

# NATIONAL COMPREHENSIVE HIV TESTING SERVICE (HTS) TRAINING

Participant  
Manual



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MINISTRY OF HEALTH-ETHIOPIA

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HEALTHIER CITIZENS FOR PROSPEROUS NATION!

Ministry of Health Ethiopia  
June 2023

## **APPROVAL STATEMENT OF THE MINISTRY**

The Federal Ministry of health of Ethiopia has been working towards standardization and institutionalization of In-Service Trainings (IST) at national level. As part of this initiative the ministry developed a national in-service training directive and implementation guide for the health sector. The directive requires all in-service training materials fulfill the standards set in the implementation Guide to ensure the quality of in-service training materials. Accordingly, the ministry reviews and approves existing training materials based on the IST standardization checklist annexed on the IST implementation guide.

As part of the national IST quality control process, this national Comprehensive HIV Testing Services IST training package has been reviewed based on the standardization checklist and approved by the Ministry.

A handwritten signature in blue ink on a light blue background. The signature is stylized and appears to read 'Dr. Getachew Tollera'.

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## Acknowledgement

The Ministry of Health is very grateful for the partner organizations and individual consultants that participated in the revision of this comprehensive HTS training material. The Ministry also would like to recognize the following experts for their contribution in the revision of the training material.

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## List of Acronyms

AIDS	Acquired Immunodeficiency Syndrome	OPD	Outpatient Department
ANC	Ante Natal Care	PCR	Polymerase Chain Reaction
ART	Anti-Retroviral Therapy	PEP	Post Exposure Prophylaxis
ARV	Anti-Retroviral Virus	PITC	Provider Initiated HIV Testing & Counseling
CBS	Couple HIV Counseling & Testing	PLHIV	People Living with HIV
CHCT	Case Based HIV Surveillances for Response	PMTCT	Prevention of Mother-To- Child Transmission
CPD	Continuous Professional Development	PNS	Partner Notification Service
DTS	Dry Tube Specimen	POC	Point of Care HTS
EDHS	Ethiopian Demographic and Health Survey	PP	Priority Population for HTS
EIA	Enzyme Immunoassay	PrEP	Pre exposure Prophylaxis
EPHI	Ethiopian Public Health Institute	PWID	People with injecting drugs
EQA	External Quality Assessment	PT	Proficiency Testing
HAPCO	HIV/AIDS Prevention & Control Office	QA	Quality Assurance
HIV	Human Immunodeficiency Virus	QC	Quality Control
HIVST	HIV Self-Testing	RDS	Respondent Driven Sampling
HRST	HIV Risk Screening Tools	RDT	Rapid HIV Test
HTS	HIV Testing Service	RTK	Rapid Test Kit
ICT	Index Case Testing	SDP	Service Delivery Unit for HTS
IgG	Immunoglobulin G	SNS	Social Networking Service
IP	Infection Prevention	SOP	Standard Operating Procedure
IQA	Internal Quality Assurance	STI	Sexually Transmitted Infections
IQC	Internal Quality Control	TB	Tuberculosis
IST	In Service Training Center	TOT	Training of Trainers
KPP	Key and Priority Population	UNAIDS	United Nations Program on HIV/AIDS
KP	Key Population	VCT	Voluntary HIV Counseling & Testing
LDD	Long Distance Truck Drivers	VMMC	Voluntary Medical Male Circumcision
MMD	Multi-month Dispensing	WB	Western Blot
MoH	Ministry of Health	WHO	World Health Organization
MTCT	Mother - To -Child Transmission		
OGHC	Ongoing HIV Counseling		

## Foreword

In Ethiopia, HIV Testing Services (HTS) have been provided for clients at health facilities and at community level for more than two decades with strong attention from the government and partner organizations as these services are important entry points to all other HIV prevention, treatment, care, and support interventions. Accordingly, the Ministry of Health and regions have been doing impressive jobs to scale up HTS to ensure service availability across the country for all clients who demand the service. To effectively guide the national endeavors while expanding and strengthening HTS, the country developed national guidelines for HIV testing and counseling in 2007 and National Guidelines for comprehensive HIV prevention care and treatment in 2014 and 2017. These guidelines helped to standardize HTS and ensure availability of quality services at all testing and counseling sites in the country.

HIV testing is the critical first step in identifying and linking PLHIV to HIV care and treatment services. It is also an opportunity to reinforce HIV prevention services among clients who have ongoing behavioral risk. Ethiopia has revised the HIV counseling and testing guideline to support the implementation of targeted testing. The focus of HIV Testing Service is to guide programs towards identifying and linking new HIV infections by targeting population groups who are at risk of acquiring HIV in locations and sites with the highest HIV burden. To efficiently identify and link HIV positive clients to care and treatment services. Targeted HTS should be implemented across the range of community and facility-based settings (using PITC, VCT and CBTC approaches). The Ministry is guiding towards a focused approach to test people more likely to be infected with HIV who are identified using epidemiological or population-based survey evidence.

To effectively implement the current HTS strategies, it is imperative to revise the existing training materials according to the updated recommendations. The MoH believes that this comprehensive HTS training material will play an instrumental role in building the capacities of service providers and ensure that the services are available for targeted population groups as well as for any individual or couples who requested for HIV testing and counseling in the country and eventually achieving the national commitment towards the three 95 targets (95% diagnosed, 95% on treatment and 95% has viral suppression).



## **Introduction to the Course**

This comprehensive training material will be used to train and build the capacity of health care workers on HIV counseling and testing. It gives details of the target audiences, rationale to the training, course goal, objectives, competencies, participant selection criteria, trainer qualification criteria/ requirement, training methods, learning materials including teaching aids, course evaluation, trainee assessment and certification criteria, general guidance for the trainer, daily and end course evaluation and pre and post course assessments.

## **Goals of the HTS Training:**

- ◆ Build the capacity of the trainees to identify people living with HIV by providing high-quality testing services for individuals, couples, and families,
- ◆ Ensure effective linkage for individuals and their families to HIV treatment, care, and support and to HIV prevention services, based on their status,
- ◆ Support the scale-up of high-impact interventions to reduce HIV transmission and HIV related morbidity and mortality.

## **Rationale of the Manual**

HIV infection is one of the global public health issues. In 2020, more than 37.7 million [30.2 million– 45.1 million] people were living with HIV, and 1.5 million [1.0 million–2.0 million] people acquired HIV. Nearly 45% of the people newly infected with HIV live in sub-Saharan Africa (UNAIDS; 2021).

The first evidence of HIV epidemic in Ethiopia was detected in 1984. Since then, HIV/AIDS has claimed the lives of millions and has left behind hundreds of thousands of orphans. The government of Ethiopia took several steps in preventing further disease spread, and in increasing accessibility to HIV care, treatment and support for persons living with HIV.

The HIV epidemic in Ethiopia is characterized as mixed, with wide regional variations and concentrations in urban areas, including some distinct hotspot areas driven by key and priority populations. According to the EDHS done in 2016, the national adult (15-49) HIV prevalence is 0.96 %; the urban prevalence was 2.9%, which is seven times higher than that of the rural (0.4%). National HIV Related Estimates and Projections (2020), also shows that the HIV prevalence varies from region to region ranging from less than 0.15% in Ethiopia Somali to 4.13% in Gambella. According to EDHS 2016, the progress towards achieving the first 95 target has been far behind the track; only 79% of PLHIV know their HIV status on the other hand spectrum (2020) data reveals 84% from the estimated PLHIV knows their status. To

accelerate the performance of the HIV case identification in Ethiopia for closing the gaps to treatment and achieve epidemic control, the remaining 21% of PLHIV need to be reached.

HIV testing services refer to the full range of services that should be provided with HIV testing, including counseling (pre-test information and post-test counseling), linkage to appropriate HIV prevention, treatment, care and other clinical services and the delivery of accurate results.

HIV testing services (HTS) should be provided to eligible clients who are at high risk of HIV infection. HTS need to focus on high-risk individuals who remain undiagnosed need to be tested and linking them to treatment and care services as early as possible. People who are HIV-negative but with an ongoing risk also need to be re-tested and provided appropriate prevention package of services.

This competency based 12 days Comprehensive HTS training is designed to build the capacity of service providers on provision of quality HTS for targeted population groups. It will enable service providers to early identify, timely link to care and treatment and, improve retention. This course has more of practical extent that gives emphasis for quality, to acquire and apply new knowledge and skills using competency-based assessment instruments, develop clinical experience sharing through demonstrations and role plays and conduct a comprehensive HTS training course for service providers. Hence the training course will support the provision of quality Comprehensive HTS in an integrated manner.

## **Course Competencies**

The following are the competencies expected to be acquired and executed after the completion of the training:

- ◆ Understand and express the current global, regional, and national distributions of HIV
- ◆ Provide HTS at point of care testing service delivery points for the targeted groups
- ◆ Demonstrate basic communication skills in counseling
- ◆ Provide person centered, safe and ethical index Case Testing (ICT), HIV Self-Testing (HIVST), risk based PITC, Social Network Testing Strategy (SNS)
- ◆ Conduct Pre and Post-test counseling through VCT and CHCT services
- ◆ Provide person centered pre and post -test information and counseling respectively for identified target groups
- ◆ Perform appropriate sample collection and HIV rapid testing
- ◆ Provide accompanied referral and linkage service for HIV positive clients comprehensive HIV care, treatment, and support services; and the negatives to appropriate prevention services.

## **COURSE SYLLABUS**

### ***Course Description***

These twelve days training course is developed for health care professionals to deliver HIV testing services for different target groups using different approaches (Client and provider initiated testing and counseling, person centered safe and Ethical ICT, HIVST, SNS) following standard national protocols and algorithms.

