



Republic of The Gambia

# The Gambia National Guidelines for HIV Testing Services (HTS)

**Ministry of Health**

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## Acronyms and Abbreviations

AGYW	Adolescent Girls and Young Women	MOH	Ministry of Health
ANC	Antenatal Clinic	MSM	Men Who Have Sex with Men
ART	Antiretroviral Therapy	NACP	National AIDS Control Program
ARV	Antiretroviral drugs	NAS	National AIDS Secretariat
BBC	Behavioural Change Communication	NASO	National AIDS Support Organization
CD4	Cluster of Differentiation 4, CD4+ T Cells	OVC	Orphans and vulnerable children
CHA	Community Health Assistants	PCR	Polymerase Chain Reaction
CHP	Community Health Partners	PEP	Post-Exposure Prophylaxis
CITC	Client-initiated testing and counselling	PITC	provider-initiated testing and counselling
CTC	HIV Care and Treatment Centre	PLHIV	People Living With HIV
DOT	Directly Observed Treatment	PMTCT	Prevention of Maternal to Child Transmission
DIC	Drop-In-Centre	PrEP	Pre-Exposure Prophylaxis
DNA	Deoxyribonucleic acid	PSHD	Presumed severe HIV disease in infants
DSD	Differentiated Service Delivery	PWID	People Who Inject Drugs
eMTCT	elimination of Mother To Child Transmission	QA	Quality Assurance
FSW	Female Sex Worker	RDTs	Rapid Diagnostic Tests
FUP	Follow Up	SDPs	Service Delivery Points
HBsAg	Hepatitis B surface antigen	SOP	Standard Operating Procedures
HIV	Human Immunodeficiency virus	STI	Sexually Transmitted Infection
HIVST	HIV Self-Testing	TB	Mycobacterium Tuberculosis
HTC	HIV Testing and Counselling	TG	Transgender
HTS	HIV Testing Services	TPT	Tuberculosis (TB) Preventative Therapy
IEC	Information, Education & Communication	TWG	Technical Working Group
IPV	Intimate Partner Violence	UNAIDS	The Joint United Nations Program on HIV/AIDS
IPT	Isoniazid Preventive Therapy	VL	Viral Load
KP	Key Population	WC	Wellness Centre
M&E	Monitoring and Evaluation	WHO	World Health Organization

## Foreword

The Gambia has joined other countries towards achieving the UNAIDS 95:95:95 targets with the vision of bringing the HIV epidemic under control by 2030. Bringing the HIV epidemic under control is integral to the socio-economic development and health well-being of all Gambians. Consequently, The Government of The Gambia declared HIV and AIDS as a major Public Health priority and has put in place policies, infrastructures and programmes to control the epidemic and alleviate its adverse effects. In response to a strong need for national guidance in the delivery of HIV services, the first National Guidelines for Voluntary Counselling and Testing (VCT) services were developed and disseminated by the Ministry of Health (MOH) through the National AIDS Control Programme (NACP) in 2005. VCT later evolved to HIV Counselling and Testing (HCT) and now HIV Testing Services (HTS). The Ministry of Health (MOH) acknowledges the need to continuously adopt new approaches in response to the changing epidemic of HIV. This prompted the ministry to focus its response efforts to target priority areas and population groups with the need for periodic HTS policy reviews to incorporate new evidence-informed approaches.

The Global Fund to Fight AIDS, Tuberculosis, and Malaria (The Global Fund) had engaged the services of FHI 360 to provide expert technical services to the Differentiated Service Delivery Strategic Initiative (DSD SI) in The Gambia. DSD is a patient-centred approach that simplifies and adapts HIV services across the cascade to reflect the preferences, expectations and needs of people living with and vulnerable to HIV, while reducing unnecessary burdens on the healthcare system. As part of the DSD SI program, FHI 360 coordinated the development of a National DSD Guidelines in April 2023, and simultaneously, coordinated the review and development of a National HTS Consolidated Guidelines.

The goal of HTS is to create access to services by allowing people to know their status, access to the elimination of Mother-to-Child Transmission (eMTCT), treatment, care and support programs. Currently, in The Gambia, there are 82 HTS sites, 76 eMTCT sites, and 23 ART sites offering HCT services. This HTS consolidated guidelines and Standard Operating Procedures (SOPs) have been prepared to maintain the momentum of scaling-up and to outline national standards that must be adhered to by all institutions, organisations and individuals in the provision of high-quality HTS in The Gambia. The higher goal of counselling is prevention of HIV infection by promoting behaviour change and provision of psychosocial support for people infected or affected by HIV. This has been taken into consideration during the development of these guidelines.

This document provides the acceptable standard of DSD service delivery models for effective HTS delivery. It also discusses key updates with a focus on new evidence, new recommendations, good practices and operational considerations that respond to the changing needs of our HIV national programs. The Guideline also offers guidance for HIV Self-Test (HIVST) delivery approaches and the various modes of distribution for HIVST and recommends different strategies for the uptake of HIVST. These Guidelines therefore offers all that service providers require to deliver a comprehensive package of high-quality HTS that addresses the needs of individuals at high risk of acquiring HIV infection and the general population.

The overall goal of this document is to provide an updated guideline reflecting national standards for HTS in a wider sense and to ensure coherence with other policies, standards and legislation. It is our hope that this guideline will provide adequate guidance for the users – the front-line health care providers and contribute towards improvement in the quality of life for those infected and affected by HIV.

We look forward to a continued partnership with you as we join forces in the fight against HIV and AIDS and reach epidemic control (EpiC) in The Gambia.

I therefore endorse and recommend this 2023 National HIV Testing Services Guidelines for use across all the health facilities and service delivery points in the country and also for individuals and organizations involved in HIV and AIDS programmes.

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Dr. Mustapha Bittaye  
Director of Health Services

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# 1.0 INTRODUCTION

## 1.1 Background

The Gambia is a small West African country, bounded by Senegal, with a narrow Atlantic coastline. The country stretches approximately 400 km eastwards, and its width varies between 80km at the Atlantic and about 28km in the inland east. The country is divided horizontally by the River Gambia and the total land area is 11,295 square km. The total population in Gambia was estimated at 2.3 million people in 2020, according to the latest census figures and projections from Trading Economics.

The Gambia has joined other countries towards achieving the UNAIDS 95:95:95 targets with the vision of bringing the HIV epidemic under control by 2030. Bringing the HIV epidemic under control is integral to the socio-economic development and health and well-being of all Gambians. The country has made progress in combatting HIV and AIDS since its first detection in the country in 1986 when the Ministry of Health, Labor, and Social Welfare established the National AIDS Control Program (NACP). The first plan developed in 1987 was health-focused and led to the setting up of the National AIDS Control Programme (NACP) within the Ministry of Health. By the mid 1990s, the Government prepared a strategic framework for HIV as part of the National Health Policy (1994-2000) and the National HIV/AIDS Policies and Guidelines, and launched programs to fight the epidemic which received support from internal and external development partners. However, the level of funding and coordination were vastly inadequate primarily due to limited visibility of the issue and a lack of commitment and leadership from the political strata till 2000.

In 2001, The Gambia got funding from the World Bank for the implementation of an HIV/AIDS Rapid Response Project (HARRP). Within the framework of this project, a National AIDS Council (NAC) and National AIDS Secretariat (NAS) was established under the Office of the President with The President being the chairman of the NAC. Great strides have been made in The Gambia since 1987 when rapid testing was first introduced, leading to rapid expansion in provision and utilization of HIV counselling and testing services to know their HIV status, to support prevention of mother to child transmission, and to encourage the population to reduce risky behaviour and gain earlier access to treatment, care, and support services through the (NAC).

The Gambia can be described as having a generalized HIV epidemic. According to WHO, most generalized HIV epidemics are mixed in nature, in which key subpopulations are excessively affected. In The Gambia, HIV prevalence in the general population was 1.9% among adults (male and female) 15-49 years according to the 2013 DHS. It is estimated that 27,000 (21,000–35,000) people are living with HIV (2021), and only 13,692 (51%) are aware of their HIV status. The most recent (2018) Integrated Bio-Behavioural Surveillance Study (IBBS) among female sex workers (FSW) and men who have sex with men (MSM) in the Greater Banjul and neighbouring areas estimates an HIV prevalence among FSW of 11% and MSM 35.5%. The HIV prevalence among FSW has decreased by 4.9 percentage points, from 15.9% in 2011 down to 11% in 2018; whilst it increased more than three-fold among MSM from 9.8% in 2011 to 35.5% in 2018.

In 2018, the Gambia started implementing WHO's recommendation to provide all people living with HIV with lifelong antiretroviral therapy (ART) regardless of clinical status or CD4 cell count. Between 2015 and 2020, impressive progress happened as new infections were cut by half and new infections

among children were reduced by 75% (National AIDS Strategic Plan, 2020-2025). All pregnant women attending antenatal clinics are routinely offered HIV tests, and all pregnant women living with HIV are eligible for ART (Option B+). Until the COVID-19 pandemic, ART uptake had increased significantly. The country also adopted task shifting for HIV/AIDS and malaria - typically enabling nurses to dispense ART and capacitating community health workers to deliver a range of HIV services.

In July 2015, following the recommendation of the World Health Organisation (WHO) in the Consolidated Guidelines on HIV Testing Services, HIV Counselling and Testing nomenclature was changed to HIV Testing Services (HTS). HTS are a unique opportunity and a door for those diagnosed with HIV to rapidly initiate lifesaving treatment and for those at higher risk of acquiring the virus to have immediate access to the effective recommended package of prevention services to remain negatives. Testing services are essential to achieving the Sustainable Development Goal 3 of the 2030 Agenda for Sustainable Development, bringing the HIV epidemic under control.

In the national response to HIV and AIDS, the goal of HTS is to create access to services by allowing people to know their status, access to the elimination of Mother-to-Child Transmission (eMTCT), treatment, care, and support programs. A total of 82 HTS and 76 eMTCT centres have been established. However, HTS services are limited to health facilities; with youth-friendly centres conducting HTS and other services for the youths.

All staff providing HTS should adhere to these guidelines and standard operating procedures (SOPs) when delivering services to meet the set standards of quality.

## 1.2 Objectives of the HTS Guidelines

**The HTS guidelines aim to:**

- Provide comprehensive policy guidance for the delivery of quality HIV Testing Services (HTS) in all approaches and settings in The Gambia.
- Offer guidance to service providers and beneficiaries of HTS operational manuals.
- Describe the responsibilities of various actors in HTS delivery at all service levels.
- Provide guidance for strengthening connections to HIV prevention, treatment, care, and support services.
- Describe the various HTS Differentiated Service Delivery (DSD) strategies for different settings and types of populations.

## 1.3 Policy Statement and Guiding Principles for HTS in The Gambia

An important bottleneck in access to HIV prevention, treatment and care is knowing one's status. HIV Testing Services (HTS) include HIV testing, counselling (pre and post testing services, disclosure, adherence) and linkage to appropriate HIV prevention, treatment, and care services. HTS have evidence of success in increasing access to treatment, care, and support services. HTS in The Gambia should be delivered with a public health and human rights-based approach that highlights priority areas, including universal health coverage, gender equality and health-related human rights such as accessibility, availability, acceptability, and quality of services. In this approach, the public health benefits must always outweigh the potential harm or risk. In addition, the main reasons for testing must always be to both benefit the individuals tested and to improve health outcomes at the

population level. HTS should be expanded with the primary aim to provide access for all people in need to appropriate, quality HTS, which is linkable to prevention, treatment, care, and support services. HIV testing services serve as the entry point to prevention, care, and treatment programs. Laboratory services should support quality assurance and delivery of correct results. All HIV Testing Services in The Gambia should be conducted in accordance with the best interest of the client (child, adolescent, adult, or key populations). HIV testing should never be coercive or mandatory, therefore it must always be voluntary, and consent for testing must be informed by pre-test information, except in unique situations like court orders.

HTS must be provided when consented to or indicated in accordance with a client-centred approach, guided by five core principles, known as the “5Cs” (Consent, Correct and accurate HIV test result,



All HIV testing services must adhere to the 5 Cs of HIV testing

**C**onsent  
**C**onfidentiality  
**C**ounselling  
**C**orrect results  
**C**onnections

World Health Organization

Confidentiality, Counselling, and Connections to HIV Prevention, Treatment, Care, and Support services). The World Health Organization (WHO) recommends that the following guiding principles of the 5Cs be observed in the provision of all HIV Counselling and testing services (1).

**Figure 1: The Guiding Principle of HTS, the 5Cs. All HTS should adhere to the 5Cs.**



### **1.3.1 Consent**

Mandatory HIV testing is neither effective for public health purposes nor ethical, as it denies individuals choice and violates principles such as the right to health, including the right to privacy and the ethical duties to obtain informed consent and maintain confidentiality. Although the process of obtaining informed consent will vary according to different settings, all those offered the test should receive sufficient information and should be helped to an adequate understanding of the testing process and possible consequences of being tested.

### **1.3.2 Correct and Accurate HIV Test Results**

HIV Testing service providers should ensure the provision of high-quality testing services including results of high accuracy. Testers should be trained and proficient through internal and external Quality Assurance (QA). QA mechanisms should be employed to ensure that people receive correct diagnoses at all stages. All persons who receive HIV-positive test results should be retested to verify and confirm their diagnoses before, or at the time of initiating antiretroviral therapy (ART). Clients should have sufficient information to agree to be tested which includes voluntarism.

### **1.3.3 Confidentiality**

All medical records, whether or not they involve HIV-related information, should be managed in accordance with appropriate standards of confidentiality. Medical records, including those with HIV-related information, must be managed in accordance with appropriate standards of confidentiality. Only health care professionals with a direct role in the management of patients or clients should have access to such records or the information they contain, and only on a “need to know” basis. Clients should be assured that their records will be stored in a secure and confidential location and should understand who will have access to them.

HIV Testing Services must therefore be confidential, which means that what is discussed by the HTS provider, and the client shall not be disclosed to anyone else without the expressed consent of the person being tested. Confidentiality should be respected, but should not reinforce secrecy, stigma, or shame. HTS providers should discuss with clients, among other issues, whom the person may wish to inform about their test results, and how they would like this to be done. Shared Confidentiality and its benefit should be discussed with client at the onset of information giving. Shared confidentiality with partners, family members, or other trusted persons as well as with other healthcare providers can be highly beneficial to ensure the accuracy of the result and for the health and well-being of the client.

Confidentiality of the client must not be breached except in unique situations where benefits outweigh risks such as when the provider has reason to believe that the client will commit suicide or otherwise harm themselves or others.

### **1.3.4 Counselling**

All clients should receive high-quality pre-and post-test Counselling which are essential components of HTS. Pre-test information can be provided on a one-on-one basis or in a group setting. However, in group setting, clients should be provided with the opportunity

to ask questions in private if they so desire. Following the HIV test, the results should always be offered to the person being tested. It is the person's decision to share this result with others.

Along with the result, clients should be offered the opportunity to receive appropriate and high-quality post-test information, counselling or referral based on their HIV test results and their situation. QA mechanisms including supportive supervision and mentoring systems should be in place to ensure the provision of high-quality counselling.

### **1.3.5 Connections to HIV Prevention, Treatment, Care and Support Services**

All individuals tested should be connected with or linked to appropriate Linkages to prevention, treatment, care, and support services based on their situations and their test results. Providers should support clients to access follow-up services by actively linking them with these services. This includes identifying barriers to accessing follow-up services and identifying strategies with clients to overcome these barriers. Providing HTS without linkage to ART has limited benefit for persons living with HIV (PLHIV).

