influential people in the community, retired professionals, PLWH, spiritual and traditional healers.

### **7.12 Institutional capacity building**

- Improve the infrastructure for expanded HTC services e.g. space and equipment
- Improve management capacity of all institutions including government facilities e.g. governance, financial management, reporting, resource mobilization, communication skills, networking, supplies management and human resource management
- All institutions should put in place, and adhere to, a quality assurance plan for both HIV counselling and HIV testing as they scale up

### **7.13 Skills Development**

Service providers' skills should be developed using the following:

- Refresher courses to update service providers on cater for emerging technologies and keeping abreast of new developments or knowledge needs e.g. training in the use of new testing technology, couples counselling and supervision
- Increasing the range of skills in HTC staff to include such skills as supportive and prevention counselling, referrals, facilitation of post-test clubs and, support groups

## Chapter 8: Monitoring and Evaluation

### Monitoring and Evaluation

The purpose of monitoring and evaluation (M&E) is to assess service operations with the view of improving quality and utilization. M&E involves the creation of an information system and determining indicators for assessment of activities. The information system has to be acceptable, comprehensive, accurate and timeous. It must cover three main areas of HTC, namely HIV counselling, HIV testing and logistics.

#### 8.1 Data collection, management and use

##### 8.1.1 Data collection tools

Standardized tools approved by the Ministry of Health (MOH) should be used by all service providers.

##### 8.1.2 Data compilation

Compilation of data should be carried out by a designated officer as follows:

- By the counselor or designated staff , at facility level
- Usually by the Community Health Nurse at the District Health Team (DHT) level and the District M&E Officers
- Hospitals
- The Data Clerk (supervised by the Epidemiologist) at the MOH level. The data is then submitted to the National AIDS Coordination Agency (NACA) for compilation at national level and feedback.

##### 8.1.3 Data flow

Below are details of how the data flows in different facilities:

Government facilities

- o Client/patient registration
- o Facilities send monthly reports to the DHT
- o DHT to send to MLG and MOH monthly
- o Hospitals send monthly reports directly to MOH
- o Integration
- o MOH submits monthly reports to NACA

Time – this has to be defined for information flow

Civil society with Head Office:

- o Submit monthly reports to Head Office
- o Head office cleans, compiles and submits monthly reports to MOH
- o MOH submits monthly reports to NACA

Time – this has to be defined for information flow

Civil society without Head Office

- o Submit monthly reports to DHT
- o DHT to submit to MOH

- o MOH submits monthly reports to NACA

Private sector including mining hospitals

- o Submit monthly reports to DHT
- o DHT to submit to MOH
- o MOH submits monthly reports to NACA

#### **8.1.4 Feedback**

MOH should provide feedback to DHTs, hospitals, civil society and private sectors.

#### **8.1.5 Data support**

MOH-approved data support methods and systems should be used at all levels. Support methods and systems will be upgraded as technologies become available.

#### **8.1.6 Data protection**

It is critical that the confidentiality of clients and patients is ensured as detailed below.

- Records should be kept under lock and key in filing cabinets.
- Pass word protection or locks can be used even for electronic data.
- Special attention should be paid to the protection of records with identifiable client information.
- Storage and transportation of client or patient records from outreach or mobile activities should ensure confidentiality of clients or patients.

#### **8.1.7 Data cleaning**

MOH should clean the data before generating reports.

Each organization in the private sector and civil society settings should clean data before reporting e.g. double counting should be avoided.

#### **8.1.8 Data storage**

Each level should keep both hard and soft copies securely.

#### **8.1.9 Data back-up**

All levels should keep a back-up copy of the data at all times. CDs, hard discs or flash drives should be used to keep soft copies.

#### **8.1.10 Data transfer**

At all levels, data should be transferred electronically. When electronic transfer is not possible, hard copy or memory sticks may be used to transfer data in a secure manner.

#### **8.1.11 Data use**

Data generated should be analyzed and reports produced. These reports should be disseminated to all levels for the purposes of improvement of services, planning and policy making, for example. Those who receive the reports should give feedback to the facilities and organizations that generate data.

## 8.2 Data Publication

Any articles or publications on HTC data should be submitted to MOH and respective organizations for clearance before publication. This includes abstracts for national and international conferences. When appropriate, other national clearing mechanisms such as the Research Unit should also be engaged.

## 8.3 Training of staff

All the staff who participate in data collection and management should receive periodic and refresher training approved by MOH. New staff should also be trained accordingly.

## 8.4 Resources for information system

Service providers need to ensure that all the necessary resources are in place for a functional information system. These include stationery, data collection tools and, computers.

## Evaluation

The HTC services should be evaluated quarterly.

## 8.5 Minimum indicators for use in HTC include the following:

- Number of service delivery facilities or outlets providing HTC according to national standards
- Number of individuals counseled and tested, and received their test results according to national standards, by age and sex
- Number of people who test HIV positive by age and sex
- Number of people trained in HTC according to national standards
- Availability of HIV test kits and supplies in the facilities
- Number of people referred to prevention, treatment, care and support services
- Number of people who accept the RHT
- Number of health facilities reporting to the various levels, e.g. how many clinics report to the DHT in a given period, how many DHTs report to the MOH etc.

## 8.6 Minimum M&E tools and records for HTC

### 8.6.1 Government level:

- Client/patient daily registration book
- Client intake form
- Hematology form
- HIV testing daily record book/form
- Outpatient card
- Referral form
- Monthly reporting form

**8.6.2 Private sector and civil society levels**

- Client card
- Client daily registration book
- Client intake form
- HIV testing daily record book/form
- Hematology form
- Client referral form
- Monthly reporting form
- Medical records

**ANNEX I: TECHNICAL REVIEW COMMITTEE**

1. Mrs M.T. Kejelepula, Ministry of Health, DHAPC
2. Mr. C. O. Ntsuape, Ministry of Health, DHAPC
3. Mrs N. H. Matumo, Ministry of Health, DHAPC
4. Mrs A. Mathew, Ministry of Health, DHAPC
5. Ms S. D. Lesotlho, Ministry of Health, DHAPC
6. Dr D. Baxter, Ministry of Health, DHAPC
7. Dr M. Mine, Ministry of Health, National Laboratory
8. Dr H. B. Jibril, Ministry of Health, DHAPC
9. Ms M. G. Alwano, BOTUSA/CDC
10. Ms K. Molosiwa, WHO – Botswana
11. Dr B. Ncube, WHO/AFRO – Technical Advisor
12. Mr. K. Mphoyakgosi, Ministry of Health, National Laboratory
13. Dr F. Gomez, Ministry of Health, DHAPC
14. Mr. S. Makathayi, Ministry of Health, DHAPC
15. Mrs. M. Magama, Ministry of Health, I. H. S.
16. Mrs B. B. Mosime, Ministry of Local Government, DSS
17. Mr. B. Monyatsi, Tebelopele VCT Centre
18. Ms O. Moseki, Botswana Network of Ethics Law and HIV/AIDS (BONELA)

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