### ***Course Goal***

The goal of this course is to enable health professionals acquire HIV testing and counseling knowledge and skills to provide the service following national HTS protocols.

### ***Course Objectives***

By the end of this course, the participants will be able to:

- ◆ Describe basic facts of HIV/AIDS and overview of HTS
- ◆ Demonstrate basic HIV counseling skills
- ◆ Describe the HTS modalities
- ◆ Describe person centered safe and ethical Index case testing
- ◆ Describe Principles and approaches of ICT
- ◆ Provide client and provider initiated HTS for individuals
- ◆ Conduct point of care HIV testing according to national testing algorithm
- ◆ Describe the Standard Operating Procedures (SOP) of HIV testing and Counseling
- ◆ Practice appropriate HTS data recording and reporting

### ***Description of Training Methods and Materials***

#### **Methods**

- ◆ Interactive presentation and Discussion
- ◆ Group work
- ◆ Buzz group Discussion
- ◆ Brainstorming
- ◆ Demonstration
- ◆ Role play
- ◆ Case studies
- ◆ Guided clinical practice
- ◆ Recap

## **Materials**

- ◆ Participant manual
- ◆ Facilitators guide
- ◆ Standardized Power point slides
- ◆ Cue cards, protocols, and test algorithms
- ◆ Role play scenarios and observer checklists
- ◆ Job aid for HIV rapid tests and finger prick procedures
- ◆ Course evaluation formats
- ◆ Knowledge assessment questionnaire
- ◆ Penile model
- ◆ Condoms
- ◆ HIV rapid test kits
- ◆ HIV Self Test Kits and HIVST Video show
- ◆ Timer
- ◆ IP Kits (gowns, gloves, capillary tubes, lancets, disinfectants, safety box, waste bags)
- ◆ Flip charts and Markers
- ◆ LCD projectors, Laptops computers

## **Participant Selection Criteria**

For basic training, health care professionals will be selected from health care facilities that are actively involved on the day-to-day health service activities and have an interest to be trained and provide the HTS after training. For TOT training participants will be selected from health facilities, training centers, higher education institutions and HIV program managers at different levels of the health system that are healthcare professionals and have the basic HTS training. The participants need to be involved in HIV service delivery or HIV program management and have proven experience and facilitation skills.

## **Trainer Qualification Criteria/ Requirement**

In selecting HTS trainers to use this training package, the following criteria should be considered:

- ◆ Demonstrated proficiency in HTS. The trainer must have Basic training on HTS and training facilitation skills
- ◆ The trainers must be health professionals at least with first degree or BSC and have received training of trainers' (TOT) course on Comprehensive HTS
- ◆ The Comprehensive HTS trainer must have experience using the master learning approach to provide the training, which is conducted according to adult learning principles:
  - Learning is participatory,
  - Relevant, and practical and uses behavior modeling,
  - Competency-based and incorporates humanistic training techniques.
- ◆ HTS trainers for this course must be aware of basic principles of transfer of learning to help the participants translate the new knowledge and skills in to comprehensive HTS provision at their workplaces and improve job performance
- ◆ It is strongly recommended that at least two clinical trainers per class of trainees conduct this HTS course
- ◆ The trainers can divide roles and responsibilities according to their expertise, such as sharing the roles of “coach” and “facilitator” throughout the course.

## ***Methods of Course Evaluation***

### **Participant Evaluation**

- ◆ Pre- and post-course knowledge assessment
- ◆ Skill assessment of observed practice during role plays and practicum
- ◆ Skill assessment of rapid HIV testing during classroom demonstrations
- ◆ Facilitators daily evaluation
- ◆ Strict attendance (100%)
  - In addition to full attendance and appropriate assessment findings during role plays and practical sessions, Participants need to score more than 70% for Basic training and more than 80% for TOT in the post course knowledge assessment to qualify for certification.

### **Course Evaluation**

- ◆ Daily evaluation will be done at the end of each day except the last day
- ◆ End course evaluation will be conducted at the completion of the course

### **Post Training Evaluation or Follow Up**

- ◆ Clinical mentorship, supportive supervision and mentoring will be done

### **Course Duration**

- ◆ The total duration for this training is twelve days, which includes a one-day practical session.

### **Training Venue Selection and Suggested Class Size**

Comprehensive HTS training needs to be delivered in ISTC, CPD or other designated center and assuming role plays and other group activities, the recommended number of participants need to be 20-25 participants per class.

## National Comprehensive HIV Testing Services Course Schedule

<b>DAY 1 (Monday)</b>	
<b>TIME</b>	<b>ACTIVITY</b>
08:30-10:15 AM	Registration (30 min)
	Opening speech (10 min)
	Participant's introduction (15 min)
	Participant's expectation (15 min)
	Establish group rules (15 min)
	Course overview (goals, objectives, course schedule) (20 min)
10:15-10:35 AM	<b>HEALTH BREAK</b>
10:35-11:05 AM	Pre-test (30 min)
11:05-12:30 AM	<b>BASICS OF HIV/AIDS</b>
	Epidemiology of HIV (20 min)
	Ways of HIV transmission (10 min)
	Window period (10 min)
	Discussion (10 min)
	HIV Prevention Methods (35 min)
12:30-02:00 PM	<b>LUNCH BREAK</b>
02:00-02:15 PM	HIV Prevention methods (15 min)
	<b>OVERVIEW OF HTS</b>
02:15-03:40 PM	Overview of HTS in Ethiopia (10)
	Targeted HTS (10)
	Service Provision Setting of HTS approaches of HTS- VCT, PITC, ICT, SNS, HIVST (55)
	HTS as an essential component of HIV prevention, care, and treatment (10 min)
03:40-04:00 PM	<b>HEALTH BREAK</b>
04:00-04:25 PM	<b>INTRODUCTION TO HIV COUNSELING</b>
	Definition of HIV counseling (5 min.)
	HIV counseling involves (10 min.)
	Qualities of a good counselor (10 min)
04:25-04:40 PM	Common errors in counseling. (15 min.)
04:40-05:15 PM	Day summary
05:15-05:30 PM	Daily evaluation

<b>DAY 2 (Tuesday)</b>	
<b>TIME</b>	<b>ACTIVITY</b>
08:30-09:00 AM	Recap of day 1 (30 min)
09:00-10:30 AM	<b>DEFINATION OF COUNSELING</b>
	Benefits of HIV counseling (30 min)
	<b>BASIC COMMUNICATION AND COUNSELING SKILLS</b>
	Definition & importance of Communication (10 min)
	Communication skills used in Counseling (50 min)
10:30-10:50 AM	<b>HEALTH BREAK</b>
10:50-12:20 PM	Communication skills continued (25 min)
	Elements of good counseling (20 min)
	Basic counseling skills (55 min)
12:30-02:00 PM	<b>LUNCH BREAK</b>
02:00-03:30 PM	Counseling process (15 min)
	HIV counseling room setting (25 min)
	Roe-play (50 min)
03:30-03:50 PM	<b>HEALTH BREAK</b>
03:50-05:20 PM	<b>Ethical and Policy considerations for HIV Testing and Counseling in Ethiopia</b>
	Key ethical principles for HIV counselors (30 min)
	Client rights during counseling and testing (15 min)
	HTC Policy statements in Ethiopia (30 min)
	Daily summary (15 min)
05:20-05:30 PM	Daily evaluation (10 min)

<b>DAY 3 (Wednesday)</b>	
<b>TIME</b>	<b>ACTIVITY</b>
8:30-9:00 AM	Recap of Day 2
9:00-10:30 AM	HTC Policy statements in Ethiopia continued (30 min.)
10:30-10:50 AM	<b>HEALTH BREAK</b>
10:50-12:30 AM	<b>VCT</b>
	Introduction of VCT (15)
	Structure of VCT Protocols (15)
	Benefits of VCT (10)
	Introduction of Counseling Protocol (20)
	Component 1: Introduction and Orientation to the Session (30 min.)
	Summary (10 min)



12:30- 2:00 PM	<b>LUNCH BREAK</b>
2:00- 3:30 PM	Component 2: Risk Assessment (40 min.)
	Component 3: Explore Options for Reducing Risk (50 min.)
3:30- 3:50 PM	<b>HEALTH BREAK</b>
3:50- 5:20 PM	Component 4: HIV Test Preparation (25 min.)
	Role-play Components 1- 4 (45 min.)
	Large group process (Role play presentation & Discussion) (25 min.)
	Daily evaluation (10 min.)

<b>DAY 4 (Thursday)</b>	
<b>TIME</b>	<b>ACTIVITY</b>
8:30-9:00 AM	Recap of Day 3
9:00- 10:30 AM	<b>Counseling a Client with HIV-Negative Result</b>
	Component 5: Provide HIV Negative Test Result (20 min.)
	Component 6: Negotiate a Risk Reduction Plan (15 min.)
	Component 7: Identify Support for Risk Reduction Plan (10 min.)
	Component 8: Negotiate Disclosure and Partner Referral (20 min.)
	Role-play Components 1- 8 (25 min.)
10:30-10:50 AM	<b>HEALTH BREAK</b>
10:50- 11:55 AM	Role-play Components 1- 8 continued (20 min.)
	Large group process (Role play presentation & Discussion) (30 min.)
	Summary (15 min)
11:55- 12:30	<b>Counseling a Client with HIV- Positive Result</b>
	Review Exercise (30 minutes)
12:30-2:00 PM	<b>LUNCH BREAK</b>
2:00- 3:30 PM	Component 9: Provide HIV Positive Test Result (20 minutes)
	Component 10: Provide Linkages to Care, Treatment, and Support Services (20 min.)
	Component 11: Negotiate Disclosure and Partner Referral (10 min)
	Component 12: Risk Reduction Issues (10 minutes)
	Role play: Component 1-4 & 9-12 Small group (30 min)
3:30- 3:50 PM	<b>HEALTH BREAK</b>
3:50- 5:20 PM	Role play: Component 1-4 & 9-12 Small group continued (30 min)
	Large group process Role play (presentation & Discussion) (30)
	Summary (30 min)
5:20- 5:30 PM	Daily evaluation (10 min.)