## 2.0 ETHICAL AND LEGAL CONSIDERATIONS

### 2.1 Eligibility

- Since HIV and AIDS have no boundary, counselling and testing will be open for all ages, irrespective of religion, ethnic or other social status.
- For those **below Sixteen (16)** years and unless for urgent medical interventions the consent of the parents or legal care giver must first be sought, while those **sixteen years and above** can consent on their own within defined national guidelines (2,3).
- The MOH will be responsible for ensuring quality in counselling and testing services according to national guidelines
- HTS services that are accessible and affordable throughout the country will be promoted
- Informed consent must be obtained as appropriate, and confidentiality maintained in all cases of counselling and testing
- All HIV test results should be reported according to national guidelines on confidentiality and the penalty for breach of confidentiality should be within the context of the Medical Ethics and code of conduct and laws of The Gambia.
- Vulnerable groups will be encouraged and counselled to do regular voluntary testing in order to know their HIV status and to seek early diagnosis and effective treatment for STIs. Special consideration will be offered for the voluntary testing of people thought to be engaged in high-risk sexual behaviour such as commercial sex workers.
- Except for the screening of donated blood routine testing for HIV and AIDS shall not be carried out without the consent of the subject.

### 2.2 Pre-test information

The counsellor will provide pre-test information to clients through individual or group information sessions and through media such as posters, brochures, websites, and short video clips shown in waiting rooms. When children and adolescents are receiving HTS, information should be presented in an age-appropriate way to ensure comprehension. Offering or recommending HIV testing to a client or a group of clients includes providing clear and concise information on:

- The benefits of HIV testing.
- The meaning of an HIV-positive and an HIV-negative diagnosis
- The services available in the case of an HIV-positive or negative diagnosis, including where ART is provided.
- The potential for incorrect results if a person already on ART is tested.
- A brief description of prevention options and encouragement of partner testing.
- The fact that the test result and any information shared by the client is confidential.
- The fact that the client has the right to refuse to be tested and that declining testing will not affect the client's access to HIV-related services or general medical care.
- Potential risks of testing to the client in settings where there are legal implications for those who test positive and/or for those whose sexual or other behaviour is stigmatized.
- An opportunity to ask the provider questions.

## Special considerations for pregnant or postpartum women

Pre-test information or health education for women who are or may become pregnant or are postpartum, in addition to the above should also include:

- The potential risk of transmitting HIV to the infant
- Measures that can be taken to reduce mother-to-child transmission, including the provision of ART to benefit the mother and prevent HIV transmission to the infant.
- Counselling on infant feeding practices to reduce the risk of HIV transmission.
- The benefits of early HIV diagnosis for mothers and infants.
- Encouragement for partner testing.

### Pre-test information are provided using the following guidelines:

- Administer informed consent either written or orally in the clients' choice of language.
- Explain to the client the advantages and disadvantages of taking an HIV test and give him/her an opportunity to ask questions.
- Ensure that the individual meets the client eligibility requirements outlined in section 2.1
- Obtain written consent either by signing or thumbprint.
- Assign a unique personal code to one individual who agrees to undergo testing and has given informed consent.

To verify that informed consent has been given, the counsellor will record his/her name, the date of consent and other client information on the Counselling and Testing Register/devices and the national HIV informed consent form. These documents will all be stored in the lockable cabinet and will be available for review by the quality assurance team/monitors or supervisors.

## 2.3 Informed Consent



The term “informed consent” refers to a person being allowed an opportunity to consider the benefits and potential implications associated with having access to information regarding their HIV sero-status, an understanding of the testing procedure, and then making the decision to be tested for HIV. A person should be able to consider the implications of a negative or positive HIV test result.

All clients in HTS should receive sufficient information and should be helped to reach an adequate understanding of what is involved. The three crucial elements in obtaining informed consent of HIV testing are to:

- Provide pre-test information on the purpose of testing and availability of care, treatment, and support services;
- Ensure the person's understanding of these messages; and
- Respect the person's autonomy.

Only when these elements are in place will clients be able to make a fully informed decision on whether to be tested. The HIV test done at the testing facility will be voluntary and will take place only after the client has provided written or thumbprint informed consent. The counsellor will also sign as a witness. However, a parent/guardian consent form must be filled out before testing is done to the following individuals:

- a. Children below 16 years (2,3).
- b. Client with communication disability.
- c. Client with mental disability.

## 2.4 Client Confidentiality

Confidentiality is one of the 5Cs guiding principles for the provision of HTS services (see Section 1.2) and must be protected. All HTS providers must remain committed to preserving confidentiality, which applies not only to the test results and reports of HIV status but also to any personal information, such as information concerning sexual behaviour and the use of illegal drugs. HTS should avoid practices that can inadvertently reveal a client's test results, or HIV status,



to others in the waiting room or in the health facility. Such practices might include counselling all people diagnosed HIV-positive in a special room or by a specific provider or making it obvious to others which clients will need or is receiving additional testing or lengthy post-test counselling. Disclosure of the results to a third person shall only be done with a preferred written consent or a witness evident verbal consent from the person tested. For minors and other persons who require parental consent for HIV testing, results should be disclosed to the parent or guardian (see section 2.1 and 2.3).

Lack of confidentiality discourages people from using HTS. Special training must be provided to Health workers and others who provide HIV testing. Sensitization should be provided to Healthcare workers regarding the confidentiality of medical records, particularly where key populations are concerned.

All clients' information will be kept confidential and private. Clients will be reassured repeatedly that all information that they provide about themselves will be kept in the strictest confidence. Counselling will be conducted in private where the conversation between the client and the counsellor cannot be overheard.

Because HIV and AIDS are highly sensitive and emotionally charged issues, information about the clients' HIV sero-status and sexual partners must be considered the most confidential information and must be protected at all times. Discussions between counsellors or health care providers and supervisors, including case discussions in supervision, shall protect the privacy of clients. Individuals' confidentiality will be protected in conversations between counsellors and other staff members.

Any staff member who breaches confidentiality is acting contrary to the professional code of conduct and may be subjected to legal action.

## 2.5 Confidential Record Keeping

All client registers, as well as informed consent records must be managed in accordance with the stipulated standards of confidentiality in the facility and where this is not available, then locked in steel cabinets. Only persons with a direct role in the management of the client should have access to these records.



## 2.6 Shared Confidentiality

Shared confidentiality is when a person accessing HIV testing wishes to involve others in the HIV testing and Counselling process. Shared confidentiality can be also applied to the disclosure of information from an individual to family members and friends. Counsellors should educate clients on the importance of disclosure of their HIV status and encourage them to do so.

## 2.7 Beneficial Disclosure

All clients, both HIV positive and negative, should be encouraged to inform their partner(s) about their HIV test results. HIV-positive persons who are reluctant or fearful to disclose their results to their partner(s) must be referred for additional, ongoing more in-depth Counselling to help them to do so. Women potentially face gender-related negative consequences following disclosure of HIV status. There will be a special pre-test Counselling component designed for all female clients. It outlines counselling and safety approaches to Intimate Partner Violence (IPV). In addition, given that a history of prior domestic violence is the best predictor of future violence, counsellors will be equipped with tools to identify women with such a history so that these women may assess their potential risks before testing and be counselled about referrals to minimize these risks.

## 2.8 Negative Life Events and Incidents

Negative life events are detrimental social interactions experienced by clients. During Counselling, clients, particularly women, may report negative events associated with testing for HIV. These may include the breakup of their marriage or sexual relationship, intimate partner violence, neglect or disownment by their family, rejection by peers, discrimination by health care providers or employers, financial problems, physical illness, illness, or death of relatives, being abused, drug use, HIV infection, AIDS diagnosis, HIV/AIDS discrimination, and sexual partner or family members infected with HIV.

## 3.0 SERVICE DELIVERY APPROACHES TO HTS

### 3.1 Aims of a Good HTS Program

Provider Initiated Testing and Counselling (PITC) should be a routine part of health care at different Service Delivery Points (SDPs) within the health facility - ANCs (antenatal clinics), Tuberculosis (TB clinics), directly observed treatment short-course-clinics (DOTS clinics) and STI (sexually transmitted infections) or in-patient services (wards, theatre, blood bank).

### 3.2 Elements of a Good HTS Program

- **Demand creation:** Create an enabling environment that promotes equal and universal access to safe, effective, and good quality HIV testing services. Highlighting evidence-based approaches and considerations for the use of incentives for HIV testing services, including linkage;
- **Counselling and message:** Encourage individuals, couples, families, and communities to test for HIV in the interests of their own health. Use messages and guidance on concise communications with emphasis on linkage and latest information on the benefits of treatment and prevention services;
- **HIV Self-Testing Services:** HIV self-testing (HIVST) should be offered as an approach to HIV testing services;
- **HIV Testing Strategies:** In response to changes in the HIV epidemic, WHO encourages countries to move toward using three consecutive reactive tests to provide an HIV-positive diagnosis;
- **HIV testing among key populations (KP):** Encourage key populations and marginalized groups to test and seek treatment in the interest of their own health;
- **Reaching social networks:** Social network-based approaches can be offered as an HIV testing approach for key populations as part of a comprehensive package of care and prevention. Social networks of key populations and adolescent girls and young women (AGYW) should be offered HIV testing through their organization as part of a comprehensive package of care and prevention. Community Health Nurses who are trained and supervised can independently conduct safe and effective HIV screening testing using rapid diagnostic tests (RDTs) in their community locations;
- **Trio HIV/syphilis/HBV rapid diagnostic tests:** All pregnant women should be tested for HIV, syphilis, and hepatitis B surface antigen (HBsAg) at least once and as early as possible. Integrate syphilis and HIV testing at the ANCs for more efficient diagnosis of HIV and syphilis among pregnant women and increased prevention of mother-to-child transmission of HIV and syphilis;
- **Program integration:** Facilitate and promote integration of HTS with malnutrition and TB clinics, family planning (FP), STI, Immunization and AGYW programs;
- **Retesting time points:** HIV retesting is advised for the following category of persons;
  - Pregnant women with an unknown or HIV-negative status during late pregnancy (third trimester) and in post-partum care.
  - People who have ongoing HIV-related high risks in all settings, for example -

- Key populations, including men who have sex with men (MSM), female sex workers (FSW), transgender people (TG), people in prison, people who inject drugs (PWID).
- Epidemic specific risk groups such as men and adolescent girls and young women and people with a known HIV-positive partner.

### 3.3 WHO-Recommended Differentiated HTS Delivery Approaches

There are different approaches for the delivery of HTS. One particular approach may not fit all target groups and as such a variety maybe required based on cultural factors and the needs of the specific group. It is also essential that cost-effectiveness, sustainability, affordability, and convenience of the clients are considered in the planning of the approach to be adopted in each setting. In all approaches used, the “5 Cs” principle should be applied. The following are the approaches recommended:

1. **Facility-based HIV testing services** should be considered and routinely provided in all service delivery points within a health facility (Multi-point testing)
2. **Community-based Outreach HIV testing services** should be used among key populations and high HIV burden settings. Scaling up screening and testing in communities by Assistant service providers (CHA (Community Health Assistants) & CHP (Community Health Partners)) and referral for confirmation at health facility.
3. **HIV self-testing (HIVST)** is recommended for underserved population such as KPs, AGYW and men.
4. **Index testing and social network referral**-based approaches: These are very important strategies in identifying new HIV cases:
  - a. Where feasible and acceptable to the client, **provider-assisted referral** should be prioritized, as it is highly effective and provides the opportunity to offer comprehensive prevention interventions to partners who are HIV-negative but remain vulnerable to HIV acquisition.
  - b. **Patient referral**, in which a trained provider encourages the client to disclose their HIV status to their partner(s), and then refer them for HTS. The client should assist the provider on the approach, time, and place to contact their partners. The choice of persons who do not want their partners to be contacted or need time to do so should be respected and supported in their decision. The details on partner notification options are described on Table 1 below:

**Table 1: Options for partner notification**

Method of partner notification	Definition
Client Referral	“Tell your partner about your positive HIV diagnosis and encourage him or her to come to the health facility for an HIV test”
Dual Referral	“If you are not confident informing your partner about your HIV status, just convince him/her to come to the facility for any reason you will give. Without disclosing your HIV status,

	we will use our expertise to work with both of you from scratch and offer HIV testing and counselling”
Contract Referral	“We will give you some time to tell you partner about your HIV positive diagnosis and encourage him or her to come to the health facility for an HIV test. If we don’t see him/her within the agreed period, we will support you reaching out to your partner using the contact details you provide”
Provider Referral	“Since you have indicated that you are not confident to reach out to your partner, I will use my expertise to reach out him/her immediately so that should benefit from HIV testing”

- c. **Family index testing:** HTS should be extended to all sexual contacts and biological children of HIV positive clients. These contacts include: spouses, other sexual partners, injection drug partners, and biological children of less than 15 year of age. Care should be exercised to ensure the process is informative, non-coercive and confidential to avoid irrational exposure of one’s sexual contacts. Adverse events such as intimate partner violence such as physical violence, sexual and emotional or other adverse events should be reported to HTS Supervisors and documented to inform refining protection of beneficiaries and program improvement.
  - d. **Risk network referral approach:** The probability of HIV index cases bringing HIV cases through their social networks is high. HIV positive people are told to bring anyone they socialize with in any way to benefit from HIV testing services.
5. Trio HIV/syphilis/HBV rapid tests are recommended for testing pregnant women in antenatal care settings, to enable rapid progress toward the elimination of mother-to-child transmission of HIV and syphilis. To provide early HIV diagnosis, and as part of broader efforts to eliminate mother-to-child transmission of HIV, syphilis and hepatitis B virus, pregnant women should be tested as early as possible, ideally in first trimester. **Trio HIV/syphilis/HBV rapid diagnostic tests (RDTs) can be used as the first test in antenatal care.**

### 3.3.1 Individuals or Couples Wanting to Know Their Status

Individuals or couples may voluntarily seek out HTS for a range of reasons: a need to know their status before entering into a new relationship or ending one where there was infidelity, deciding to test following a risk encounter, testing because they want to plan for the future, and so on. Individuals seeking HIV testing should always be counselled, and an informed consent must be obtained before testing.

### 3.3.2 HTS May Also be Offered in the Following Circumstances:

1. **Post-Exposure Prophylaxis (PEP):** This is providing ARVs within 72hrs to people with accidental exposure to a potentially HIV positive source, such as in accidental prick from a high-risk source or a rape event (See The Gambia HIV Treatment Guidelines). PEP must be preceded by pre-test counselling and HIV testing.
2. **Research and other screening purposes:** HIV testing for research purposes, includes –

Sero-sentinel survey with anonymous antenatal screening - for determination of PMTCT needs and national HIV prevalence through The Gambia Demographic and Health Survey.

3. Domestic violence and rape: In the case of domestic violence and rape, provide pre-test counselling and HTS, and give PEP as quick as possible, within 72hrs.
4. HIV screening of blood and blood products, and organ donation (see Box 1 for summary of required information)

### **Box 1: Summary of principles related to HIV and blood donation**

**Testing the donors' blood:** All donors are screened for laboratory evidence of HIV-1 and HIV-2, syphilis, hepatitis B, hepatitis C and malaria. **All such donors must have the opportunity to learn their results and be referred for appropriate treatment.**

**Consent:** There must be informed consent, and it should include an explanation of the tests that will be performed on the donor's blood.