<b>DAY 5 (Friday)</b>	
<b>TIME</b>	<b>ACTIVITY</b>
8:30-9:00 AM	Recap of Day 4
9:00- 10:30 AM	<b>Overview of Couple HIV Testing and Counseling</b>
10:30-10:50 AM	<b>HEALTH BREAK</b>
10:50- 12:30 PM	Disclosure and its benefits
12:30-2:00PM	<b>LUNCH BREAK</b>
2:00- 3:30 PM	<b>Providing Discordant Results</b>
	Factors influence the transmission of HIV (10 min)
	Essential counselor responsibilities (10 min)
	Provide discordant test result 5-C (10 min)
	Discuss coping and mutual support 6-C (10 min)
	Discuss positive living and HIV care and treatment 7-C (10 min)
	Discuss risk reduction 8-C (10 min)
	Discuss family planning & PMTCT options for discordant couples 9 - C (10 min)
	Discuss Disclosure –10 -C (10 min)
	Summary (5 min)
3:30- 3:50 PM	<b>HEALTH BREAK</b>
3:50- 5:25 PM	<b>Role play: Small group (30 min)</b>
	Large group: role play presentation & discussion (30 min)
	Summary (30 min)
	Daily evaluation (10 min)
5:25- 5:30 PM	Daily evaluation (5 min.)

<b>DAY 6 (Saturday)</b>	
<b>TIME</b>	<b>ACTIVITY</b>
8:30-9:00 AM	Recap of Day 5
9:00- 10:30 AM	<b>Provider -Initiated HIV Testing and Counseling for adults</b>
	Introduction (10 min.)
	Initial Provider-Client encounter (45 min)
	<b>Role play&amp; presentation (35 min.)</b>
10:30-10:50 AM	<b>HEALTH BREAK</b>
10:50-12:30 AM	Providing HIV Negative result (60 min)
	Providing HIV Positive (40 min.)
12:30- 2:00 PM	<b>LUNCH BREAK</b>
2:00 - 3:30 PM	<b>Role plays small group: Providing HIV Positive &amp; Negative (60 min)</b>

	Large group: Role play presentation & discussion (30 min)
3:30- 3:50 PM	<b>HEALTH BREAK</b>
3:50- 5:25 PM	<b>Provider-Initiated HIV Testing and Counseling for Infants, Children and Adolescents</b>
	Rationale for testing infants, children, and adolescents (30 min.)
	Testing of Adolescents (20 min.)
	Testing Infants and Children (40 min.)
5:25- 5:30 PM	Daily evaluation (5 min.)

<b>DAY 7 (Monday)</b>	
<b>TIME</b>	<b>ACTIVITY</b>
8:30-9:00 AM	Recap of Day 6
9:00- 10:30 AM	Testing Infants and Children continued (60 min.)
	Disclosing Children their HIV Status (15 min.)
10:30- 10:50AM	<b>HEALTH BREAK</b>
10:50- 12:30 PM	Index Case Testing (ICT)
12:30- 2:00 PM	<b>LUNCH BREAK</b>
2:00- 3:10 PM	ICT Principles, Rationale, Notification, Steps
3:10 -3:30 PM	<b>HEALTH BREAK</b>
3:30- 5:15 PM	ICT for Sexual Partner, Biological Children's, and ICT in context of KP
5:15- 5:30 PM	Daily Summary and evaluation

<b>DAY 8 (Tuesday)</b>	
<b>TIME</b>	<b>ACTIVITY</b>
8:30-9:00 AM	Recap of Day 7
9:00-10:30 AM	Overview of SNS
10:30-10:50 AM	<b>HEALTH BREAK</b>
10:50-12:30 AM	Overview of HIVST, Approaches & Distribution channel of HIVST
12:30-2:00 PM	<b>LUNCH BREAK</b>
2:00- 2:35 PM	Care giver assisted HIVST (2-15 years old child)
2:35- 3:30 PM	<b>MONITORING &amp; EVALUATION</b>
	SOPs (25 min),
	Recording & reporting (20),
	Quality Assurance (15)
3:30: - 3:50 PM	<b>HEALTH BREAK</b>
3:50: - 5:25 PM	Referral and linkage (30 min)

	Monitoring and evaluation, Indicators (20 min)
	Exercise on Recording and reporting (40 min),
	Summary (5 min)
5:25- 5:30 PM	<b>Daily evaluation</b>

<b>DAY 9 (Wednesday)</b>	
<b>TIME</b>	<b>ACTIVITY</b>
8:30-9:00 AM	Recap of Day 8
9:00- 9:45 AM	<b>OVERVIEW OF HIV TESTING TECHNOLOGIES</b>
	Unit Introduction (5 min.),
	Expansion of HIV Testing (5 min.),
	Spectrum of HIV Tests (5 min.)
	EIAs, Rapid and Complexity (10 min.),
	HIV Rapid, Advantages and Disadvantages (10 min.),
	Interpreting Individual HIV Rapid Test Results (10 min.)
9:45- 10:35 AM	<b>HIV TESTING STRATEGIES AND ALGORITHMS</b>
	Strategies and Algorithms (15 min.),
	Evaluating Test Performance (15 min.),
	Testing Algorithms (10 min.),
	Interpreting HIV Status Using Testing Algorithm (5 min.),
	Possible Outcomes of HIV Testing (5 min.)
10:35- 10:55 AM	<b>HEALTH BREAK</b>
10:55 - 11:50 AM	<b>SAFETY AT THE HIV RAPID TESTING SITE</b>
	Safety Practices (50 min.),
	Summary (5 min.)
11:50 - 12:30 AM	<b>PREPARATION FOR TESTING— SUPPLIES, KITS, AND WORKING SPACE</b>
	Supplies and Materials (10 min.),
	Identifying Supplies and Materials (10 min.)
	Examining Test Kits (10 min.),
	Organizing Work Area (10 min.)
	Summary (5 min.)
12:30-2:00 PM	<b>LUNCH BREAK</b>
2:00-2:40 PM	<b>BLOOD COLLECTION—FINGER PRICK</b>
	Overview of Initial Steps and Finger Prick Procedures (15 min.)
	Finger pricking (20 min.),
	Summary (5 min.)

2:40: - 3:30 PM	<b>PERFORMING HIV RAPID TESTS</b>
	Overview of Testing Procedures (30 min.),
	National Testing Algorithm (10 min),
	Possible Outcomes in Serial Algorithm (10 min)
3:30-3:50 PM	<b>HEALTH BREAK</b>
3:50-4:50 PM	<b>ASSURING THE QUALITY OF HIV RAPID TESTING</b>
	What Is Quality? Why Quality? Who Is Responsible for Quality? (10)
	Quality Assurance vs. Quality Control (10 min.),
	Why Do Errors Occur? (10 min.),
	What Is Quality Control? Internal versus External Quality Control (10),
	Troubleshooting Invalid Results (5 min.),
	Maintaining QC and Periodic Review of Records (5 min.),
	EQA: Definition and Methods (5 min.),
	Summary (5 min.)
4:50- 5:25 PM	<b>DOCUMENTS AND RECORDS</b>
	Documents Vs. Records (10min),
	SOPs (10 min),
	Recordkeeping (10 min)
	Summary (5 min)
5:25-5:30 PM	Daily evaluation

<b>DAY 10 (Thursday)</b>	
<b>TIME</b>	<b>ACTIVITY</b>
8:30-9:00 AM	Recap of Day 9 and Agenda of day 10
<b>9:00- 10:30AM</b>	HIV rapid testing practical session (90 min.)
10:30- 10:50 AM	<b>HEALTH BREAK</b>
10:50- 12:30 AM	HIV rapid testing practical session continued (100 min.)
12:30-2:00 PM	<b>LUNCH BREAK</b>
<b>2:00- 3:30PM</b>	HIV rapid testing practical session continued (90 min.)
<b>3:30- 3:50 PM</b>	<b>HEALTH BREAK</b>
<b>3:50- 5:25 PM</b>	Summary and discussion
<b>5:25- 5:30 PM</b>	<b>Daily evaluation</b>

<b>DAY 11 (Friday)</b>	
<b>TIME</b>	<b>ACTIVITY</b>
8:30-9:00 AM	Recap of Day 10 and Agenda of day 11
<b>9:00- 12:30 AM</b>	<b>PRACTICAL ATTACHMENT</b>
12:30-2:00 PM	<b>LUNCH BREAK</b>
<b>2:00- 3:30PM</b>	<b>PRACTICAL ATTACHMENT</b>
<b>3:30- 3:50 PM</b>	<b>HEALTH BREAK</b>
<b>3:50- 5:25 PM</b>	Compile report and lesson learned in each practicum group
<b>5:25- 5:30 PM</b>	<b>Daily evaluation</b>

<b>DAY 12 (Saturday)</b>	
<b>TIME</b>	<b>ACTIVITY</b>
8:30- 10:30 AM	Practicum group presentation, Discussion & Feedback
<b>10:30- 10:50 AM</b>	<b>HEALTH BREAK</b>
10:50- 12:30 AM	Practicum group presentation, Discussion & Feedback...
12:30-2:00 PM	<b>LUNCH BREAK</b>
<b>2:00- 3:30PM</b>	HTS course summary, Posttest, Course end evaluation
<b>3:30- 3:50 PM</b>	<b>HEALTH BREAK</b>
<b>3:50- 4:30 PM</b>	The way forward and Certificate and closing

**MODULE ONE**  
**BASICS OF HIV AND HTS**

## CHAPTER 1: BASICS OF HIV

**Learning objectives:** By the end of this session the participants will be able to:

- ◆ Describe the current global, regional, and national status of HIV epidemic
- ◆ Explain modes of HIV transmissions
- ◆ Interpret the concept of window period and seroconversion
- ◆ Describe the HIV combination prevention methods

### Contents

- ◆ Epidemiology of HIV
- ◆ Ways of HIV transmission
- ◆ Window period and seroconversion
- ◆ Combination HIV Prevention methods

### 1.1. EPIDEMIOLOGY OF HIV

#### Updates of global, Regional & national estimates of HIV/AIDS

HIV infection is one of the global public health issues. In 2020, more than 37.7 million [30.2 million– 45.1 million] people were living with HIV, and 1.5 million [1.0 million–2.0 million] people acquired HIV. Nearly 45% of the people newly infected with HIV live in sub-Saharan Africa (UNAIDS; 2021).