**Blood Donor questionnaire (The Donor Screening Tool):** Each donor shall answer various health and behaviour questions. Donors shall be counselled on the blood donation process including the testing for blood transmissible infections. In addition, donors shall be given the opportunity to receive a copy of any positive test result with referral to counselling regarding the significance of that result.

**For donors that express concern about knowing their HIV status:** First reassure on the benefit of knowing HIV status and follow the etiquettes of HTS (Section 4).

## 4.0 SERVICE DELIVERY FOR HIV TESTING SERVICES

### 4.1 HIV Testing and Counselling Approaches in The Gambia

As part of the move towards the acceleration of HIV prevention, treatment, care and support, the Ministry of Health (MOH) has approved the introduction and scaling up of self-testing and index testing services. Client-Initiated Counselling and Testing (CICT), Provider-Initiated Testing and Counselling (PICT), self-testing and index testing will be provided so that they complement each other in addressing the prevention, treatment, care, and support needs of the population.

The benefits of one knowing their HIV status at the individual, community and population levels are as follows:

- At the individual level, there is enhanced ability to reduce the risk of acquiring or transmitting HIV, coping with HIV status, planning for the future, accessing HIV prevention, treatment, care, and support services and protecting unborn babies and exposed infants from acquiring HIV.
- At the community level, a wider knowledge of HIV status and its links to interventions can lead to a reduction in stigma and discrimination.
- At the population level, knowledge of HIV status and trends can influence the policy environment, normalize HIV and AIDS and reduce stigma and discrimination.

Different approaches to HIV Counselling and testing in The Gambia are as follows:

1. **Client-Initiated Counselling and Testing (CICT):** In this approach, the client voluntarily decides to know his or her HIV status and seeks Counselling and testing services out of his or her own will for the prevention of HIV infection and personal life decision making.
2. **Provider-Initiated Counselling and Testing (PICT):** PICT refers to HIV Counselling and testing which is recommended by health care providers to persons attending health care facilities as a standard component of medical care (\*). The major purpose of such counselling and testing is to enable specific clinical decisions to be made and/or specific medical services to be offered that will not be possible without knowing the person's HIV status. The following are considered priorities for the implementation of PICT in The Gambia.
  - Children and adults seeking In-patient and Out-patient services
  - TB and STI patients.
  - Reproductive Maternal neonatal Child and Adolescent health services, including family planning services.
3. **HIV screening of blood and blood products, and organ donation:** This refers to screening for HIV and other blood-borne viruses of whole blood and other blood products that are destined for transfusion and replacement.

- Routine screening of donors is required before any procedure involving the transfer of bodily fluids or parts, such as artificial insemination, corneal grafts and organ transplant etc.
  - Mandatory testing can only be ordered by a court.
4. **Home Based/Family Counselling and Testing:** Provision of Counselling and testing services to clients and family members at household level. This can be done by using index client or door-to-door testing. The approach focuses on community localities especially underserved areas.
  5. **HIV Self-Testing:** a process in which a person collects his or her specimen (oral fluid or blood) and then performs an HIV test and interprets the result, often in a private setting, either alone or with someone he or she trusts.
  6. **Index testing:** all adults living with HIV should be counselled to bring all children for testing. Likewise, parents and siblings of children diagnosed as HIV-positive should be tested.

## 4.2 Provider Initiated Testing and Counselling

Provider Initiated Testing and Counselling (PITC) refers to HIV testing and counselling recommended during treatment by health care providers to enable specific clinical decisions to be made and/or specific medical services to be offered. A brief Counselling or pre-test education/information should always accompany testing even for diagnostic purposes and clients/patients should never be forced to undergo testing against their will. In clients/patients presenting with symptoms or signs of illness possibly attributable to HIV, it is a basic responsibility of health care providers to recommend HIV testing and Counselling (HTC) as part of routine clinical management.

PICT also aims to identify unrecognized or unsuspected HIV infection in clients/patients attending health facilities. Providers may therefore recommend HIV testing and counselling to clients/patients who do not exhibit obvious HIV-related symptoms and signs. Such HTS is recommended by the health care provider as part of a package of services provided to all clients/patients during all clinical interactions in the facility.

PITC encompasses both the “opt-in” or “opt-out” strategies used in HTS, “opt-in” generally refers to where a client/patient explicitly consents to the test after a pre-test information. With the “opt-out” approach, individuals may specifically decline the HIV test after a pre-test information, without this decision affecting their clinical care.

### 4.2.1 Pre-test information

- Create rapport with the client/patient.
- Discuss the need for HIV testing, highlighting the benefits of accessing the service.
- Ascertain interest in being tested for HIV.

- Move on to preparing for HIV testing if the client/patient is agreeable to the test.
- Client/patient declining the test should be offered assistance to access either client-initiated (CICT) or provider-initiated HIV testing and counselling (PITC) in the future.

#### 4.2.2 Prepare for HIV Testing

If the client/patient decides to proceed with HIV tests, then you need to prepare them for the testing by employing the following:

- Solicit the client/patient's knowledge about the HIV antibody test and any previous testing experiences.
- Provide information about the test as needed and correct any misconceptions about testing and/or test results.
- State the meaning of a negative test result and a positive test result.
- Discuss with the client/patient an action plan in case of a negative test result or a positive test result.
- Ensure sufficient time is given to think through the issues.
- At the end of the preparation for testing, ask the client/patient if he or she would like to proceed with HIV testing.
- If the answer is no, thank the client/patient, plan to refer to a HTS counsellor and inform him or her that not testing for HIV will in no way interfere with their access to the other services offered by the health facility.
- If the answer is yes, fill out the laboratory form or register with the client/ patient's name and hospital registration number.
- Refer the client/patient to testing staff for taking the sample and testing or proceed with the testing if you are doing it yourself.
- The testing staff will then prepare for the test according to laboratory SOPs. The testing procedure will run for about 15 to 20 minutes during which the patient may be asked to rest in a waiting room or space. If testing is done elsewhere, it is an opportunity for the health provider to see another patient.

#### 4.2.3 Prepare For Providing Client/Patient with their HIV Test Results

- The test result will be given to the health provider by the testing staff or will be available to the provider if he or she does the test by himself/herself.
- The provider will then invite the client/patient to return to the Counselling process and will check with the client/patient to determine if he or she is prepared to receive the test result and post-test Counselling.
- For continuity purposes, it is recommended that the same provider offers both pre-test information, prepares for testing and does post-test counselling to the patient. If further Counselling is needed referral to a counsellor will be provided.
- The results will be given to the client/patient during post-testing Counselling.

#### 4.2.4 Post-Test Counselling

Post-test Counselling involves the disclosure of test results. It is a dialogue that connects the client with the counsellor, who answers questions and makes sure that the client/patient understands the information provided. Key components of HIV Counselling are given in Box 2.

##### Box 2: Key components of HIV counselling

###### Counselling includes:

- Establishing supportive relationships with clients
- Having purposeful conversations.
- Listening actively
- Helping clients to tell their story
- Giving clients correct and appropriate information
- Helping clients make informed decisions
- Helping clients recognize and build on their strengths
- Helping clients develop a positive attitude to life.

###### Counselling does not include:

- Giving advice
- Making decisions on behalf of clients
- Interrogating clients
- Blaming clients
- Preaching to or lecturing clients
- Making promises that you cannot keep
- Imposing your own beliefs
- Arguing with clients.
- Giving your story

##### 4.2.4.1 Giving negative results

- a. Make sure you have the test results ready.
- b. Greet the client/patient when they enter the consultation room. Establish rapport.
- c. Give the client/patient time. Ask the patient: “Are you ready to receive your HIV test result?”
- d. If the client is ready, state in a neutral tone: “Your test result is negative meaning you are not infected with HIV”
- e. Pause and wait for the client to respond before continuing. Give the client/patient time to express any emotions.
- f. Client/patient should be shown the result slip if they so wish
- g. Check the client/patient’s understanding of the meaning of the results
- h. Discuss and support patient’s feelings and emotions.
- i. If there was a recent risk exposure, discuss the need to retest.
- j. Discuss ways to remain negative and assist the client/patient in exploring future risk reduction so that her or his status remains negative, in view of the high risk associated with new infections.
- k. Ask whether the client/patient has questions or concerns. Explain to the client how to contact a HTS clinic or counsellor in case any new concerns arise as well as for retesting for HIV in three months.

- l. Remind pregnant mothers and families that Counselling will be available throughout pregnancy in PMTCT to help them to plan for the future and to obtain the services they need.
- m. Refer the client for screening and treatment of STIs when necessary.
- n. Continue treating patient for initial medical problem.
- o. Assure the client that the services will be provided even if you are not available

#### 4.2.4.2 *Giving negative results*

- a. Make sure you have the correct test results.
- b. Greet the patient. Re-Establish rapport.
- c. Ask whether the client/patient has any questions that have arisen since testing was performed. Answer questions and tell the client/patient that Counselling will continue to be available in order to help with important decisions.
- d. Give the client/patient time. Ask the patient: “Are you ready to receive your HIV test result?”
- e. State in a neutral tone: “Your test result is positive meaning you have been infected with HIV”.
- f. Pause and wait for the patient to respond before continuing. Give the client time to express any emotions.
- g. Client should be shown the result slip if they so wish.
- h. Check the client/patient’s understanding of the meaning of the result.
- i. Explain to the patient that feelings and emotions may change frequently at this time.
- j. Go over what was said during the pre-test information session. Tell the patient that you are doing this to make sure he or she can recall the information that was given.
- k. Assure the client that the services will be provided even if you are not available. Additionally ask the following questions:
  - ⇒ Do you know the differences between HIV and AIDS?
  - ⇒ How is the knowledge of your status going to help you?
  - ⇒ How can you protect yourself from further infection?
  - ⇒ Who else will be affected by this result?
  - ⇒ Discuss disclosure and support issues and subsequent Counselling sessions.
    - ◆ Establish who the client\patient would like to tell about their positive status, focus on when and how they will disclose; the reactions they anticipate from these people (this could best be done through role-play).
    - ◆ Emphasize the importance of disclosure to current and future partner or partners, children, and other family members.

#### **Discuss Positive Living**

When the client/patient is emotionally stable, tell him/her what “positive living” is. Enquire whether the client/patient knows that “Positive living means taking care of their health and emotional wellbeing in order to enhance the quality of life”;

- a. Ways to stay healthy and encourage an active lifestyle
- b. Adequate and proper nutrition;

- c. Prompt medical attention including referral to Care and Treatment Centre, prophylaxis and treatment of opportunistic infections;
- d. Reducing the risk of infecting others;
- e. Screening and treatment for sexually transmitted infections and TB in some settings and for certain high-risk populations which have capacity and treatment, referral for viral hepatitis screening may be appropriate
- f. Where appropriate, revisit PMTCT issues such as:
  - ⇒ Exclusive breastfeeding for six months and no mix feeding;
  - ⇒ ARV prophylaxis for exposed infants from birth to six weeks
  - ⇒ Early Infant Diagnosis of the exposed infants at six to eight weeks.
  - ⇒ If PCR (Polymerase Chain Reaction) test negative at six weeks, repeat the test at nine months.
  - ⇒ Start Cotrimoxazole prophylaxis from six weeks
  - ⇒ Stop Cotrimoxazole prophylaxis at 18 months if antibody test is negative.
  - ⇒ Continue with Cotrimoxazole prophylaxis and start ARVs at 18 months if the antibody test is positive.
  - ⇒ Do antibody test for the exposed infant at 18months and or a week after cessation of breastfeeding if PCR test is negative.
  - ⇒ Childbirth plans including contraceptive use;
  - ⇒ Antiretroviral Treatment for the mother;
  - ⇒ Proper condom use;
  - ⇒ Partner testing.
- g. Identify sources of support for the client, such as family, friends, and community-based services, spiritual, paralegal and psychosocial support and treatment options. Make referrals when appropriate.
- h. Ask whether the client has questions or concerns.
- i. Explain to the client how to contact the clinic in case any concerns arise.
- j. Discuss the importance of testing for other family members including children with consent from parent or guardian.
- k. Continue treating patient for initial medical problem

### 4.3 Client-Initiated Testing and Counselling

#### Introduction

Voluntary counselling and testing for HIV (VCT) is a client-initiated testing and counselling model through which individuals can be made aware of their HIV status. This traditional approach of HIV testing and counselling was underpinned by individual's rights to know his or her HIV status. Voluntary Counselling and Testing (VCT) involves individuals actively seeking HIV counselling and testing. VCT is conducted in a wide variety of settings including health facilities, stand-alone facilities outside health institutions, through mobile services, in community-based settings and even in people's homes.

The counselling and testing intervention includes at least one pre-test counselling session and one post-test counselling session. It is anticipated that counselling sessions will last at least 30 minutes each, depending on the individual client's situation. Pre- and post-test counselling is separated by the length of time required to generate test results (approximately 20 minutes). If there are many clients, consider having group pre-test information sessions.

### 4.3.1 Pre-test Counselling

Counselling is a dialogue that connects the client with the counsellor who answers questions and makes sure that the client understands the information provided.

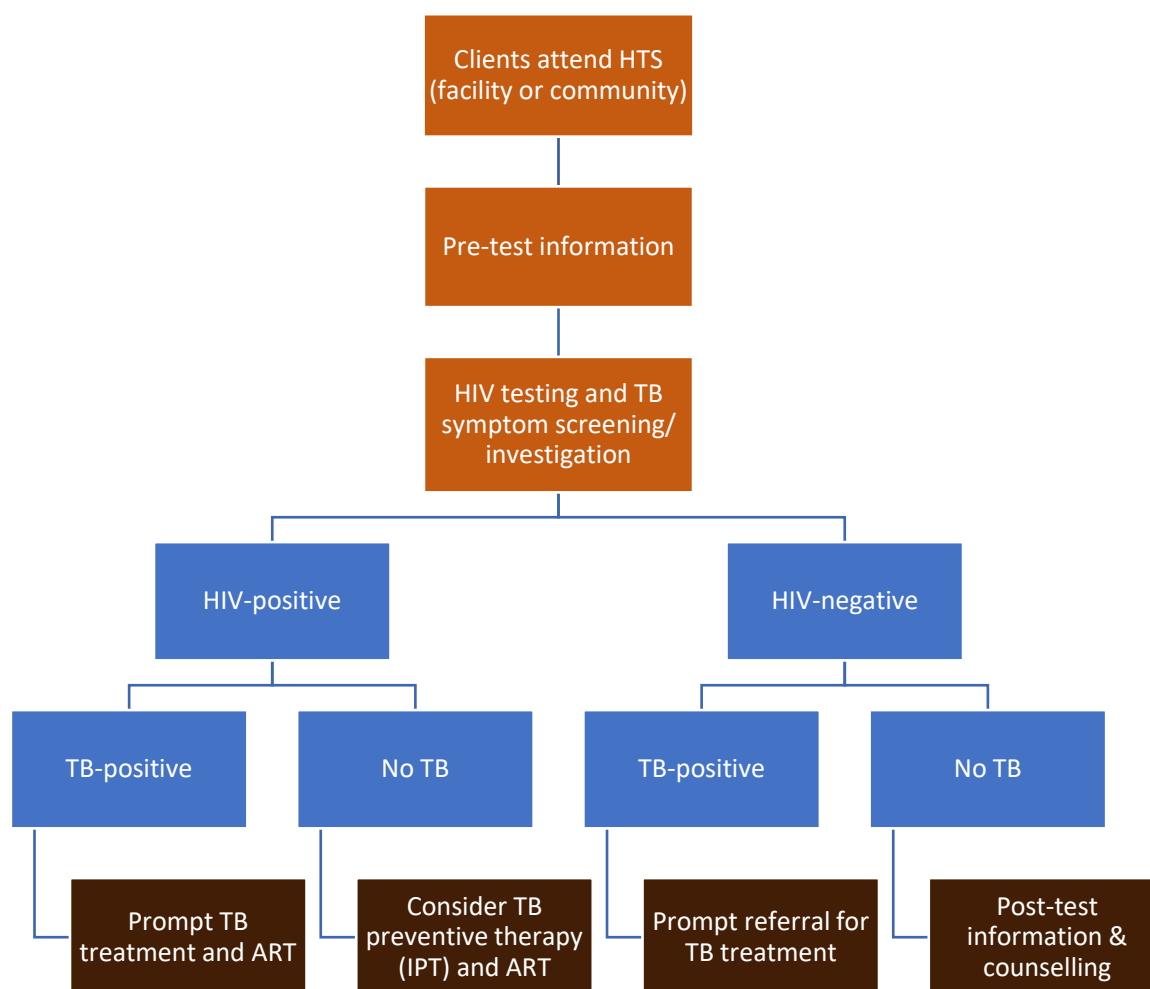
The process includes:

- Review client knowledge on HIV and AIDS and correct any misperceptions about HIV and AIDS and transmission of HIV.
- Engage the client in the assessment of his or her own HIV-related risk behavior and negotiating a realistic, personalized risk reduction plan.
- Build an alliance with the client to undertake the risk assessment, including gathering information about the client's sexual and other risk behavior as well as his or her interpersonal, social, and resource situation.
- Work with the client to develop strategies to reduce his or her risk. For each risk reduction behavior, assess internal and external barriers to change, perceived efficacy to enact the new behavior, readiness to change, and the availability of resources to change.
- Acknowledge and support the client's strengths and his or her enactment of the personalized risk reduction plan, work with the client to solve problems regarding the anticipated difficulty in enacting the plan.
- When appropriate, the risk reduction plan may be written and given to the client to remind and reinforce behavior change.
- Assess clients' knowledge on the proper use of condoms and do a condom demonstration.
- Confirm that the informed consent has been obtained and assure client confidentiality.
- Inform the client that they can withdraw consent at any stage of the HTS process.