The first evidence of HIV epidemic in Ethiopia was detected in 1984. Since then, HIV/AIDS has claimed the lives of millions and has left behind hundreds of thousands of orphans. The HIV epidemic in Ethiopia is characterized as mixed, with wide regional variations and concentrations in urban areas, including some distinct hotspot areas driven by key and priority populations. According to the EDHS done in 2016, the national adult (15-49) HIV prevalence is 0.96 %; the urban prevalence was 2.9%, which is seven times higher than that of the rural (0.4%). National HIV Related Estimates and Projections (2020), also shows that the HIV prevalence varies from region to region ranging from less than 0.15% in Ethiopia Somali to 4.13% in Gambella.

The progress towards achieving the first 95 target has been far behind the track; According to, EDHS 2016 study only 79% of PLHIV know their HIV status, however spectrum 2021 data shows about 84% from the estimated PLHIV are diagnosed/know their status. To accelerate the performance of the HIV case identification in Ethiopia for closing the gaps to treatment and achieve epidemic control, the remaining PLHIV need to be reached.



Key populations are disproportionately infected compared with the national average: 18.1% (NSP 2021-2025) among Female Sex Workers (FSW), 4.9% long distance truck drivers and 4.2% among inmates. Ethiopia has made tremendous progress in fighting the HIV epidemic. The HIV prevalence declined by more than 65% in both women and men age 15-49 (from 4.1% for women and 3% for men) in 2004 to (1.4% for women and 0.9% for men) in 2016. New HIV infection has dramatically declined by more than 80% from its peak (141,000) in 1994 to 27,000 in 2016 and 11,715 in 2020. HIV related deaths fell from 82,000 where it had reached its peak in 2004 to 22,000 in 2016 and 12,685 in 2020. Similarly, Mother to Child Transmission (MTCT) rate including through breast feeding has fallen by 50% from 35% in 2001 to 16% in 2014 and. MTCT rate at six weeks reduced from 19% to 9% in 2001 and 2014 respectively.

Different high HIV case finding strategies and recommendations have been developed and adopted to maximize the response and to sustain the gains. In 2015 Ethiopia adopted the UNAIDS “95-95-95” targets. These ambitious targets have the potential to end the AIDS epidemic by 2030. In line with these in 2020, there were an estimated 622,326 People Living with HIV (PLHIV) in Ethiopia of whom 7% (44,138) were aged less than 15 years old, 72,561(17%) were young people (15-24).

With the goal of achieving the 95-95-95 targets, (95% of the total estimated number of PLHIV know their HIV status, 95% of total PLHIV received ART and Third 95 is among those who received ART 95% achieved viral suppression among those who took ART,) the country plans to test around 8.3 million people annually over the next years through targeted approach. To strengthen the HIV case finding in key and priority populations taking the best practice from Addis Ababa Operation Triple -A HIV case finding strategy (Accelerate Addis Ababa), the MoH launched a “Replicate Operation Triple – A (RoTA) for HIV case finding in all regions. This has showed a promising result and taking the lessons in to account, the implementation will continue for the upcoming years.

Currently, the MoH has identified gaps of the first 95 coverage among Children and Adolescent. The HIV infection in Children and adolescents is still a major public health problem, the New HIV infections continued in children & adolescents, the coverage of EID is still low. Moreover, there is a gap in demand creation and the engagement of leadership and PLHIV association is low. To address the gaps in pediatrics HIV prevention, Care and treatment services and accelerate the progress towards the three 95, MoH launched the “Pediatric HIV Program Acceleration Initiative (PHPAI)”. – This initiative will enhance the overall case detection in the country.

The country has also adopted different treatment recommendations and service delivery models. The most important ones include adoption of the treat all recommendation, implementing of differentiated service delivery (3MMD, 6MMD), implementation of HIV self-testing (directly assisted and unassisted) and pre-exposure prophylaxis (PrEP).

## **1.2. WAYS OF HIV TRANSMISION**

### **1.2.1. How Is HIV transmitted?**

It is very important for you to understand how HIV is transmitted as you learn how to talk with clients who will be tested for HIV. Part of HIV testing and counseling is providing your clients who test HIV- positive with information about not spreading HIV to their partners and children and talking with those who are HIV-negative about how to remain uninfected and linking them to appropriate prevention services such as PrEP.

### **1.2.2. Modes of HIV transmission:**

- ◆ People can be infected with HIV by having unprotected sex with an infected partner. Unprotected sex is sex that does not involve the correct and consistent use of a condom.
- ◆ HIV can be transmitted from mothers to their babies during pregnancy, labour, and delivery, or through breastfeeding.
- ◆ People can also be infected by an exposure to infectious blood and body fluids through accidental cuts with sharp instruments and needles.
- ◆ Transfusion with HIV-infected blood.
- ◆ Exposing an uninfected person's broken skin or wound to blood or bodily fluids that are infected.

### **1.2.3. HIV is not transmitted through:**

- ◆ Coughing, sneezing and any other airborne exposure
- ◆ Insect bites
- ◆ Touching or hugging
- ◆ Drinking water
- ◆ Preparing or eating food
- ◆ Kissing (Social kissing)
- ◆ Going to a public bath or swimming pool
- ◆ Shaking hands
- ◆ Working or going to school with and HIV-positive person

- ◆ Using telephones
- ◆ Sharing cups, glasses, plates or other meal and beverage utensils
- ◆ Using the same toilets

### **1.3. WINDOW PERIOD AND SEROCONVERSION**

The window period represents the period between HIV infection and the detection of HIV-1/2 antibodies using serological assays, which signals the end of the seroconversion period. The period prior to detection of HIV-1/2 antibody is often referred as “acute infection” whereby HIV viral particle in the body is very high associated with higher infectivity and rate of transmission.

The detection of HIV-1/2 antibodies by serological assay signals the end of the window period for diagnosis. Seroconversion is a term used to describe the change that occurs when antibodies are produced and the blood tests positive.

The length of the window period is determined primarily by the type of serological assay used and by an individual’s immune response. In most people, it takes the body from four to six weeks, to make enough antibodies to be detected by laboratory tests. The type of the body fluid that can be used for detection of the antibody has also some influence on the duration of window period. Oral fluid specimen exhibiting longer window period compared to venous or capillary blood and serum plasma. It is important to explain the definition of the window period to your clients who test negative but may have had a recent HIV exposure.

In many settings post-test counseling messages recommend that all people who have a non-reactive (HIV-negative) test result should return for retesting to rule out acute infection that is too early for the test to detect – in other words, in the window period. However, retesting is needed only for HIV- negative individuals who report recent or ongoing risk of exposure. For most people who test HIV- negative, additional retesting to rule out being in the window period is not necessary and may waste resources.

## **1.4. COMBINATION HIV PREVENTION METHODS**

There is no single magic bullet for HIV prevention. However, a Combination HIV prevention including Behavioral, Biomedical and Structural interventions have shown promising result in protecting against HIV transmission and acquisition that includes knowledge of sero-status, adoption of behavioral risk reduction, proper use of condoms, male circumcision, treatment of curable sexually transmitted infections, and use of antiretroviral medications. Some of HIV prevention methods are discussed as follows:

### **1.4.1. Abstinence, being faithful, use Condom (ABC) and Dialogue & Discussion**

- A. Abstain sexual activity before testing
- B. Being faithful after testing
- C. Consistent and correct use of condom
- D. Dialogue OR discussion on HIV risk issues, need for Periodic test, and concern

### **1.4.2. Prevention of Mother to Child Transmission (PMTCT)**

Mother-to-child transmission (MTCT) is the transmission of HIV from an infected pregnant woman to her fetus. Most children infected with HIV virus through MTCT. Mother to child transmission of HIV occurs during pregnancy (ante partum transmission), labor and delivery (intrapartum transmission), and through breastfeeding (postnatal transmission).

Among 100% of HIV-infected mothers, around 20 - 40% of them transmit the HIV virus to their babies without any intervention. The percentages mode of transmission of HIV through MTCT.

#### **Without intervention:**

- ◆ During pregnancy: 5–10% become infected with HIV
- ◆ During labor and delivery: about 10 -15% become infected with HIV
- ◆ During breastfeeding: 5–15% become infected with HIV

#### **The four prongs of PMTCT**

Ethiopia has adopted the WHO PMTCT strategy of the four prongs approach as a key entry point to HIV care for HIV positive pregnant, laboring, and lactating women and their infants.

**Primary Prevention of HIV:** for the general population with a focus on women in the reproductive age group, since remaining HIV-negative is obviously the best option.

**Prevention of Unintended Pregnancies:** among HIV-infected women.

**Preventing HIV Transmission:** from HIV-infected women to their fetus and infants.

**Provision of Care and Support:** to women infected with HIV, their infants, and their families.

### **1.4.3. Prevention and treatment of STIs**

The main mode of transmission of STI is through unprotected penetrative sexual intercourse. Link between STIs and HIV/AIDS are very strong as they share the same behavior and mode of transmission. The presence of an untreated inflammatory and or ulcerative STI increases the risk of transmission of HIV during unprotected sex. Preventing and treating other STIs reduce the risk of sexual transmission of HIV.

### **1.4.4. Anti-Retro viral Therapy (ART)**

ART reduces the multiplication of the HIV virus in the body. When clients are on ART, their viral loads significantly decrease and their CD4 cell counts increase. As a result, clients an immune function will be improved. The benefits of early treatment initiation improving survival and reducing the incidence of HIV infection to the partner, restore hope, reduce vertical transmission, prevent and revers the opportunistic infections, and improve the quality of life of HIV positive clients.

ART should be initiated for all individuals (children, adolescents, and adults) living with HIV immediately after HIV diagnosis, regardless of WHO clinical stage and CD4 cell count.

### **1.4.5. Infection Prevention (IP)**

IP is defined as an intervention that protects clients, health care providers and supportive staff from infection and minimizes the risk of transmission of serious diseases such as hepatitis B, C, and HIV infection. Standard precautions mean placing physical, mechanical, or chemical barriers between microorganisms and an individual to prevent infections.

#### **It includes:**

- ◆ Hand washing
- ◆ Wearing gloves
- ◆ Proper handling of sharps
- ◆ Proper handling of specimen
- ◆ Using physical barriers (personal protective equipment)
- ◆ De-contaminating all instruments and surface, using antiseptic reagents
- ◆ Washing and rinsing of all instruments

- ◆ Proper sterilization or high-level disinfection
- ◆ Proper storing and handling of processed instrument
- ◆ Safely disposing infectious waste materials
- ◆ Using safe workplace
- ◆ Process instruments and other items after use

#### **1.4.6. Post Exposure Prophylaxis (PEP)**

It is a short-term antiretroviral treatment to reduce the likelihood of HIV infection after potential exposure, either occupationally or in case of sexual assault. PEP should be provided as part of a comprehensive package to protect the health care providers, supportive staff from the potential exposure to infectious hazards at workplace and for a GBV survivor who are faced sexual assault.

#### **Things to be done: Immediately after the injury:**

Risk of HIV infection after a needle stick or cut exposure to HIV-infected blood is estimated to be 0.3% (3 in 1000). The risk of HIV infection after exposure of mucous membranes to HIV-infected blood is estimated to be 0.1% (1 in 1000). However, risk could vary depending on severity of injury and viral load in the source patient.

Antiretroviral treatment immediately after exposure to HIV can reduce risk of infection by about 80%.

#### **Steps to manage potential HIV exposed person. Treat the exposure site /immediate measures/**

- ◆ Percutaneous injury or injury to non-intact skin:
  - ◆ Wash the exposed site with soap and water as soon as possible, without scrubbing.
  - ◆ Avoid using antiseptics.
  - ◆ Allow free bleeding but do not squeeze the wound.
- ◆ Exposed mucous membranes:
  - ◆ Irrigate copiously with clean water or saline

## **Assessment of exposure risk:**

### **Low-risk exposure:**

- ◆ Exposure to small volume of blood or blood contaminated fluids
- ◆ Following injury with a solid needle
- ◆ Asymptomatic source patient

### **High-risk exposure:**

- ◆ Exposure to a large volume of blood or potentially infectious fluids.
- ◆ Exposure to blood or potentially infectious fluids from a patient with clinical AIDS or acute HIV infection or known positive with high viral load.
- ◆ Injury with a hollow needle.
- ◆ Needle used in source patient's artery or vein.
- ◆ Visible blood on device.
- ◆ Deep and extensive injury

**N.B.** Please refer the current national guideline for additional information from page 12 to 16.

#### **1.4.7. Pre-Exposure Prophylaxis (PrEP)**

PrEP is the use of antiretroviral (ARV) drugs by people who do not have HIV infection to prevent the acquisition of HIV. (WHO Nov 2015)

PrEP is offered to all individuals with substantial risk of acquiring HIV. The target populations for PrEP service are FSWs and HIV negative partners of sero-discordant couples with substantial risk of acquiring HIV. N.B. Refer the national guideline for the detailed information. Page 8 to 11.

#### **1.4.8. Voluntary Medical Male Circumcision (VMMC)**

VMMC service is one of the prevention strategies and offered as part of a combination HIV prevention effort to reduce the incidence of HIV in high HIV Prevalence area and low Male Circumcision (MC) prevalence settings. In Ethiopia, VMMC service is being provided only in Gambella region.

## **CHAPTER 2: OVERVIEW OF HIV TESTING SERVICES**

**Learning Objectives:** By the end of this session the participants will be able to:

- ◆ Discuss overview of HTS
- ◆ Explain the goals of HTS and core principles.
- ◆ Describe targeted testing
- ◆ Discuss HIV testing service provision settings.
- ◆ Discusses approaches of HTS

### **Contents**

- ◆ Overview of HTS
- ◆ Goals of HIV testing services
- ◆ Core principles of HTS Targeted HIV testing.
- ◆ Service provision settings of HTS
- ◆ Approaches of HTS

### **2.1. OVERVIEW OF HIV TESTING SERVICES**

HIV testing services refer to the full range of services that should be provided with HIV testing, including counselling (pretest information and post-test counselling) linkage to appropriate HIV prevention, treatment, care and other clinical services and the delivery of accurate results. HIV testing services (HTS) should be provided to eligible clients who are at high risk of HIV infection. HTS need to focus on high-risk individuals who remain undiagnosed need to be tested and linking them to treatment and care services as early as possible. People who are HIV negative but with an ongoing risk also need to be re-tested and provided appropriate prevention package of services. As we move closer to epidemic control, case finding will become more and more difficult hence HIV testing services should utilize to all sexual and biological children less than 19 years of age of index clients without HIV risk screening tools. However, A health care provider working at health facility using PITC approach should use HIV risk screening tool to determine whether the client is eligible for the HIV testing or not.



## **2.2. Goals of HIV testing services**

- ◆ Identify people living with HIV by providing high-quality testing services for individuals, couples, and families.
- ◆ Effectively link individuals and their families to HIV treatment, care, and support and to HIV prevention services, based on their status.
- ◆ Support the scale-up of high-impact interventions to reduce HIV transmission and HIV related morbidity and mortality.

HTS service quality should not be compromised, hence standard operating procedures (SoPs), protocols, and other necessary job aides must be followed and regularly monitored.

## **2.3. Core Principles**

Effective and efficient HTS provision settings and approaches should focus on:

- ◆ Reaching the largest number of individuals who remain undiagnosed with higher HIV risk.
- ◆ Increasing acceptability, equity, and demand to reach those left behind, including key populations.
- ◆ Prioritizing approaches that are most cost effective and efficient.
- ◆ Achieving national program targets (95-95-95)
- ◆ Ensure linkage to treatment for individuals who are diagnosed HIV positive and providing appropriately tailored prevention for those who test HIV negative.

## **2.4. Targeted HIV testing service**

Targeted HTS is a process whereby individuals who are at risk of acquiring of HIV infection are tested for HIV if found eligible based on HIV risk screening tool. The focus of targeted testing is towards identifying of new HIV positive cases through proper utilization of HRST which is important to implement targeted testing and achieve the first 95 of the UNAIDS goals.

Targeted HTS should be implemented across the range of community and facility- based settings through different approaches. By targeting high burden geographic areas and focusing on high-risk population groups will be expected to improve the overall HIV testing yield and linkage to care.

The eligible Target clients for routine HTS by using PITC approach are\*:

- All pregnant at first ANC visit, laboring, and postpartum women with unknown HIV status.
- Partners of HIV positive pregnant/ postpartum women
- Sexual partners of index cases and all under 19 children of PLHIV; biological siblings and biological parents.
- Female sex workers with unknown HIV status
- All TB patients and presumptive TB cases with unknown HIV status
- All patients with Sexually transmitted infections (STIs) and their partners
- Children orphaned by AIDS.
- Patients with clinical signs or symptoms of HIV/AIDS visiting health facilities

*NB \* the above-mentioned target population are directly eligible for HTS. Other patients/clients should be screened by national HIV risk screening tools including priority populations for other risk in addition to being among priority population (using the annexed HIV Risk Screening Tools).*

It's mandatory for all health care providers to use HIV risk screening tool at every POC/SDPs.

## **2.5. HIV testing service provision settings**

**HIV testing and counseling services can be provided in two major settings:**

### **1. Facility setting**

Currently, the HIV testing and counseling services in health facilities are:

#### **I. Client initiated HIV counseling and testing (VCT)**

**II. Provider initiated HIV testing and counseling (PITC)**, which is provided by opt-out approach using HIV risk screening tool at all clinical service delivery points except during first ANC testing.

#### **III. Mandatory HIV testing**

Mandatory HIV testing can only be performed for specific reasons with individuals or groups when requested by the court. HIV is a blood borne pathogen readily spread by blood transfusion or tissue/organ transplantation: therefore, it is mandatory to test blood or tissue for HIV before transfusion, transplantation, or grafting. Mandatory screening of donated blood/ organ/tissue is required prior to all procedures involving transfer of body fluids or body parts, such as artificial insemination, corneal grafts, and organ transplant. Donors should be specifically informed about HIV testing of donated blood, organ or tissue and link those with HIV positive test results to posttest counselling, care, and treatment services.