#### 4.3.1.1 Intensified TB Case Finding Incorporation into HTS

Tuberculosis (TB) is a common presenting illness among PLHIV. Early detection and linkage to TB treatment along with ART can save lives and HTS provides an opportunity for intensified TB case finding.

HIV testing services should integrate screening for TB symptoms into the pre-test session before HIV testing in all settings. All clients with TB symptoms should be investigated, and all clients diagnosed with TB should be promptly registered and started on anti-TB treatment. HIV-positive clients diagnosed with active TB should be urgently started on ART, regardless of CD4 count. HIV-positive clients who do not have TB should be considered for isoniazid preventive therapy (IPT) (see figure 2).



**Figure 2: Intensified TB Case Finding Algorithm for HTS**

### 4.3.2 Preparation for testing

This is done during pre-test counselling. The counsellor should:

- Solicit the client’s knowledge about the HIV antibody test and any previous testing experiences.
- Provide information about the test as needed and correct any misconceptions about testing and/or test results:
  - State the meaning of a negative and positive test result.
  - Discuss with a client an action plan in case of a negative test result or a positive test result.
  - Provide contact information for crisis management in the case of negative HIV-related life events.
  - Ensure sufficient time is given to think through the issues.
  - At the end of pre-test counselling, ask the client if he or she would like to proceed with HIV testing.
  - If the answer is no, thank the client, plan for the next counselling session and let him/her go.

- If the answer is yes, fill out the laboratory form with the client’s unique personal code. The counsellor can conduct the test or refer the client to a testing staff for taking the sample and testing or proceed with the testing if you are doing it yourself.
- The testing staff will then prepare for the test according to laboratory SOPs. The testing procedures will run for about 15 to 20 minutes during which the client is asked to rest in a waiting room or space.

### 4.3.3 Disclosure of results

The test result will be given to the counsellor by the testing staff or will be available to the counsellor if she/he does the test by themselves.

- The counsellor will then invite the client to return to the counselling room and will check with the client to determine if he or she is prepared to receive the test result and post-test counselling. Where the test is done in the presence of the client- the discussion will then be around the interpretation of the findings.
- For continuity purposes, it is recommended that the same counsellor offers both pre- and post-test counselling to the client
- The results will only be disclosed to the client during post-testing counselling

### 4.3.4 Post-test Counselling

Post-test Counselling involves the disclosure of test results.

#### 4.3.4.1 Giving negative results

- Make sure you have the test results ready.
- Greet the client. Establish rapport.
- Give the client time. Ask the client: “Are you ready to receive your HIV test result?”
- If the client is ready, state in a neutral tone: “Your test result is negative meaning you have not been infected with HIV.”
- Pause and wait for the client to respond before continuing. Give the client time to express any emotions.
- Client should be shown the result slip if they so wish.
- Discuss and support the client’s feelings and emotions.
- Check the client’s understanding of the meaning of the results.
- Discuss the following questions:
  - ⇒ Do you remember the differences between HIV and AIDS?
  - ⇒ How is the knowledge of your status going to help you?
  - ⇒ How can you protect yourself further from HIV infection?
  - ⇒ Who else will be affected by this result?
  - ⇒ Inform the client to consider having another test in three months and/or encourage his/her partner to go for testing.
- If there was a recent risk exposure, discuss the need to retest. For persons with ongoing risk of exposure, recommend follow -up testing at least every three months.

- k. Discuss ways to remain negative and assist the client in exploring future risk reduction so that his/her status remains negative, in view of the high risk associated with new infections.
- l. Discuss disclosure support and subsequent counselling sessions.
- m. Discuss the following basic risk-reduction strategies with the client:
  - ⇒ Good clinic attendance;
  - ⇒ Good nutrition status;
  - ⇒ Avoidance of alcohol and drug abuse;
  - ⇒ Use of condoms;
  - ⇒ Limiting the number of sexual partners.
- n. Encourage the client about partner testing.
- o. Discuss availability of oral PrEP services with at substantial risk of being infected with HIV (if available)
- p. Inform the client that counselling is available for couples.
- q. Ask whether the client has questions or concerns. Explain to the client how to contact the HTS facility in case any new concerns arise.
- r. Remind pregnant mothers and families that counselling will be available throughout pregnancy to help them to plan for the future and to obtain the services they need.
- s. Refer the client for screening and treatment of STIs when necessary.
- t. Assure the client that the services will be provided even if you are not available

#### **4.3.4.2 Giving positive results**

Counselling is a dialogue that connects the client with counsellor, answer questions and make sure that the client understands the information provided.

- a. Make sure you have the test results.
- b. Greet the client. Establish rapport.
- c. Ask whether the client has any questions that have arisen since testing was performed. Answer the questions and tell the client that counselling will continue to be available to help the client to make important decisions.
- d. Give the client time. Ask the client: “Are you ready to receive your HIV test result?”
- e. State in a neutral tone: “Your test result is positive meaning you have been infected with HIV”.
- f. Pause and wait for the client to respond before continuing. Give the client time to express any emotions.
- g. Client should be shown the result slip if they so wish
- h. Check the client’s understanding of the meaning of the result.
- i. Explain that the client’s feelings and emotions may change frequently at this time.
- j. Go over what was said during the pre-test counselling session. Tell the client that you are doing this to make sure he or she can recall the information that was given.
- k. Ask the following questions:
  - Do you remember the differences between HIV and AIDS?
  - How is the knowledge of your status going to help you?
  - How can you protect yourself from further infection?
  - Who else will be affected by this result?

- l. Discuss positive living including:
  - adequate nutrition;
  - prompt medical attention, prophylaxis and treatment of opportunistic infections;
  - ways to stay healthy including exercises;
  - treatment and support services;
  - reducing the risk of infecting others and re-infecting oneself;
  - Screening and treatment for sexually transmitted infections and TB.
- m. Where appropriate, revisit PMTCT issues such as:
  - Exclusive breastfeeding for six months and no mix feeding;
  - ARV prophylaxis for exposed infants from birth to six weeks
  - Early Infant Diagnose of the exposed infants at six to eight weeks.
  - If PCR test negative at six weeks, repeat the test at nine months.
  - Start Cotrimoxazole prophylaxis from six weeks
  - Stop Cotrimoxazole prophylaxis at 18 months if antibody test is negative.
  - Continue with Cotrimoxazole prophylaxis and start ARVs at 18 months if the antibody test is positive.
  - Do antibody test for the exposed infant at 18months and or a week after cessation of breastfeeding if PCR test is negative.
  - Childbirth plans including contraceptive use;
  - Antiretroviral Treatment for the mother;
  - Proper condom use;
  - Partner testing
- n. Identify sources of hope for the client, such as family, friends, community-based services, spiritual supports and treatment options. Make referrals when appropriate.
- o. Discuss disclosure and support issues and subsequent counselling sessions.
- p. Ask whether the client has questions or concerns. Explain to the client how to contact the clinic in case any concerns arise.
- q. Remind mothers and families that supportive counselling will be available throughout pregnancy in order to help them to plan for the future and obtain the services they need.
- r. If the client already has children, discuss and plan their testing.
- s. Refer for psychosocial support, medical assessment, treatment and follow-up.
- t. Assure the client that the services will be provided even if you are not available

## 4.4 Couple HIV Testing Services

### Introduction to Couple HIV Testing Services (CHTS)

Couple HIV counselling and testing is emerging as one of the most important interventions aiming at preventing transmission of HIV between sex partners and those living together (cohabiting or married) (1,5). Couple Counselling aims at:

- 1) Providing accurate information and behavioral change messages that make them seek HTS;
- 2) Removing tension and reducing blame as to the possible cause of infection;

- 3) Reducing myths about HIV transmission;
- 4) Creating a safe environment for disclosing HIV sero-status; and
- 5) Finding options to be used for disclosure of HIV sero-status to their children and helping them in the decisions of testing the children when felt to be necessary.

When a counsellor deals with a couple, they should ensure that they demonstrate non-biased concern for both pairs of the couple; show respect in the couple's relationship and facilitate equal participation during the Counselling session by both partners. The counsellor should also allow the couple to speak between them and raise difficult issues that the couple will need to address.

During the Counselling encounter with the couple the counsellor should try to look at the future rather than the past; where any discussion or potential hostility is anticipated, the counsellor needs to redirect and reframe questions and discussions at the same time addressing any underlying hostile feelings. In doing so, the counsellor and the couple do not spend time looking for the source of infection but look into the expressed ability of the couple in dealing with HIV-related issues.

For couples to get couple counselling they should agree to discuss their HIV-related risks and receive test results together; commit to shared confidentiality and the need to make mutual disclosure decision.

#### **4.4.1 Pre-test Couple Counselling Session (CHTS)**

- Introduce yourself and describe your role.
- Discuss the benefits of CHTS.
- Describe the conditions of receiving CHTS.
- Obtain concurrence to get CHTS.
- Look into the expectations, roles and responsibilities of the couples in the session.
- Give the session overview including timing and contents:
  - a. Review the couple's situation;
  - b. Discuss HIV risk issues and concerns (not risk assessment);
  - c. Preparation for rapid HIV testing, the testing process and possible results;
    - Discuss with couples about getting same results all negative (discuss the meaning of HIV negative results);
    - Discuss with couples about getting same results all positive (discuss the meaning of HIV positive results);
    - Discuss that the couple may get different results, one HIV negative and another HIV positive (discuss the meaning of discordant results);
  - d. Conduct the rapid HIV test to each individual;
  - e. Disclosure of the results and post-test Counselling.
  - f. Assure the client that the services will be provided even if you are not available

- g. Pause and wait for the couple to respond before continuing. Give the couple time to express their emotions.
- h. If the couple wishes to see the results, provide them.
- i. Check the couple's understanding of the meaning of the HIV test result.
- j. Validate their feelings.
- k. Discuss the result within the context of recent risks outside their relationship:
  - Encourage a mutual faithfulness relationship;
  - Remind them that their status is not a reflection of past relationships;
  - Address issues affecting faithfulness.
- l. Discuss the couple's HIV specific concerns.
- m. Emphasize use of condoms outside their permanent relationship
- n. Explore what is needed to reduce risks.
- o. Encourage the couple's communication.
- p. Build confidence between the partners in completing risk reduction plan and protecting each other.
- q. Encourage the couple to become advocates of CHTS.
- r. Provide the couple with referrals to STI and FP clinics, ANC care or any other support where indicated

#### 4.4.2 Giving concordant HIV positive results

- a. Make sure you have the test results.
- b. Greet the couple and establish rapport.
- c. Ask whether the couple has any questions that have arisen since testing was performed. Answer the questions and tell the couple that Counselling will continue to be available to help them with important decisions.
- d. Inform the couple that their HIV test results are available.
- e. Give the couple time. Ask the couple: "Are you ready to receive your HIV test result?"
- f. State in a neutral tone: "Both your test results are positive."
- g. Pause and wait for the couple to respond before continuing. Give the couple time to express their emotions.
- h. If the couple wishes to see the results, provide them.
- i. Check the couple's understanding of the meaning of the HIV test result.
- j. Encourage mutual support and diffuse blame.
- k. Invite each pair of the couple to express their feelings and concerns.
- l. Promote acceptance of the HIV test results and normalize the couple's feelings as well as dealing with HIV positive test results.
- m. Ask the couple how best they can support each other.
- n. Recall on the couple's strengths and convey hope that they will be able to cope and adjust themselves with living with HIV.
- o. Let the couple address immediate concerns.

- p. Discuss positive living (ART, safer sex practices, nutrition, peer support, ongoing psychosocial support, lifestyle modification) and HIV care and treatment.
- q. Discuss risk reduction strategies.
- r. Discuss children, family planning and PMTCT options.
- s. Discuss disclosure and getting support.
- t. Assure the client that the services will be provided even if you are not available

#### 4.4.3 Giving discordant HIV positive and negative results

- a. Make sure you have the correct test results.
- b. Greet the couple and establish rapport.
- c. Ask whether the couple has any questions that have arisen since testing was performed. Answer questions and tell the couple that Counselling will continue to be available to help them with important decisions.
- d. Inform the couple that their results are available.
- e. Give the couple time. Ask the couple: “Are you ready to receive your HIV test result?”
- f. State that the test results are different, “**x** your results are positive, while **xx** your test results are negative”. Pause for a short time to ensure there is an understanding of what the results mean.
- g. Show the couple the result slip, if they so wish.
- h. Review the explanation of the couple’s different HIV test results.
- i. Invite each pair of the couple to share their feelings and concerns.
- j. Facilitate acceptance of the HIV test results and normalize the couple feelings as well as dealing with discordant HIV test results.
- k. Ask the un-infected partner how best he or she can support the partner.
- l. Recall the couple’s strengths and convey hope that they will be able to cope and adjust themselves to the situation.
- m. Assist the couple address immediate concerns.
- n. Discuss positive living and HIV treatment, care and support.
- o. Discuss healthy living (ART, safer sex practices, nutrition, peer support, ongoing psychosocial support, and lifestyle modification).
- p. Discuss how to protect the HIV-negative partner from HIV infection (PrEP services).
- q. Discuss linking the positive partner to the support groups’ activities.
- r. Discuss testing of the child (ren) 16 years and below, family planning and **PMTCT** options for discordant partners.
- s. Discuss disclosure and getting support.
- t. Assure the client that the services will be provided even if you are not available

## 5.0 TYPES OF HIV TESTING

This section outlines the procedures related to the HIV testing process;

### 5.1 HIV SELF-TESTING (HIVST)

HIVST has been shown to be an empowering, discreet and highly acceptable option for many users, including key populations, men, young people, health workers, pregnant women and their male partners, couples and general population groups. Please refer to Operational Guideline for the delivery of HIV self-testing in the Gambia, September 2022 (4), for SOPs and guidelines regarding HIVST.