**Mandatory HIV testing is required:**

- ◆ HIV testing that will be done by the court order
- ◆ Testing of blood after donation, and
- ◆ Testing of organs before organ transplant

### **2. Community setting**

Refers to HTS offered in the community, outside of a health facility. It can be delivered in many ways and in different settings and venues. These include HTS at fixed locations in the community, mobile outreach in hotspots and community sites such as bars, youth centers, workplaces, and home based. It can also be delivered either alone or in combination with testing and screening for other infectious diseases such as TB, hepatitis and STIs.

As for any HTS, linkage to appropriate services after community-based testing is critical. While providing HTS services in the community, providers should use nationally approved protocols as appropriate.

## **I. Workplace HTS:**

HTS in the workplace is an effective strategy for reaching high risk individuals such as mining, the transport and logistics sector, mega projects, large farming areas, the military and other uniformed services.

## **II. Targeted mobile outreach:**

Targeted mobile outreach focuses on high-risk populations to avail HTS as mobile outreach in areas of low coverage and poor accessibility. HTS services can also be provided to high-risk populations such as widows, divorced and female sex workers.

## **III. Home-based HTS:**

HTS using ICT approach can be offered in the home has the potential to reach undiagnosed partners of index cases and eligible biological children. It can effectively reach undiagnosed individuals if offered at timings outside of work hours.

## **2.6. Approaches of HTS**

Strategic mixes of different HIV testing approaches are needed for an effective and efficient national HTS program depending on the epidemiology and resources available. Differentiated HIV testing service delivery approaches are recommended to address the needs of a variety of population groups, contexts, and epidemic settings.

The following HTS approaches are recommended to reach the 2030 global target to end HIV/AIDS epidemic control:

1. Client Initiated: Voluntary Counseling and Testing (VCT)
2. Provider Initiated Testing and Counseling (PITC)
3. Index Case Testing (ICT)
4. Social Network based HIV testing (SNS)
5. HIV self-testing (HIVST)

The implementation of the VCT, PITC and ICT approaches will use the respective protocols. However, if couples would like to get HTS together, and their test result is concordant negative or positive the VCT protocol will be used. For discordant test result, the discordant couple counseling and testing (CHCT) protocol will be used. Each protocol has different components having tasks and scripts. Counselors will be using it accordingly.

## Module One Summary

- ◆ The current country HIV prevalence is 0.96 % (EDHS 20216)
- ◆ Know the current epidemiology of HIV is curtail for effective prevention intervention activity.
- ◆ Since currently we are using a third generation RTKs, window period has reduced to 6 weeks.
- ◆ A singly approach is not effective to prevent HIV. Combination HIV Prevention methods is significantly useful.
- ◆ HIV testing services refer to the full range of services that should be provided with HIV testing, including pre-test information and post-test counselling, linkage to appropriate HIV prevention, treatment, care and other clinical services and the delivery of accurate results.
- ◆ The goals of HIV testing services are to identify people living with HIV by providing high-quality testing services for individuals, couples, and families, most importantly, link individuals and their families to HIV care and treatment services based on their status.
- ◆ All program managers and service providers should respect and apply the core principles.
- ◆ Targeted testing is very important implementation approach to focus on most at risk of population groups.
- ◆ Service provision settings of HTS are a way of means of providing testing services to the clients.
- ◆ Service providers should be familiar with the Approach of HTS and implement according to the need of their clients.

# **Module 2**

## **Basics of Counselling**

## CHAPTER 1: INTRODUCTION TO HIV COUNSELING

**Learning objectives:** By the end of this course, Participants will be able to:

- ◆ Define HIV counseling
- ◆ Elaborate benefits of HIV counseling
- ◆ Describe qualities of a good counselor
- ◆ Explain common errors in counseling

### Contents

- ◆ Definition of HIV counseling
- ◆ Benefit of HIV counseling
- ◆ Qualities of a good counselor
- ◆ Common errors in counseling

### 1.1. DEFINITION OF COUNSELING

**Counseling** is a two-way communication process that helps individuals to help themselves to examine personal issues, make decisions and plans for action.

**In a simple term of definition counselling is:** - helping people to help themselves and supporting them to use their internal strength to live their live more effectively.

**In the context of HIV/AIDS,** counseling is a confidential two-way communication between a counselor and client (s) aimed to make personal decisions related to HIV/AIDS.

### 1.2. QUALITIES OF A GOOD COUNSELOR

A good counselor must have the following qualities:

- ◆ **Self-confident:** certain of having the ability.
- ◆ **Empathetic:** not disregarding nor detached.
- ◆ **Accepting:** warm and friendly
- ◆ **Genuine:** not artificial e.g., behaving like he/she is perfect or knows everything
- ◆ **Trustworthy:** deserving trust or able to be trusted
- ◆ **Competent:** having enough skill or ability to do something well

### 1.3. COMMON ERRORS IN COUNSELLING

The following are some of the common errors in counseling:

- Interrupting the client
- Using of jargons
- Looking away frequently or not maintaining eye contact
- Inappropriate Physical Environment. (Lack of privacy, noise, and distractions)
- Being judgmental,
- Frowning, scowling, or yawning
- Speaking too quickly or too slowly,
- Finishing the sentences of clients
- **Controlling** rather than encouraging the client's spontaneous expression of thought, feeling and needs
- **Moralizing, preaching, and patronizing** – telling clients how they ought to behave.
- **Providing unwarranted reassurance**, diverting a client's attention from an issue, and inducing undue optimism by claiming that the problem is easy.
- **Pressure Tactics (Imposition)**- not accepting the client's feelings.
- **Advising** before the client has had enough information to arrive at a personal solution.
- **Interrogation**, using question in accusatory "why" questions often sound accusatory.'
- **Encouraging dependence**-inflating the client's need for the counselors continuing presence. support and guidance
- **Using unacceptable paraphrasing**, or suggestions like "You should", "will tell you what to do" "must try ", "the only way out is" "It is a must "etc



## CHAPTER 2: BASIC COMMUNICATION AND COUNSELING SKILLS

**Learning objective:** By the end of this course, participants will be able to:

- ◆ Define communication
- ◆ Discuss basic communication skills in counseling
- ◆ Describe the elements of good counseling
- ◆ Apply basic counseling skills
- ◆ HIV Counseling Room Setting

### Contents

- ◆ Communication & skills
- ◆ Communication skills in counselling
- ◆ Elements of good counseling
- ◆ Basic counseling skills
- ◆ HIV Counseling Room Setting

### 2.1. DEFINITION OF COMMUNICATION

Communication is a process by which information is exchanged between or among individuals. Through a common system of symbols, signs, and behavior and discusses their views. It allows feelings, ideas, and views to flow freely and to be understood. Communication can only take place in a climate of acceptance and understanding, where a relation of respect and friendship exists.

### 2.2. Communication skills used in counseling

**The following skills are like a bag of tools.**

1. **Active listening:** involves not only receiving sounds but, as much as possible, accurately understanding the meaning. As such it entails hearing words, being sensitive to vocal cues, absorbing movements and considering the context of communication.
2. **Attending:** refers to the behavioral skills of paying attention to the client by limiting distractions and equalizing the power between the counselor and the client.
3. **Paraphrasing:** is a verbal statement that is interchangeable with the client's statement and is concerned with the cognitive (thought) content of the client.

In other words, the counselor repeats back the essence of the client's main words and thoughts in response to what client shares with the counselor.

4. **Reflection of feelings** is like paraphrasing, but the focus is more on feelings (emotions) of the client. Emotions are considered basic to cognitive and intellectual life and a clear understanding of the client's feelings provides an important basis for understanding the client's decisions, thoughts, and attitudes. In learning the skills of reflection of feelings, it is first helpful to label emotions.
5. **Questioning:** is one of the most important tools the counselor uses to guide the client through the counseling processes. There are two major categories into which questions fall. They are:
  - A. Closed ended questions.
  - B. Open ended questions

Asking open-ended questions is the most important communication skill for services providers to use. Open-ended questions cannot be answered with a Yes or a No. They start with words like, "Who? What? When? Where? How?"

6. **Summarizing:** is the gathering together of a client's verbalizations, behavior, and feelings and presenting them to the client in an outlined form. Summarization involves attending to the client and integrating and ordering the contents of the interview.
7. **Reframing:** refers to the client's individual experience pictured from the counselor's point of view. A skillful counselor can change the way a client perceives events and the orientation by "reframing" the picture, which the client has described. The counselor puts a new frame around the picture so that the picture looks different.

***Example:***

A client says, "You can't feel anything when you wear condoms."

Counselor says "You're right, condoms can reduce sensation. And, you know, lots of men find that when they use condoms, they stay erect longer, and they do not have to worry about unplanned pregnancies, STIs, and HIV".

8. **Confrontation:** is a communication technique used to reflect a contradiction expressed by a client.
9. **Self-disclosure:** is a situation where the counselor communicates to the client his/her feelings or perceptions about the client and reveals something about him/her.

## 2.3. ELEMENTS OF GOOD COUNSELING

**1. RESPECT:** Respect for the client's beliefs, attitudes, values, and culture should be maintained all the time even if they differ from that of the counselor.

**2. GENUINENESS:** The counselor should be open minded, authentic, honest, and congruent during the entire process of counseling. Genuineness promotes trust and positive relationship between the client and the counselor.

**3. CONFIDENTIALITY:** This forbids any reference to, or discussion about a client, except within a professional relationship, and then only with the consent of the client. The counseling environment should also provide privacy for the client.

**4. SHARED CONFIDENTIALITY:** This is a form of confidentiality in which the discussion matters will be limited to the counselor, the client and to those individuals who will be involved in the care and management of that specific client.

**5. PRIVACY:** This refers to the need for privacy in the counseling interaction. This includes:

- ◆ Location (conducive, maintain confidentiality)
- ◆ Understanding the fact that the client request for counseling help in a personal capacity.

**6. UNCONDITIONAL POSITIVE REGARD:** This is another attitude the counselor must adopt to express empathy. Counselors should view clients as individuals with problems, and respect them without judging or condemning their past behavior. The counselor should not add to the self-blame or guilt which is characteristic of many clients.

**7. ACCEPTANCE:** Counselors should not be judgmental of clients, but rather should try to accept clients, regardless of their socioeconomic, ethnic, or religious background, occupation, sexual orientation or personal relationships.

**8. AUTONOMY:** This refers to the liberty to choose one's own course of action, to take full responsibility of the outcome of action and it is the cornerstone of the client's right of participation. Counselors promote the client's control over his/her own life, respect client's ability to choose, decide, and change in the light of his/her own beliefs, values, and circumstances.

**9. EMPATHY:** Empathy is showing warmth, concern and caring attitudes and responses. It understands the other person's point of view. It is being able to think and feel through the other person's (client's) perspective. It is an active process that needs to be practiced by the counselor by clarifying communication, reflection of feeling, and imagining others' thoughts. So, empathy involves '**being with the client**'. Empathy is not synonymous with "sympathy".

## 2.4. BASIC COUNSELING SKILLS

Skills are like a bag of tools. The following are the most important counseling skills that counselors use in HIV counseling:

- 1. ESTABLISHING RAPPORT:** - It is crucial in all counseling situations and is a key in developing a trusting relationship. Developing rapport demonstrates the counselor's interest in and respect for a client's issues and concerns. Building rapport is an ongoing process that can be facilitated by: Warm greetings and introduction as an ice break appropriate to culture and communicating with clients with much respect.
- 2. ACKNOWLEDGING DIFFICULT FEELINGS:** - is an unavoidable component of counseling to help the clients to address difficult feelings. Counselors should be aware of their clients' feelings and acknowledge the clients' feelings using third person statements to normalize and validate client's feelings.
- 3. AFFIRMING:** providing an interchangeable validation of client's statement towards the positive actions that they have been able to take. It is very much important to encourage the clients towards maintaining the proposed plan.
- 4. CORRECTING FALSE INFORMATION/MISCONCEPTION:** - There are many incorrect facts about HIV that should be corrected if raised by clients wrongly. This needs to be done carefully with respect to the client's idea. Counselors should acknowledge false information and then correct it according to the facts. It is not necessary to give a detailed explanation of the facts.
- 5. USING THIRD-PERSON TECHNIQUE / IMPERSONAL STATEMENT:** - using third person technique is helpful in reflecting clients' feelings that are unexpressed however perceived. This technique is very much useful in acknowledging, reflecting on, and normalizing the client's feelings and helps to avoid defensiveness of the client.

## 2.5. HIV Counseling Room Setting

### Maintaining "SOLER" or "ROLES"

The concept of SOLER is very important in communicating clients who come for Counseling.

SOLER: - stands for as follows (S: Sit Directly, O: Open Gesture, L: Lean Forward, E: Eye Contact and R: Relax)

Service providers are required to develop a broad range of skills to effectively communicate with a wide variety of people, at many different levels.

## CHAPTER 3: ETHICAL AND POLICY STATEMENTS FOR HTS

**Learning objectives:** By the end of this unit, participants will be able to:

- ◆ Describe the key ethical principles of HTS.
- ◆ Demonstrate client's right during HTS
- ◆ Review Policies related to HTS

**Contents:**

- ◆ Ethical principles for HTS
- ◆ Clients' rights during HTS
- ◆ Policies related to HTS

### 3.1. ETHICAL PRINCIPLES FOR HTS

Ethical principles are outlining the fundamental values of counseling. Counselors should understand these values to maintain a professional relationship with their clients. It serves to safeguard, integrity, impartiality, and respect, about both parties. The following section outlines the main features of ethical principles.

#### 3.1.1. GUIDING PRINCIPLES FOR HTS

1. **Consent:** People receiving HIV counseling and testing must give informed verbal consent to be tested and counseled. Written consent is not required. They should be informed of the process for HIV counseling and testing and their right to decline testing. In Ethiopia, for pediatric age group (less than 15 years of age), the parents or guardian need to consent verbally. Mature minors (13-15 years old who are married, pregnant, commercial sex workers, street children, heads of families, or who are sexually active) can give verbal consent by themselves. Unconscious or patient who is not in status of providing self-consent, should not be tested for HIV unless the clinician determines it is necessary to establish diagnosis and make treatment decisions. Consent of kin should be obtained during counseling.
2. **Confidentiality:** HTS are confidential, meaning that what the HIV counseling and testing provider and the person discuss will not be disclosed to anyone else without the expressed consent of the person being tested. Counselors should raise, among other issues, whom else the person may wish to inform and how they would like this to be

done. Shared confidentiality with partner or family members and trusted others and with health care providers is often highly beneficial.

3. **Counseling:** HIV counseling and testing services must be accompanied by appropriate and standardized pre-test information and post-test counseling.
4. **Correct testing:** HIV counseling and testing providers should strive to provide standardized testing services to reach to correct diagnosis.
5. **Connection:** Connections to prevention, care and treatment services should include the provision of effective referral to appropriate follow-up services as indicated, including long-term prevention care and treatment services

### **3.2. CLIENTS' RIGHTS DURING COUNSELING**

**Clients have the right to:**

- ◆ Confidentiality
- ◆ Privacy
- ◆ Refuse testing.
- ◆ Be treated with respect.
- ◆ Asking Information or question

### **3.3. POLICY RELATED TO HTS**

The following policy and ethical statements reflect existing National Comprehensive HIV Prevention, Care and Treatment guideline.

#### **3.3.1. GENERAL HTS SERVICES**

**Policy objectives:**

To promote and provide standard HTS to individuals, couples, and community groups of all ages especially to vulnerable and high-risk groups regardless of gender.

#### **POLICY STATEMENTS**

- ◆ HTS shall be standardized nationwide and shall be authorized, supervised, supported, and regulated by appropriate government health authorities.
- ◆ Informed consent for testing shall be obtained in all cases, except in mandatory testing.
- ◆ Adequate pre-test information, post-test counseling shall be offered to all clients.
- ◆ Test results, positive or negative, shall be declared to clients in person and must be provided with post-test counseling.

- ◆ No results will be provided in certificate form; however, referral will be offered to access post-test services (prevention, care, treatment, and support).
- ◆ Clients' confidentiality will be always maintained. Results can be shared with other persons only at clients' request or agreement, and with those involved in clinical management of clients. Clients can be referred if required or upon request.
- ◆ Mandatory HIV testing is a violation of human rights, only permissible in exceptional cases by order of a court of law. Mandatory testing will be done on all voluntary blood, tissue, and organ donors, who shall be informed about HIV testing and given opportunity to learn their test results.
- ◆ Couples shall be encouraged to be counseled, tested, and receive results together. Partner notification shall be encouraged in cases where one partner receives the results alone.
- ◆ The privacy and autonomy of the couple and individual must be respected. Informed decisions shall be encouraged among discordant couples to protect negatives and support positives.
- ◆ Women shall be routinely offered HTS during pregnancy, labor, post-natal and at family planning with the right to refuse testing.
- ◆ HIV testing for children under the age of 15 shall only be done with the knowledge and consent of parents or guardians, and the testing must be done for the benefit of the child.
- ◆ **Children aged 13-15**, who are married, pregnant, commercial sex workers, street children, heads of families, or sexually active are regarded as "**mature minors**" who can consent to HIV testing.
- ◆ **Persons 15 years and above** are considered **mature enough** to give informed consent for themselves.
- ◆ In some special cases, such as child adoption, a counselor may refuse a testing request when not in the best interest of the child.
- ◆ Children who have been sexually abused and put at risk of HIV infection shall receive counseling, be encouraged to test for HIV and helped to access appropriate GBV services.
- ◆ The result of HIV testing is the property of the child tested and shall not be disclosed to third parties unless clearly in the best interest of the child.
- ◆ Youth-friendly counseling and testing services shall be made widely available for youth population.
- ◆ HTS shall accommodate the special needs of people with visual and hearing impairments by adopting appropriate media of communication.
- ◆ Individuals under the immediate influence of alcohol or addictive drugs (substance use) shall not be offered HIV testing due to a mental inability to provide informed consent.

- ◆ HTS for a mentally impaired individual requires the knowledge and consent of his/her guardian and should be for the benefit of the individual or patient.
- ◆ All service providers shall abide by the rules, regulations and protocols contained in this document and other related national guidelines.
- ◆ All service providers shall observe the ethical requirements of confidentiality, informed consent, proper counseling, anonymity, and privacy.
- ◆ Shared confidentiality shall be promoted as an avenue to demystify and destigmatize HIV/AIDS.