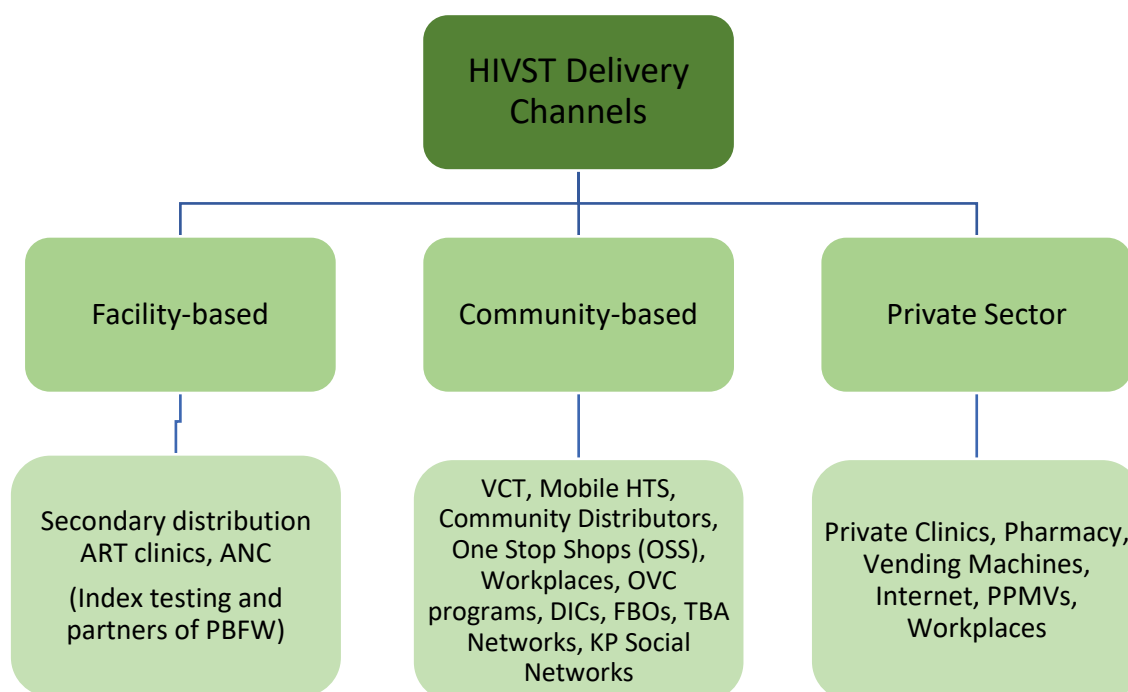
HIVST represents another forward step in line with efforts to increase patient autonomy, decentralize services and create demand for HIV testing among those unreached by existing services.

HIVST may enhance health system efficiency by focusing health services and resources on people with a reactive self-test result who are in need of further testing, support and referral, thereby directing services more appropriately. Also, by reducing the number of facility visits for frequent testers, and eliminating the need for individuals to travel distances or wait in long lines to access HIV testing, HIVST may be more convenient for users. WHO recommends that HIV self-testing should be offered as an additional approach to HIV testing services. HIVST kits should not be used as a first-line test for HTS.

#### 5.1.1 HIVST Delivery Channels

HIV self-testing will be delivered in the community and private sector distribution points. However, health facilities will serve as points for secondary distribution as well as avenues for referral and linkage services for persons who are reactive and non-reactive to HIVST. Figure 3 shows an illustration of the HIVST delivery channels:

**Figure 3: An illustration of the HIVST delivery channels**



### 5.1.2 HIV Self-Testing Strategy

The result of a single self-test is not sufficient to make an HIV-positive diagnosis. HIVST requires self-testers with a reactive (positive) result to receive further testing from a trained provider using a validated national testing algorithm.

All self-testers with a non-reactive test result should retest if they might have been exposed to HIV in the preceding six weeks, or are at high ongoing HIV risk in 14 days.

HIVST is not recommended for people taking anti-retroviral drugs, as this may cause a false non-reactive result.

Any person who is uncertain about how to correctly perform the self-test, or interpret the self-test result, should be encouraged to access facility- or community-based HIV testing.

### 5.1.3 HIVST IN PRACTICE

HIVST should be highly targeted to **individuals in groups not currently being reached by existing HIV testing services (HTS)**. HIVST distribution approaches should be tailored to populations with low testing coverage and at ongoing HIV risk. **For the highest impact and cost-effectiveness, HIVST should not replace conventional HTS but should be used to:**

- a. **Improve access for people with high HIV risk and vulnerability**, including people, people who do not currently use HTS, adolescents, high-risk men and hard-to-reach key populations.
- b. **Facilitate partner testing and index testing** by providing kits to people with HIV or at high risk of HIV so that they can offer HIVST to their partners or other people in their social networks.
- c. **Improve testing coverage by integrating it into clinical services** where testing is needed but not routinely provided or where testing is poorly implemented. In this context, HIVST can replace components of provider-initiated HIV testing. Offering HIVST at high-volume clinics in high-HIV-burden settings and sexually transmitted infection (STI) or family planning clinics makes efficient use of clients' waiting time and ensures links to care services.
- d. **Create demand and increase uptake of HIV prevention services**. Those with a nonreactive self-test result will not need confirmatory testing, but HIVST is an opportunity to direct these people to prevention services (e.g., pre-exposure prophylaxis (PrEP), voluntary medical male circumcision (VMMC), condoms, and STI screening/treatment).

The World Health Organization (WHO) and U.S. President's Emergency Plan for AIDS Relief (PEPFAR) have identified several populations as a high priority for HIVST:

- Adult men in high-HIV-burden settings
- Adolescents and young people (ages 15–24 years) in high-HIV-burden settings
- Key populations: men who have sex with men (MSM), people who inject drugs (PWID), Female sex workers (FSWs) and their sexual partners, transgender people, and people in prisons.

- Other high-risk groups, including STI patients; women presenting for family planning services in high-burden settings; couples and partners, including partners of PLHIV; refugees; young at-risk men; and other groups that face high levels of stigma and discrimination.

There may be other target groups depending on the country's HTS and antiretroviral therapy (ART) gaps.

#### 5.1.4 AGE OF CONSENT FOR HIVST AND HIVST WITH YOUNG ADOLESCENTS

The age of consent for HIV testing is 16 years for The Gambia (2,3). HIVST has a high acceptance rate among older adolescents and youth, and adolescents are more likely to accurately use oral self-test kits. Although HIVST holds the potential to increase HTS coverage among adolescents, programs will need to ensure that adolescents who screen positive are linked to diagnostic HTS and treatment services, if confirmed positive. A reactive HIVST result, not confirmed with the standard national HIV testing algorithm CANNOT be used to initiate a client on anti-retroviral therapy.

#### 5.1.5 CORE HIVST PROGRAM COMPONENTS

1. **Demand creation/mobilization:** A comprehensive, user-centred communications and marketing strategy should increase awareness and demand among priority populations and engage with key stakeholders.

2. **Testing process:** Distribution is either direct (offered to the client who will use it) or indirect (offered to an intermediary) and can be unassisted or assisted when a trained provider or peer gives information on how to use the kit and interpret the result and demonstrates use before giving it to the client.

**Assisted** HIVST does not mean that the provider directly assists the client and/or is present when the client conducts the self-test. Self-test users can test on-site or take the test kit home.

3. **Linkage:** Have tools available that support testers' links to confirmative testing, Counselling, treatment, and/or prevention after a self-test. Tools should allow the tester to opt-in, use available technology to enhance access to target population (e.g., phone, Internet, smartphone), offer the option of speaking to a human and direct community follow-up, and protect the privacy and confidentiality of the self-testing experience. The Gambia through FHI360 DSD SI will be implementing virtual interventions that will support linkages, test booking and reporting.

Tools should not pressure self-testing clients to disclose their test results nor compromise the privacy of the testing experience. People who use a self-test kit at a facility or community event should be offered confirmatory testing and linkage services on site. Linking self-testers who test off site is more challenging, so innovative follow-up approaches, such as calls, SMS, WhatsApp contact might be required.

## 5.2 PARTNER NOTIFICATION AND INDEX CLIENT TESTING

WHO strongly recommends testing the sex-partners and children of a known HIV-positive client, and Persons who share needles such as PWID, this is a priority in low-prevalence settings. Partner notification is a voluntary process where a trained healthcare worker asks people diagnosed with HIV about their sexual partners and, if the client agrees, offers these partners HTS. Partner notification

may be passive or assisted. In addition, any child of an HIV-positive client should also be offered HIV testing.

- **Passive notification** is when HIV-positive clients are encouraged by a trained healthcare worker to disclose their status to their sexual or drug-injecting partners by themselves and to suggest HTS to the partner.
- **Assisted partner notification** is when a consenting HIV-positive client is assisted by a trained healthcare worker to disclose their status or to anonymously notify their sexual partners. The provider then offers HTS to these partners. Assisted partner notification is done using contract referral, provider referral or dual referral.
  - **Contract referral:** The client makes a contract with a trained healthcare worker and agrees to disclose their status by themselves and to refer their partner to HTS within a specific time. If the partner does not access HTS, the healthcare worker will contact the partner directly to offer HTS.
  - **Provider referral** is when, with the consent of the HIV-positive client, a trained healthcare worker confidentially contacts the person's partner directly and offers the partner voluntary HTS.
  - **Dual referral** is when a trained healthcare worker accompanies and provides support to the HIV-positive client when they disclose their status and may then provide HTS to the partner. Capacity building to support HCWs to perform index client testing and partner notification will be integrated into the HCW HIV training package.

### 5.2.1 STANDARD OPERATING PROCEDURE FOR PARTNER NOTIFICATION AND INDEX CLIENT TESTING IN THE GAMBIA.

1. All clients, when tested HIV positive, should be advised to invite the following people for HTS:

- Their current and previous sexual partners if their status is unknown or they have not been tested within the past six months.
- Their children of age 18 years and below if their status is unknown
- Other close household contacts.

2. Information on the status of partners and family members should be recorded in the client care folder.

3. Where the client agrees to notify and invite their current partner, previous partners and children to attend, they should be given time to attend for HTS.

4. Where the client does not agree to notify the current partner or previous partners, the healthcare worker should offer to perform assisted anonymous or dual notification of the partner(s) tactfully.

5. If the client has agreed to invite their partners and children for HTS, and they have not attended after some time, community-based index client testing should be offered. **With the client's consent**, the community health nurse or community volunteer who is trained to test should be informed of the

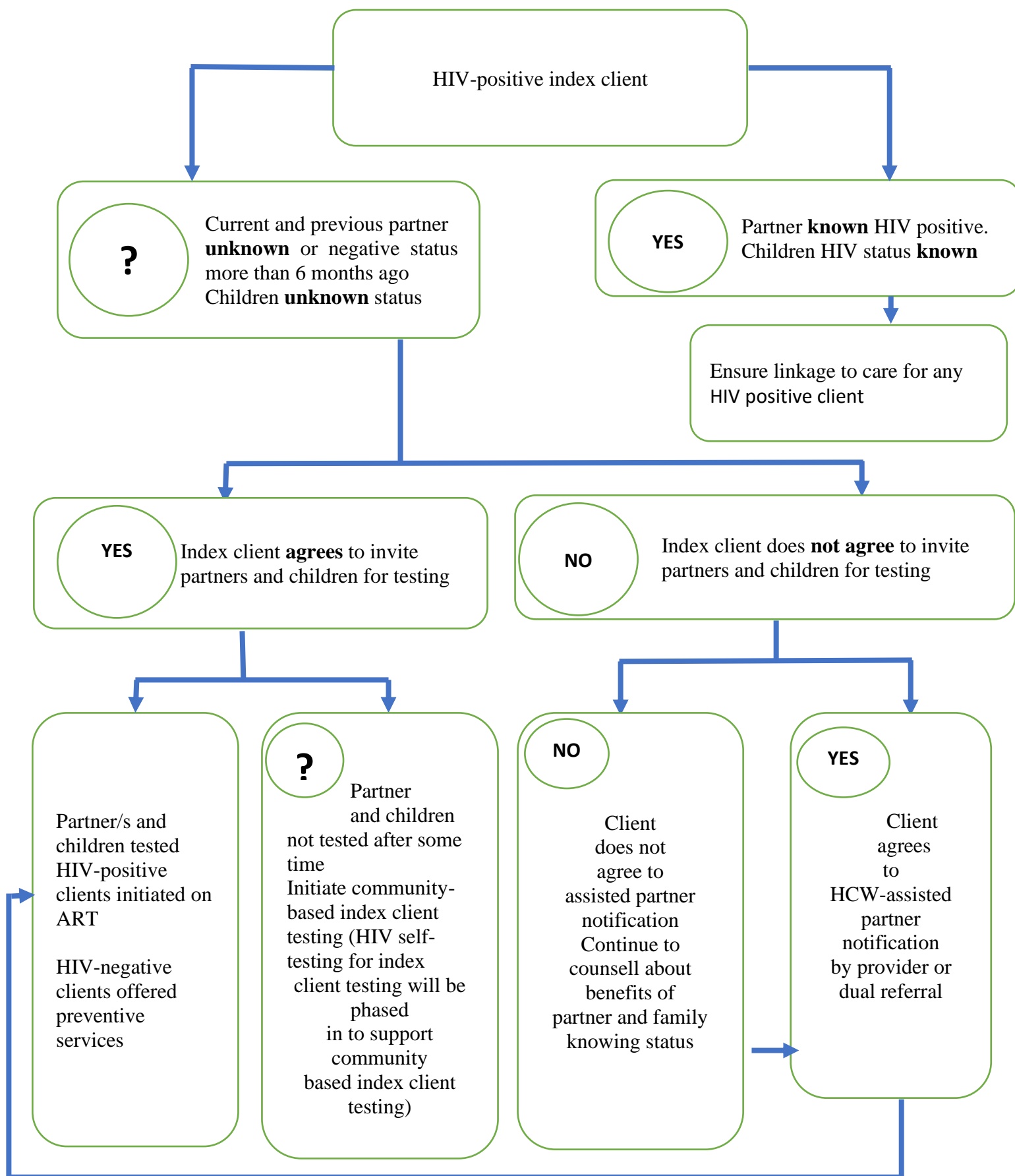
index family to be tested. Facilities should establish links with their local CSOs to support community-based testing.

6. HIV testing should be offered at home or in an agreed community location by the community health nurse or community volunteer as part of an integrated health screen, including screening for malnutrition, hypertension, diabetes, TB, STIs and HIV.

7. The person performing the test should then ensure linkage to ART services for any client who tests HIV positive.

8. In the future, HIV self-test kits may also be provided to the index client at the facility so that they can perform the HIV test for their partner and children at home. **With the client's consent**, their community health nurse should follow up the outcome of the test during a routine home visit and ensure linkage of any HIV positive client to the facility.

Figure 4: Algorithm for partner notification and index case testing



### 5.3 Referral to Other HIV Clinical Services

Post-test HIV services for clients who test positive includes the following and illustrations in Figure 5:

- a) Palliative and psychosocial support
- b) Prevention of Mother to Child Transmission of HIV (PMTCT) services for pregnant women.
- c) Anti-retroviral services (ART) for treatment and associated laboratory investigations where necessary (This is limited now with adoption of test and treat).
- d) TB screening (symptoms screening- cough, fever, weight loss, night sweats) Send all PLHIV with any of these signs for further TB evaluation.
- e) Those with Stage III-IV HIV, or when available CD4 <200, should refer for serum CrAG test and TB-LAM tests.

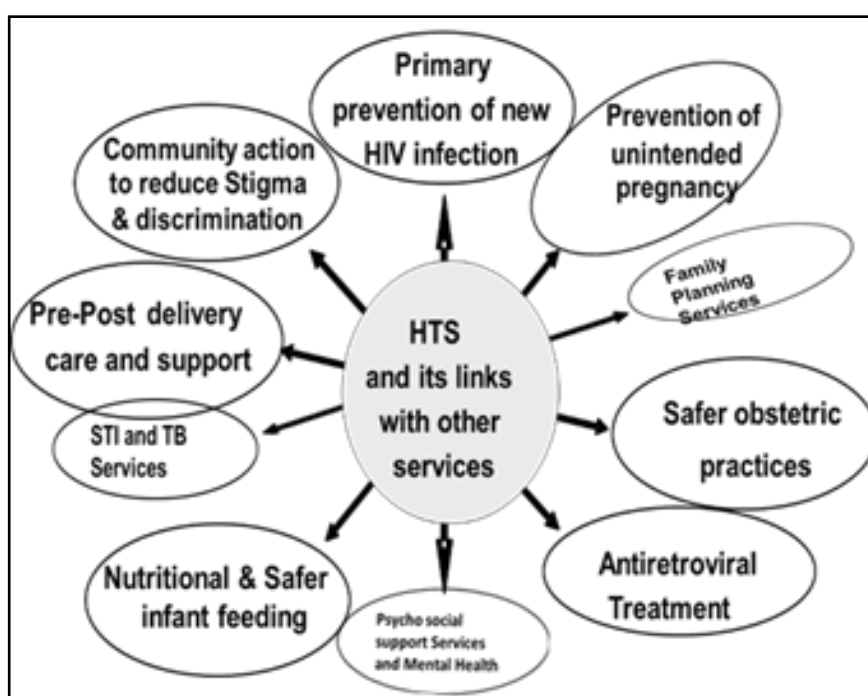


Figure 5: HIV testing service links

### 5.4 Frequency of Testing

How often patients are advised to re-test depend on the continued risk assessment for each client. Re-testing every 6-12 months may be beneficial for individuals at higher risk of HIV exposure, such as persons with a history of STIs, sex workers and their clients, men who have sex with men, people who inject drugs and sex partners of people living with HIV.

Risks of HIV transmission to the infant is very high if the mother acquires HIV during pregnancy or while breastfeeding. HIV-negative women should be tested as early as possible in each new pregnancy, particularly in high-prevalence settings and in the case of women who are at high risk of HIV exposure.

Repeat testing late in pregnancy should also be recommended to HIV-negative women in generalised epidemic settings.

HIV counselling and testing should generally be recommended to patients where doubt exists about the patients' prior testing history or the accuracy or veracity of prior test results.

## 6.0 COUNSELLING AND TESTING IN SPECIAL POPULATIONS

### 6.1 Pregnant Women

For the woman's own health and that of the unborn child, provide HIV and Syphilis dual testing and counselling to all pregnant women of unknown HIV status during first antenatal visit or when they present; late pregnancy, labour/delivery or immediate post-partum. Women who test negative in early pregnancy should have the test repeated in late pregnancy, during delivery and during breast feeding.

The Gambia mandates the use of dual HIV-Syphilis rapid test kits for the benefit of an efficient screening and management of both STIs simultaneously.

### 6.2 Adolescents

Early sexual debut among adolescents (10-19 years) and early child marriages in The Gambia, particularly girls, puts them at high risk of acquiring HIV. Encounters in clinical settings are an opportunity to provide sexual and reproductive health information and HTS services in a non-judgemental manner.

### 6.3 Children

#### 6.3.1 Identifying Which Children to Test

HIV disease progresses more rapidly in children than in adults, hence they may be the first to be identified as HIV-positive in the family. Figure 5 gives the algorithm for HIV diagnosis in children less than 24 months of age.

Providers should be pro-active in efforts to detect children with HIV:

- Link all HIV exposed children from PMTCT records to Care and Treatment Program in ART clinics.
- Children with severe pneumonia, malnutrition, chronic/persistent diarrhoea and TB must be tested for HIV infection
- Children less than 14 years born to parents diagnosed with HIV infection should be tested
- Orphans and vulnerable children (OVC) are at special risk of HIV infection
- All adults living with HIV should be counselled to bring all children for testing. Likewise, parents and siblings of children diagnosed as HIV-positive should be tested (**this is called index testing**)

If one or two of the following symptoms are present, a child should be referred for HTS:

1. Recurrent pneumonia
2. Ever had ear discharge
3. Low weight for age
4. Losing weight / unsatisfactory weight gain
5. Floppy, weak or tired
6. Unable to sit up by 6 months
7. Unable to stand up by 12 months
8. Unable to say one word by 15 months
9. Ribs showing

10. Fast breathing
11. Persistent diarrhoea in the past 3 months
12. Enlarged lymph glands in 2 or more sites
13. Oral thrush (white sores in mouth)
14. Parotid enlargement.
15. Enlarged liver with no evidence of Malaria and/or any other cause of liver enlargement

### 6.3.2 Consenting Minors

Children less than 16 years need parental consent for HIV testing. A child married, pregnant, a commercial sex worker, street teenager, family head or with known history of sexual intercourse is regarded as *mature (or emancipated) minor* and can consent for HIV testing.

HIV testing for children below 16 years of age can only be performed with the knowledge and consent of their parents or guardians.

Exceptions to this include:

- Children below 16 years of age presenting with convincing signs or symptoms of HIV, and the parents or guardians are refusing to consent to a test. The Department of Social Welfare at Ministry of gender and children protection may be contacted to facilitate testing. Every effort should be made to explain to the parents or guardians the necessity and benefit of knowing the child's HIV status.
- Children who have been sexually abused and put at risk of HIV infection shall receive supportive counselling and be encouraged to take a test. Parents or guardians should be asked for their consent prior to testing.

### 6.3.3 Right to Defer Request for Testing of a Minor

The welfare of the child must be the primary concern when considering the testing of a child for HIV. When children are brought to a facility providing HIV Testing Services, the counsellors should meet with the parents or guardians to determine the reasons for testing, if the counsellor feels that testing is not in the best interest of the child, then the counsellor reserves the right to refuse testing. Counselling should be provided to both the child and the parent or legal guardian, and referral made for the child to be tested at an appropriate medical or child health facility if tested positive.

The counsellor or health care provider has the right to refuse a request for testing if he/she believes that the result is not being obtained with the best interest of the child in mind. Examples may include test requests linked to child adoption or testing of orphans in residential institutions.

### 6.3.4 Disclosure for Minors

Minors should be encouraged to disclose the result of HIV testing to their parents or guardians. However, the test result shall not be disclosed to third parties, unless the counsellor or health care provider determines this to be to the benefit of the child, especially in circumstances where the child would have identified the parent/guardian as a potential treatment supporter.

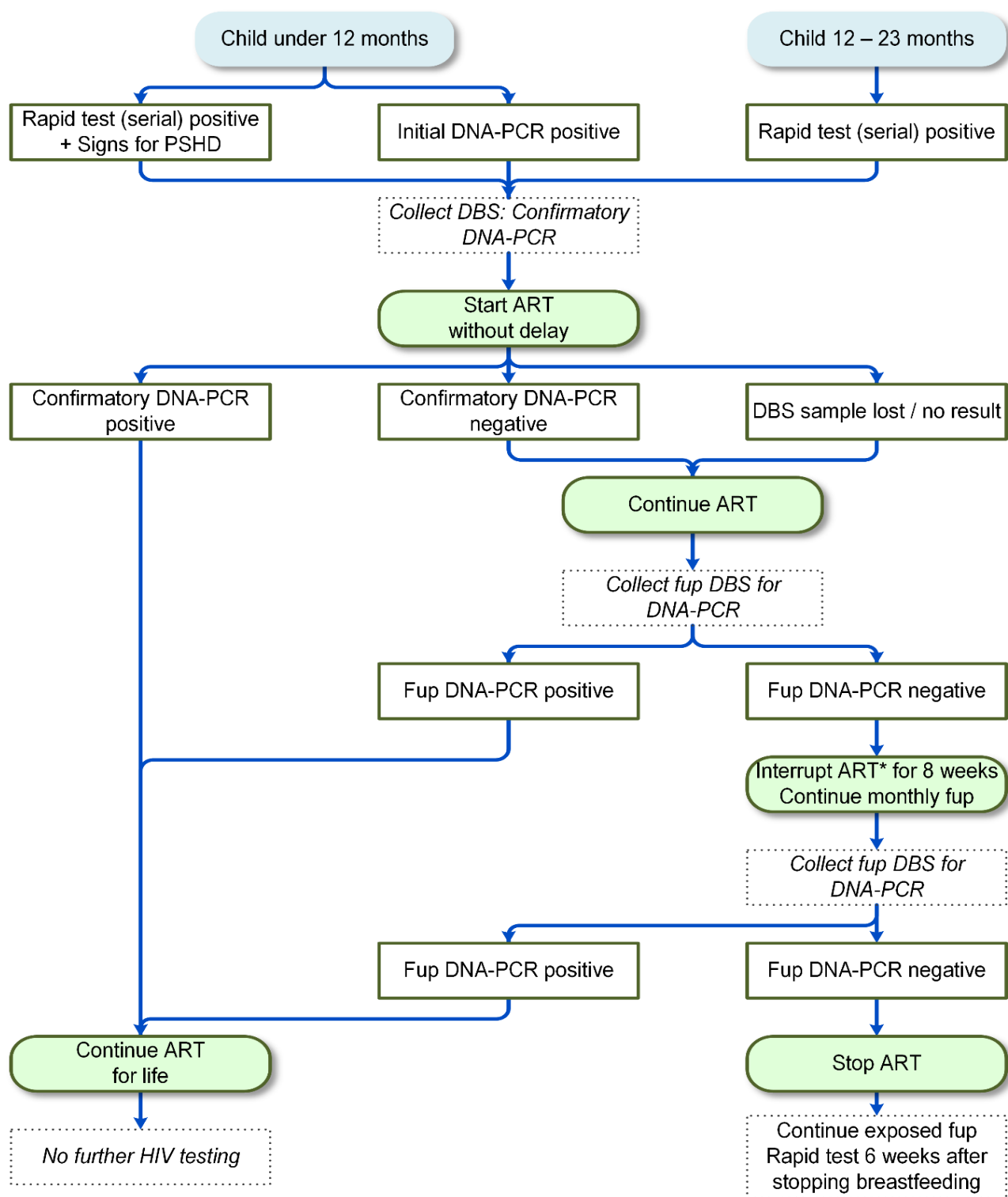


Figure 6: Algorithm for HIV diagnosis in children less than 24 months of age

## 6.4 Unconscious Patients

In the event that a patient is unable to give consent (e.g., unconscious or acute confused state):

- Non-consensual HIV testing of patients who are too unwell should be undertaken only in a situation where there is doubt about the diagnosis or if there is evidence of chronic dementia or **where results of a HIV test will change the management of the patient**. Consent is required

from a legal guardian, partner, parent for a minor, and adult child of the patient. Gaining consent does not imply sharing of HIV test results to the person giving consent.

- Treatment should be initiated for any suspected opportunistic infection where there is evidence of immunosuppression and a diagnosis of HIV is strongly suspected. When the patient has sufficiently recovered to give consent, counselling and testing should be performed as per protocol.

In both situations, the clinician must be the only person to decide whether an HIV test will be performed on the patient and results must not be disclosed to relatives. **All patients must receive post-test counselling** at the first appropriate opportunity.

## 6.5 Health-Care Providers and Workers Exposed to HIV

Health care workers who are exposed to HIV through a needle stick injury should be supported to establish their HIV status through confidential HTS, and access PEP immediately according to the guidelines, within 24 hours to 72 hours of exposure in order to minimise the risk of HIV infection.

## 6.6 Survivors of Sexual Assault

Survivors of domestic violence or rape require an empathetic approach by the health care professionals. The routine offer of HIV testing is recommended as part of the comprehensive clinical management of post-sexual assault. Principles in delivering this package of care are outlined here:

- Counselling should always precede and follow HIV testing.
- Informed consent must be obtained before testing.
- Whenever possible, the client should also be screened for syphilis, Hepatitis B and C. Discussion about confidentiality should explore the barriers faced by the client in disclosure. If the client is in an abusive relationship, the client should not be pressurised to disclose to his or her partner and should be referred to appropriate service providers for support.
- If the results are HIV negative, the full course of PEP should be provided as soon as possible, within 72 hours of the exposure.
- If the results are HIV-positive, the client should be counselled and referred to appropriate services for management and support.
- Clients receiving PEP should be encouraged to test again at six weeks, three months and six months after the initial exposure.
- For those who choose not to be tested, they should be advised that it is not possible to give PEP without prior testing, and they should be provided with information about where they can go for testing in future. They should also be provided with information and referrals for emergency contraception and other support services.

## 6.7 Key Populations (KPs)

Key Populations (KPs) are populations with increased behavioural risk to HIV infection, and includes FSWs, MSMs, TGs, PWIDs, etc. Due to societal stigma and discrimination on these populations, easy access to health care and HIV testing is often challenging. Integration of HTS in MARP-friendly

programs, STI clinics and anti-drug dependence initiatives have shown increased HIV testing and access to ART services for these population, thereby mitigating community transmission.

### 6.7.1 Female Sex Workers (FSWs) and Their Clients

Among men who reported paying for sex, only half reported using a condom during their last transactional sex, exposing the extent of risky behaviour (6). More research is required to understand the extent and complexities of transactional sex in The Gambia in order to develop appropriate strategies to increase access to HTC for female Sex Workers (CSWs) and their clients.

### 6.7.2 Men Who Have Sex with Men (MSM) and Drug Users

The vulnerability of men who have sex with men is heightened not only by social stigma but also by the legislation denying Men who have sex with men (MSM) to freely express their sexuality. There is little known or reported about intravenous drug use in The Gambia as a form of drug use directly responsible for high risk of transmission of HIV.

### 6.7.3 Convicted Sexual Offenders

HIV testing of a **convicted** rape perpetrator can only be performed with a court order. The *HIV Law* does not make provisions for testing an alleged rape perpetrator. Disclosing the HIV test result of a perpetrator may only be provided “when the health professionals are called upon to testify upon the request of a court of competent jurisdiction” (section 18.23 (c) 3 of the HIV Law) (2) and the results disclosed to the Magistrate or Judge handling the case.

The health-care provider should offer the sexual offender pre-test counselling or ensure that pre-test counselling has been done. In addition, the offender should be provided with all the necessary information about HIV and AIDS.

Strict requirements apply to confidentiality of the results. In the opinion of the health care provider, there is a significant risk of transmission of HIV by the person living with HIV to the sexual partner.

The survivor or the interested person who applies for the testing of the convicted sexual offender should be counselled prior to receiving the HIV results of the offender. The investigating officer and the health care provider involved in the case should ensure that such counselling occurs before handing over the test results.

### 6.7.4 Prisoners

Prisoners and detainees are entitled to the same level of confidentiality as non-detainees and have the right to access quality health services including care and treatment for HIV.

On admission to a detention facility, authorities should ensure access to:

- STIs and TB screening for detainees and follow this with treatment where necessary.
- Offer HIV counselling and testing according to this guideline.
- Advise detainees and prisoners of risk of sexual transmission of STIs in a prison environment and provide condoms. The difference between consensual and non-consensual sex must be explained.
- Encourage detainees and provide confidential facilities to report rape; inmates must be informed about PEP at the time that they enter a detention facility.

**For female prisoners** - on admission to a detention facility:

- Pregnant prisoners should receive basic ANC including HIV counselling and testing by health professionals and in accordance with the approved PMTCT programme.
- Female prisoners who reveal that they are pregnant in prison should have access to a local maternity facility or a midwife obstetric unit, allowing them access to the PMTCT programme for themselves and the infant if born in prison.

### **6.7.5 Individuals with Mental Health Problems**

The welfare of people who are mentally unwell should be the primary concern of the counsellor when HTS is requested. The counsellor reserves the right to refuse testing, if he or she determines that the patient is not competent to make decisions about testing. In such a case a referral should be made to a mental health clinician for appropriate assessment. HTS, however, can be provided in the company of a legal guardian in deserving cases.

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

### **6.7.6 Refugees**

Mandatory HIV testing of refugees and asylum seekers is not allowed under international humanitarian law. Known persons living with HIV in this category should be assisted to access ART services quickly.

### **6.7.7 People with Mental & Physical Disabilities**

Consent for HIV testing can be given by a carer or guardian where an individual is assessed as incapable of making an informed decision. Every attempt should be made to provide information in appropriate materials and ways that the care provider traditionally uses to communicate with the client, to enable informed consent for such individuals.

## 7.0 QUALITY ASSURANCE AND QUALITY CONTROL

The testing staff must ensure that the testing procedures are correctly performed, the environment is suitable for reliable testing, ensure that confidentiality can be assured, and that the test kit works as expected to produce accurate and reliable results (7).

Steps in the testing process should follow the path of workflow and begin with tasks done before testing (pre-analytic), followed by tasks done during (analytic) and after testing (post-analytic). When using HIV rapid test kits, there are a number of steps in these three parts of the path of workflow that are essential in order to assure accurate and reliable test results.

A laboratory standard operating procedure (SOP) document has been developed to provide detailed instructions on all aspects of the testing, to include transport of specimens, storage and inventory information, test requesting, environmental requirements, specimen collection and management, test performance, quality control instructions, test interpretation, reporting and recording results, appropriate use of the testing algorithm, and any external quality assessment requirements.

Each testing product (SD Bio-line, Determine, Multi-Sure, HIV syphilis duo, First Response etc) needs its own written SOP and should be available at testing site, and should always be followed when conducting tests.

The testing staff should perform the following procedures while conducting tests:

### 7.1 Pre-analytic

- A standard QA system should be embedded in the HTS program, for routine and ongoing quality assurance on the testing protocol.
- Check inventory and test kit lots as needed.
- Receive requests for testing. Ensure client lab. Request form is duly filled (Appendix 9.1 shows the Laboratory Test Request Form).
- Set up test area.
- Record all needed data, such as kit lot number, operator identity.

### 7.2 Analytic

Follow the biohazardous safety precaution as is shown in the laboratory safety procedures and disposal.

Perform internal quality control according to instructions.

- a Run a negative and a positive control (weekly when possible) at the following times:
  - At least once weekly, preferably at the beginning of the week;
  - When a new operator (a trained staff member who has not been doing testing for a while or a newly trained operator) is performing testing;

- When beginning the use of HIV rapid test kits with a new lot number;
  - Whenever a new shipment of test kits is received;
  - If rapid test kits are exposed to environmental conditions that fall outside the range needed for stability as defined by the manufacturer.
- b. Correctly identify person to be tested. Invite into the testing room.
  - c. Greet the client/patient and establish rapport. Ensure client confidentiality, reassure and alleviate his or her fear of needles or sight of blood.
  - d. Collect the specimen, including specimen for External Quality Assessment (EQA).
  - e. Perform the test as directed by the manufacturer (follow Laboratory SOP for each test product).
  - f. Interpret the test results. The serial testing with a tie breaker is recommended by the MoH guidelines (see the algorithm below).

### 7.3 Post-analytic

- a. Re-check patient identifier and report results.
- b. Clean up and dispose bio-hazardous waste.
- c. Package and transport EQA re-test specimens to referral laboratory, or appropriately store until next shipment to referral laboratory, if needed.

### 7.4 Quality Assurance and Quality Control

Quality Assurance activities in an HTS setting are essential to ensure the provision of quality counselling and accurate and reliable HIV testing. The quality of counselling has an implication on the outcome of a client's decision to test or not to test as well as how the client handles and copes with the test results. Also, regardless of whether a test result is positive or negative, it has major implications on a client's life. In this regard, HIV testing must be done properly using reliable tests, reagents and correct procedures. Quality Assurance Protocols are developed and made available to all persons working in and managing HTS. Clear Standard Operating Procedures manual and protocols are established for service delivery. The areas covered include:

- a. Client registration and intake;
- b. Obtaining informed consent;
- c. Maintaining confidentiality;
- d. Pre-test counselling or pre-test information in PICT;
- e. Delivery of HIV testing, PEP; laboratory protocols;
- f. Post-test counselling, care and support;
- g. Beneficial disclosure;

- h. Ensuring non-discrimination in service provision;
- i. Existing referral mechanisms.

Quality improvement processes are required for auditing adherence to policies, protocols and procedures. It is important to use these processes to assess issues such as staff competency/proficiency, counsellor skills, counselling protocols, the adequacy of laboratory testing and the perspective of clients on the accessibility and acceptability of testing and counselling services.

## 7.5 Quality assurance of counselling services

- a. Quality assurance is a way of monitoring and evaluating the quality of counselling services provided in accordance with established guidelines, policies and standards.
- b. Approaches for assessing quality of counselling include regular training, assessment checklist, supportive supervision, counsellor self-assessment and stress management sessions, client exit interviews and suggestions to measure client satisfaction, and regular monitoring of all activities along the workflow
  - o The cue cards that will support counsellor during the counselling process is included as a separate document to be used together with the SOPs. These cue cards aim to standardize the language and the foundation for continued learning. The cue cards are one tool that will be use by counsellors and providers to sustain the skills of quality HTS ([CUE cards will be developed and made available to HTS providers](#)).
- c. Quality control procedures consist of regular supervision of all staff, weekly staff meetings, regular feedback to individuals by project coordinator and bi-annual evaluation of staff performing counselling.

## 7.6 Quality Assurance of HIV testing

Quality Assurance (QA) is defined as the overall programme that ensures that the final HIV test results reported are correct. A false result may irrevocably damage the reputation of the HTS and the consequences to the client may result in social, psychological and stigmatization problems. Two levels of Quality Assurance are recognized:

### 7.6.1 Internal Quality Assessment (IQA)/Quality control procedures

These are essential to ensure that the testing process has been carried out properly and that the kit reagents are performing as intended. These are activities conducted during testing in order to quickly identify and correct deviations from protocol as well as identify “less than optimal performance”. The quality control procedures are designed to maintain the integrity of the components by assessing adherence and assisting staff in meeting goals. IQA involves the following:

- a. Good laboratory practices with set standards for performing HIV testing;
- b. Systems for management of HIV test results;
- c. Tracking records on available test kits, batch numbers and expiry dates;

- d. Internal Quality Assurance system in place: Periodic inclusion of previously characterized samples in order to identify problems with competency of the personnel performing the HIV tests, and also identifying problems with new lots of test kits;
- e. All quality control data are well recorded for easy review and analysis.

### 7.6.2 External Quality Assessment (EQA)

This involves objective assessment of a test site's operations and performance by external agency or personnel. Laboratory practitioners have a vital role to play in the supervision of activities at the HIV rapid testing sites. EQA involves the following:

- a. Proficiency Testing: All personnel providing HIV testing services will receive HIV proficiency samples from the reference or consultant hospital laboratories at least twice a year. All personnel failing the proficiency tests need to receive additional technical supervision and support.
- b. On-site Monitoring and Evaluation: This involves periodic site visits to assess practices at the HIV testing sites. The supervision role should be undertaken by the laboratory practitioners in Charge. On-site assessment will also be done by the Consultant Hospital and National Reference Laboratories when deemed necessary. In order to make the assessment objective, a standardized on-site evaluation checklist is established for use during the supervision. On-site monitoring and evaluation at HTS site shall be done at least twice yearly.

Re-test of specimens: Retest specimens are randomly selected from all tested clients daily. Both positive and negative samples are taken for retest. Depending on the volume of bloods tested in the facility, every fifth positive and twentieth negative samples are collected and transferred to reference laboratory weekly for retesting.

## 7.7 Infection Prevention and Control

Ensure the use of standard infection prevention and control (IPC) during HIV testing, from specimen collection to storage, transporting and disposal of biohazard wastes to minimise occupational risk exposure to HIV, hepatitis B virus (HBV) and other transfusion transmissible infections. Every person (patient or staff) should be considered potentially infectious and susceptible to infection.

All laboratories handling infectious materials should always have a biohazard spill kit containing paper towels, gloves, disinfectant and heavy-duty biohazard disposal bags. Supervisors should report any HIV exposure events to the medical director, OIC or supervisor. Supervisors should ensure that PEP logbooks are maintained (See PEP protocol on the HIV treatment guidelines).

Components of standard precautions:

1. Hand hygiene including hand washing, antiseptic hand scrub and surgical hand scrub.
2. Personal protective equipment including gloves, gowns, aprons, goggles and masks. These will be routinely provided with other HIV test consumables in all HTS delivery points.
3. Careful handling and disposal of sharp instruments
4. Safe disposal of infectious waste contaminated with body fluids.
5. Proper handling of soiled linen.
6. Sterilization and disinfection

## 8.0 References

1. Consolidated Guidelines on HIV testing services 2015. 5Cs: Consent, Confidentiality, Counselling, Correct Results and Connection. WHO Press, World Health Organization.
2. Republic of The Gambia. HIV and AIDS Prevention and Control Act 2015.
3. Counselling Skills, Ethical Codes and Supervision of Counselling Practice for HIV and AIDS Voluntary Counselling and Testing, Module 8, MoHSW, NACP, Tanzania, February 2008
4. Ministry of Health. Operational Guideline for the delivery of HIV self-testing in the Gambia, September 2022
5. Couple HIV Counselling and Testing, Trainers Manual, United States Centre for Disease Control and Prevention, November 2008
6. Gambia Bureau of Statistics (GBOS). The Gambia Demographic Health Survey, GDHS, 2013
7. Guidelines for Assuring the Accuracy and Reliability of HIV Rapid Testing: Applying a Quality System Approach, U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, WHO, 2005

## 9.0 APPENDIX

### 9.1 Appendix: Initial Lab Request Form

#### INITIAL LAB REQUEST FORM

H/ Region ----- H/F-----Lab. No. -----

Date-----/-----/..... Reason for Test -----

HCT/ PMTCT NO. ----- Village----- Sex: M/F Age-----

-----

Haematology: HB. -----g% BF----- Urine: Sugar -----

Sickle test----- Blood group----- Albumin -----

Serology: RPR----- TPHA-----

Determine/SD HIV Syphilis Duo \_\_\_\_\_ SD Bio line/First response \_\_\_\_\_ MultiSure HIV 1 / 2

\_\_\_\_\_

Sputum: AFB 1-----AFB 11----- Gene Xpert-----

HBsAg \_\_\_\_\_ HCV \_\_\_\_\_

Other tests -----

Sample to Ref. Lab.-----/-----/-----.

Signature----- (Requesting)

Signature----- (Lab Personnel)

## 9.2 Appendix: Consent Form

### CONSENT OF CLIENT


I have / have not consented for the HIV test

Date ...../..... /..... HTS/PMTCT No. .... Signature.....

Name of Counsellor .....Signature.....


## 9.3 Appendix: National HIV Testing Algorithm

### National HIV Testing Algorithm



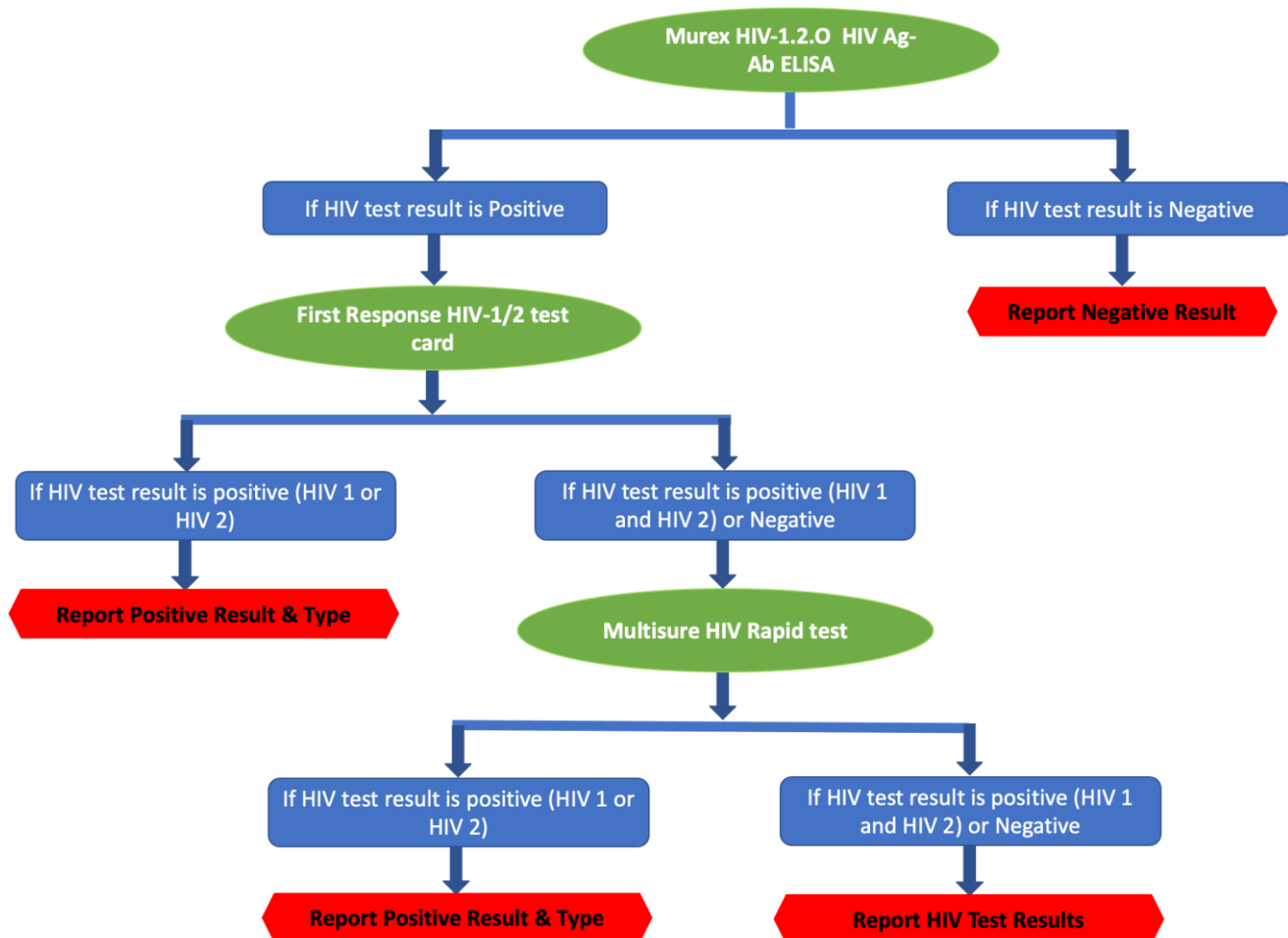
THE REPUBLIC OF THE GAMBIA  
Tel: (+220) 4466799

**National Public Health Laboratories**  
Ministry of Health & Social Welfare  
Bertil Herding Highway, Kotu Layout  
info@moh.gov.gm

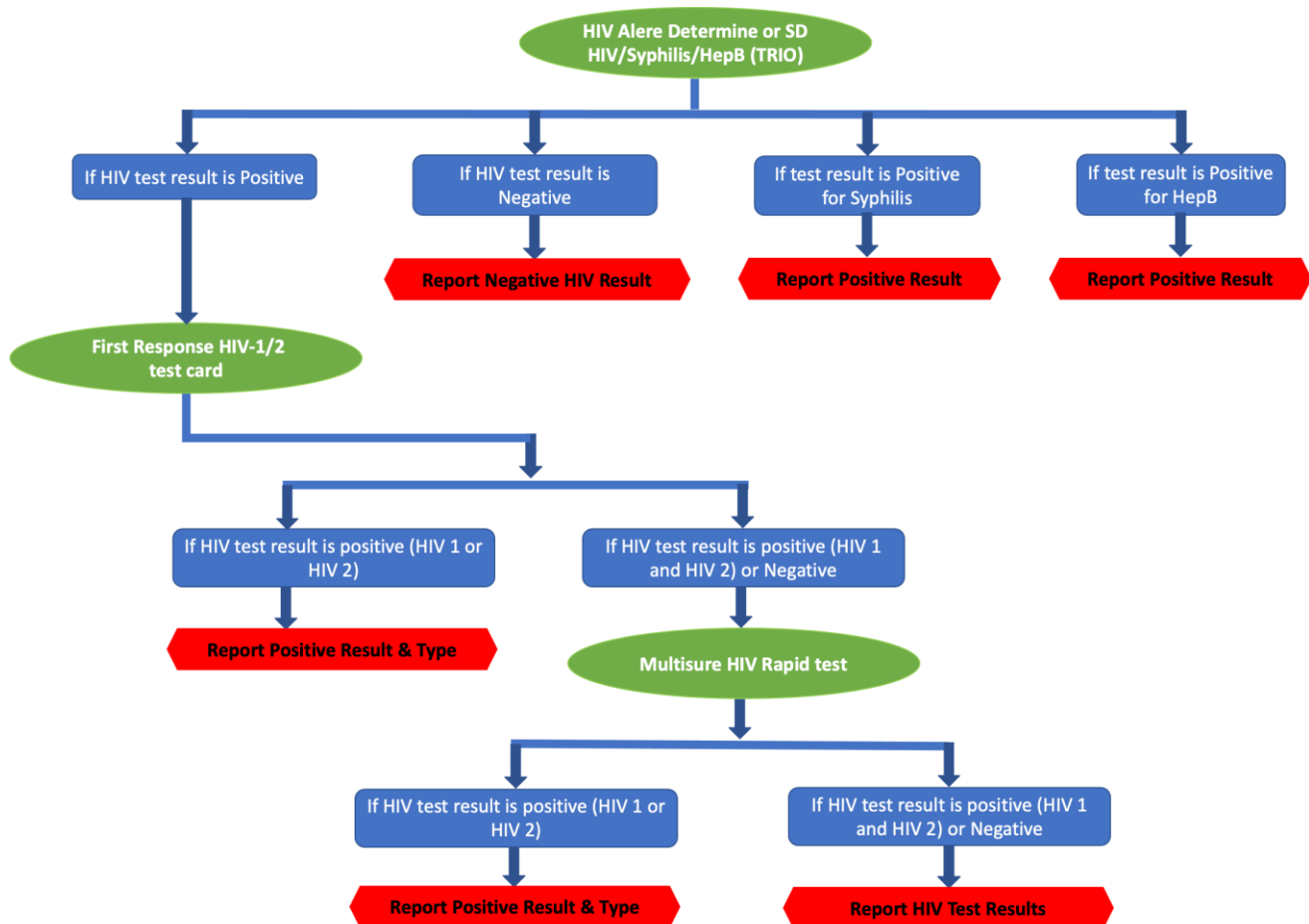


National Public Health Laboratory Services  
Fax: (+220) 4414431

#### REFERENCE SEROLOGY LABORATORY – HIV TESTING ALGORITHM



## PERIPHERAL LABORATORIES HIV-1/2 TESTING ALGORITHM



**NOTE: SD HIV/SYPHILIS/HB (TRIO) will only be used for antenatal and Blood transfusion services whilst Alere Determine for everyone else.**

### 9.4 Appendix: HIV Counselling and Testing Set-Up

#### HIV COUNSELLING AND TESTING SET-UP

**Client Initiated Counselling and Testing (CICT) services.**

#### HTS Site Set-up

HTS sites are organized in a manner that is convenient to clients. All measures are taken to assure client comfortability from the point of entry to the point of exit as per the national guidelines of the MOH:

#### Reception area set-up

The reception area shall meet all conditions of privacy and confidentiality. It shall be furnished with two chairs and a table with lockable drawers for safekeeping of clients' records.

For outreach services, mats or stools may be used and the counselling session can be held in a secluded open area that allows for privacy.

### **Waiting area set-up**

The waiting room shall be adequately spaced, well-furnished and have a comfortable seating arrangement.

Health education materials including those with information on HIV and AIDS shall be displayed and distributed liberally. Where available, audio and audio-visual equipment can also be used to relay and disseminate health information.

Information, Education, and Communication/behavioral change communication (IEC/BCC) materials in waiting area can be:

- a. Site information leaflet
- b. General HIV and HTS brochure
- c. Male and female condoms
- d. Pamphlets on male and female Proper condom use
- e. Others including those that relate to positive living and where to get access post-test services like Care and Treatment Centre (CTC), Prevention of Mother to Child Transmission (PMTCT), Sexually Transmissible Infections (STI) and Tuberculosis (TB) treatment.

### **Counselling room set-up**

The counselling room shall be clean, well ventilated, well lighted and assure privacy. It shall be furnished with the following important equipment and furniture:

1. A table with lockable drawers
2. At least three (comfortable) chairs to allow for couple/group counselling.
3. Lockable cupboard for client records
4. Disposal bin for sharps as stipulated in the Injection Safety Guidelines by the MOH and foot-operated buckets for other waste.
5. Running water, wash basin, soap and disposal towels.

### **Counselling area materials and supplies:**

- a. HTS guidelines, SOPs for HTS services and HTS cue cards
- b. Informed Consent Information Sheet
- c. Staff schedule
- d. Laboratory/test request form
- e. Male and female condoms
- f. Pamphlets on male and female Proper condom use

- g. Envelopes to carry condoms and information.
- h. Penile model
- i. Model pelvis/vagina
- j. Box of tissues, pens, pencils, paper

**Referral Materials:**

- Information sheets about Post Test Support Services (PTSS)
- HTS-PTSS referral cards

**Testing room set-up**

A separate room or curtained-off space shall be set aside for testing. The testing room shall offer privacy and have the following equipment:

1. Two chairs
2. A table
3. Lockable cupboard
4. Running water, wash basin, soap and disposal towels
5. Disinfectant and antiseptics
6. Disposal bin for sharps and foot-operated buckets for other waste
7. Refrigerator or cooler box with ice
8. Enough supplies including gloves, vacutainer syringe ad tube, syringes with a self-retracting needle, lancers, tourniquet, cotton wool, stamp and stamp pad.
9. Testing kits according to approved algorithm
10. Functional First Aid box
11. PEP procedures
12. Testing SOPs and algorithm

**Provider Initiated Testing and Counselling Services (PICT)**

**Consultation room**

PICT will often be delivered where other health care services are provided, therefore, there is a need to ensure an area where consent and test result can be given in confidence and with privacy. The PICT sites are organized in a manner that is convenient to patients and health care providers. All measures are taken to assure patient comfortability from the point of entry to the point of exit as per the guidelines from the MOH:

**Reception area set-up**

The reception area shall be furnished with comfortable chairs and a table with IEC/BCC materials that the patient can take way at the conclusion of their hospital visit.

**Waiting area set-up**

The waiting room shall be adequately spaced, well-furnished and have a comfortable seating arrangement.

Health education materials including those with information on HIV and AIDS shall be displayed and distributed liberally. Where available, audio and audio-visual equipment can also be used to relay and disseminate health information.

- a. IEC/BCC materials in waiting area can be:
- b. Facility information leaflet
- c. General HIV and PICT brochure
- d. Male and female condoms
- e. Pamphlets on male and female Proper condom use
- f. Others including those that relate to positive living and where to get access post-test services like Care and Treatment Centre (CTC), Prevention of Mother to Child Transmission (PMTCT), Sexually Transmissible Infections (STI) and Tuberculosis (TB) treatment.

### **Consultation room set-up**

The consultation room shall be clean, well ventilated, well lighted and assure privacy. It shall be furnished with the following important equipment and furniture:

1. A table with lockable drawers
2. At least three (comfortable) chairs to allow for relative to escort couple counselling.
3. Lockable cupboard for client records
4. Disposal bin for sharps as stipulated in the Injection Safety guidelines by the MOH and foot-operated buckets for other waste.
5. Running water, wash basin, soap and disposal towels.
6. Counselling area materials and supplies:

### **PICT guidelines, SOPs for HTS services**

- a. Informed Consent Information Sheet
- b. Staff schedule
- c. Laboratory/test request form.
- d. Male and female condoms
- e. Pamphlets on male and female Proper condom use
- f. Envelopes to carry condoms and information.
- g. Penile model
- h. Model pelvis/vagina
- i. Box of tissues, pens, pencils, paper
- j. Referral Materials:
  - Information sheets about post-test support services (PTSS)
  - Referral cards

### **Testing room set-up**

Testing can be carried out in the consulting room. A separate room or curtained-off space shall be set aside for testing. The testing room shall offer privacy and have the following equipment:

1. Two chairs
2. A table
3. Lockable cupboard
4. Running water, washbasin, soap and disposal towels
5. Disinfectant and antiseptics
6. Disposal bin for sharps and foot-operated buckets for other waste
7. Refrigerator or cooler box with ice
8. Enough supplies including gloves, syringes, needles, lancers, tourniquet, cotton wool, stamp and stamp pad.
9. Testing kits according to approved algorithm
10. Functional First Aid box
11. PEP procedures
12. Laboratory testing SOP and algorithm

## 9.5 Appendix: Key elements and considerations for HCT settings

### Key elements and considerations for HCT settings

<b>Standalone services:</b> Stand-alone HCT services are those situated outside Health facilities.	
<p><b>Key Elements:</b></p> <ul style="list-style-type: none"> <li>• High level of public awareness required to stimulate demand, including community mobilisation of appropriate messaging and social marketing strategies.</li> <li>• Location in a busy and easily accessible area, where there will be a high concentration of clients.</li> <li>• Staff dedicated to providing full HTS</li> <li>• Strong linkages with providers of support services</li> <li>• Anonymous and confidential testing offered.</li> <li>• Flexible hours of operation including evenings and weekends</li> <li>• Targets general public, especially those who would not normally visit health facilities e.g., men and youths.</li> <li>• Nominal fee charged to clients who can afford to pay.</li> <li>• Youth friendly activities should be incorporated to encourage access by young people.</li> </ul>	<p><b>Possible Challenges:</b></p> <ul style="list-style-type: none"> <li>• Sustainability as many is donor- funded and managed by NGOs without long-term plans for funding.</li> <li>• Entails significant commitment in terms of time, resources, infrastructures and staff.</li> <li>• Need to ensure good referral mechanism for follow-up care.</li> <li>• High possibility of stigmatization</li> <li>• High likelihood of staff burnout as they have little relief from HIV and AIDS counselling.</li> <li>• Clients who cannot afford to pay should not be denied services.</li> <li>• Fear among clients of unintentional disclosure by association with a dedicated HIV service and stigma for attending nominated HTS site.</li> </ul>

**Integrated HTS services:** Integrated services are provided within health facilities, including maternal and Child health (MCH) services, STI, TB, opportunistic infection (OI), in-patient and out-patient clinics.

<p><b>Key Elements:</b></p> <ul style="list-style-type: none"> <li>• Ideal for rapid scaling-up of HTS, as the basic infrastructure and health are already in place.</li> <li>• Existing staff must receive training in the provision of HIV counselling and testing service.</li> <li>• Close links with other medical services already exist and facilitate clinical referral.</li> <li>• It is important to hold regular meetings among different departments to ensure good liaison and cross referral.</li> <li>• Potentially less expensive, since existing facilities and staff are utilised.</li> <li>• Low stigmatization, as people could be attending the facility for other reasons.</li> </ul>	<p><b>Possible Challenges:</b></p> <ul style="list-style-type: none"> <li>• Staff must be given adequate space to provide HIV counselling and testing services.</li> <li>• Limited space can also affect privacy and expansion of services.</li> <li>• May exclude people who do not frequent formal health services, e.g., men and youths</li> <li>• Inflexible hours may limit access to HTS services.</li> <li>• Translates into added responsibility for existing staff.</li> <li>• shortage of staff due to transfers, and staff engagement in primary responsibilities</li> </ul>
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**Out-reach HIV Testing Services:** services offered through mobile teams of providers, aim to increase access for special populations such as people living in the remote rural areas, internally displaced populations, highly mobile populations, (e.g., long distance truck drivers, fishermen) and vulnerable groups, e.g., prisoners, commercial sex workers. Services may be provided at premises such as community halls, school halls, youth facilities and mobile structures such as vehicles can also be utilised for service provision.

<p><b>Key Elements:</b></p> <ul style="list-style-type: none"> <li>• Strong support system and referral mechanisms must be established at community level before initiating an out-reach HIV Testing service.</li> <li>• Ideal for rapid scaling-up of HTS, as the basic infrastructure and health are already in place.</li> <li>• Existing staff must receive training in the provision of HIV counselling and testing service.</li> <li>• Close links with other medical services already exists and facilitate clinical referral.</li> <li>• It is important to hold regular meetings among different departments to ensure good liaison and cross referral.</li> <li>• Potentially less expensive, since existing facilities and staff are utilised.</li> <li>• Low stigmatization, as people could be attending the facility for other reasons.</li> </ul>	<p><b>Possible Challenges:</b></p> <ul style="list-style-type: none"> <li>• Staff must be given adequate space to provide HIV testing services.</li> <li>• Limited space can also affect privacy and expansion of services.</li> <li>• May exclude people who do not frequent formal health services, e.g., men and youths</li> <li>• Inflexible hours may limit access to HIV Testing services.</li> <li>• Translates into added responsibility for existing staff.</li> <li>• Shortage of staff due to transfers, and staff engagement in primary responsibilities.</li> </ul>
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**Private Sector:** may be provided by companies or organizations that offer work-place HIV services or at private medical entities. The private sector caters for some important segments of the

population including those who can afford to pay for services, have medical insurance, or are provided with medical services by their employers.

**Key Elements:**

- Convenient for those not willing to access services through public sector facilities.
- Convenient for employees, if services are provided at workplaces.
- May have more assurance of confidentiality, if services are provided by private practitioner.

**Possible Challenges:**

- Quality of HTS may be difficult to monitor.
- Limited supervision of counsellors
- Inaccessible to general public
- Concerns about confidentiality among employees
- May be expensive to clients.