### **Module Two Summary**

- ◆ Counseling is a two-way communication, totally different from advice, guidance, or education.
- ◆ Service providers should avoid error while they are providing HIV testing services.
- ◆ All steps of the counseling process should be tailored to the behaviors, circumstances, and specific needs of each client as part of a client-centered approach.
- ◆ The purpose of counseling is to help people help themselves by providing targeted information to the client and assisting the client in making a realistic informed decision.
- ◆ Communication and counseling are the two sides of a coin that help to establish a common ground where two or more people meet and discuss their views and make to enable the best self-decisions.
- ◆ Relationship building starts when a counselor meets a client and continues right through the session.
- ◆ Communication and counseling skills should be implemented and utilized by all service providers.
- ◆ Ethical principles are fundamental values of counseling which need to be followed by counselors to safeguard integrity, impartiality, and respect, regarding both parties.
- ◆ The five Cs of WHO HIV services guidelines should be implemented to assure high quality of counseling services.



# **MODULE THREE**

## **VCT**

## CHAPTER 1: INTRODUCTION TO VCT

**Learning Objectives:** By the end of this session the participants will be able to:

- ◆ Apply required knowledge and commitment to conduct VCT
- ◆ Demonstrate skills required to conduct a quality VCT session
- ◆ Conduct VCT session using protocol components

**Content:**

- ◆ Definition of VCT
- ◆ Definition of key terms
- ◆ Structure and Protocol of VCT
- ◆ Introduction of VCT Cue Cards

What is Voluntary Counseling and Testing?

VCT is initiated by clients seeking to know their HIV status. It one of the HTS approaches that gives the client an opportunity to confidentially explore his/her HIV risks to learn about his/her HIV test result. It is a process by which an individual undergoes counseling to enable him/her to make an informed choice about being tested for HIV.

Definition of key terms

Cue card: a consecutive guides /tool of the counseling session with the client that will help the provider to stay on task and redirect clients to keep them on track.

Protocol: An organized series of content areas and activities covered by the counselor with an individual or couple that in combination accomplish a prevention intervention. E.g., VCT, CHCT, and PITC protocol.

Component: A sequence of related tasks that comprise a specific and important topic area to be addressed in delivering the prevention intervention. E.g., Introductions and Orientation to the Session.

**Structure of VCT**

- ◆ The VCT protocol consists of 12 components.
- ◆ Each component has a goal and specific tasks that builds on the previous component.
- ◆ The protocol is a series of questions that guide the counselor- client discussion.
- ◆ The counselor systematically selects questions relevant to the client based on the context of the client's exposure or complaints

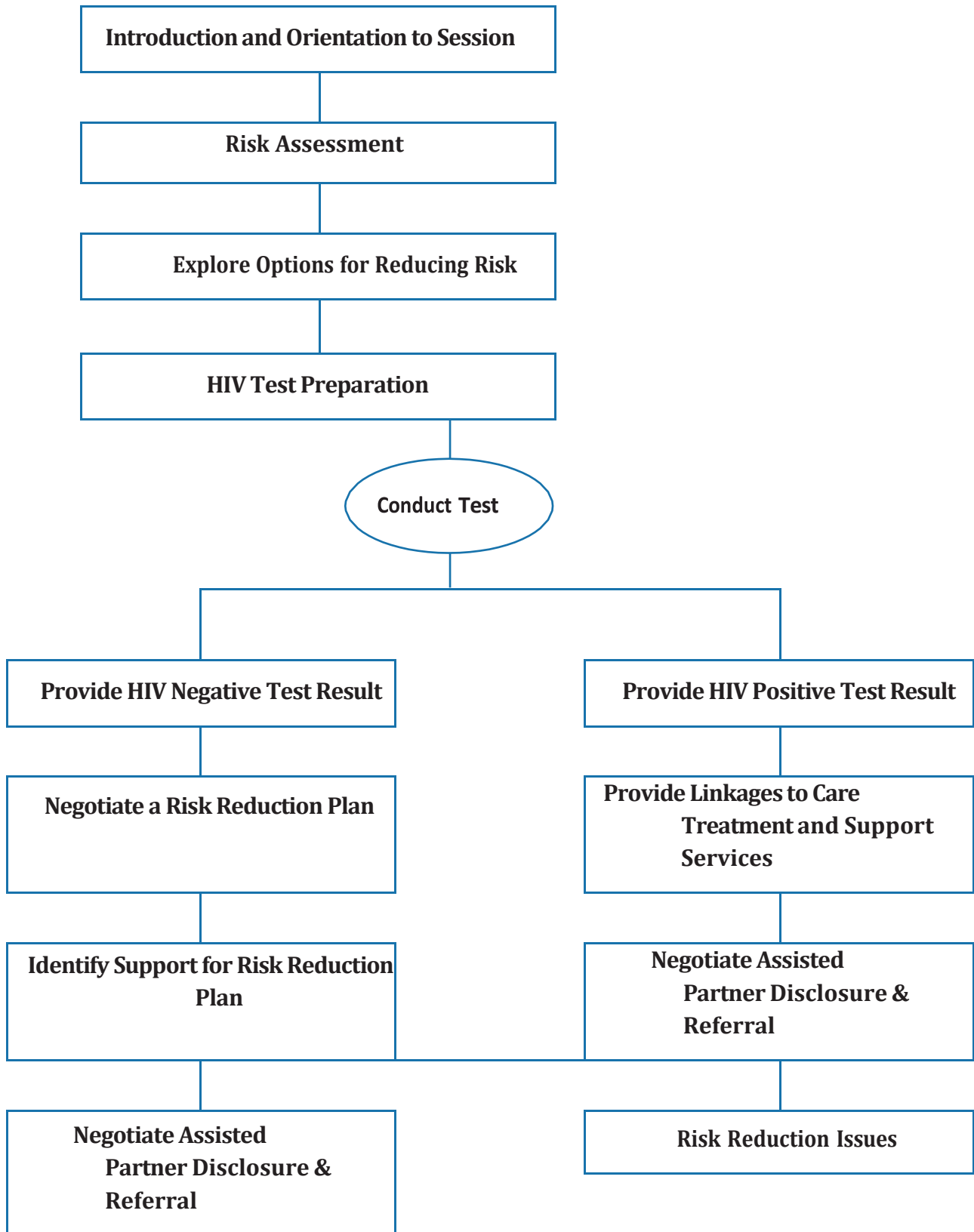


Figure: VCT Protocol

## CHAPTER 2: VCT PRETEST COUNSELING

**Learning objectives:** By the end of this course, participants will be able to:

- ◆ To apply the first four components of pretest counseling of the VCT session
- ◆ To establish good rapport and provide the client with accurate information on HIV pre/post- test counseling and testing procedure
- ◆ Explore the client's HIV concerns, risk issues and enhance their understanding of risk behavior
- ◆ Explore barriers toward behavior change, and provide understanding and support to protect him/her self and others that might be affected by the client's risky behavior
- ◆ Ensure that the client understands the meaning of the possible HIV test results and underscore the importance of linkage to prevention, care and treatment services based on the HIV test result

### Contents

Component 1: Introduction and Orientation to the VCT Session

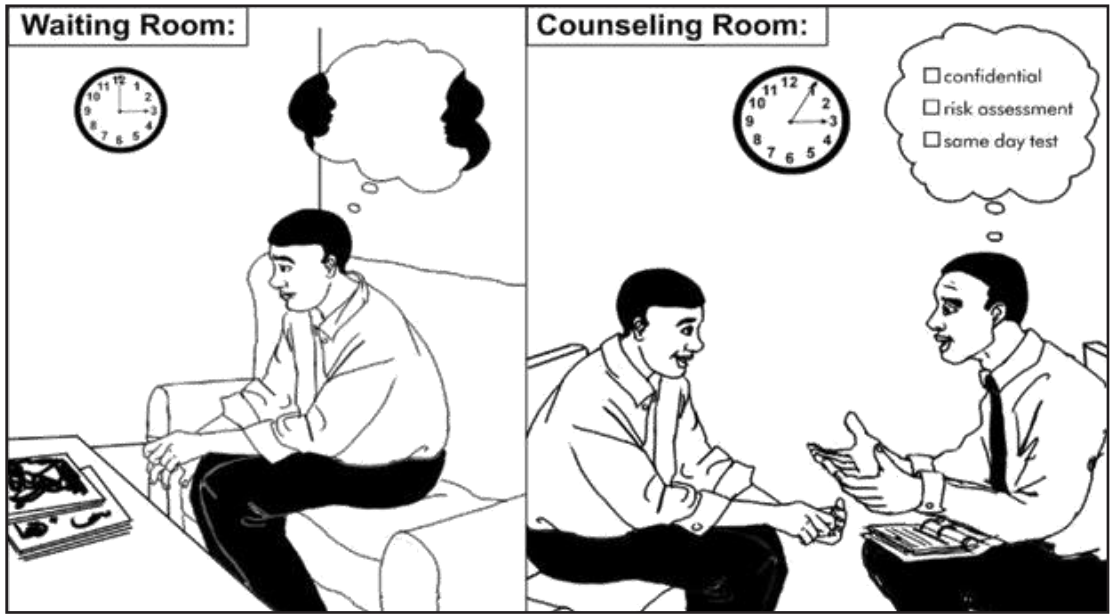
Component 2: Risk Assessment test counseling and testing procedure test counseling and testing procedure

Component 3: Explore Options for Reducing Risk

Component 4: HIV Test Preparation

Component 1: Introduction and Orientation to the VCT Session

In order to establish rapport with the client, the counselor needs to convey positive regard, genuine concern, empathy and explain confidentiality. The client should be helped to feel comfortable with the counseling and testing procedures, understand the role of the counselor, and be clear about the content and purpose of the session. This connection will help build trust and will set the tone of the session. The counselor must be professional and respectful to every client.



*Figure: Importance of Introduction & Orientation to VCT, with privacy and confidentiality.*

This figure is intended to demonstrate that a client is often anxious when coming in for VCT. As a client he/she may be thinking: what's going to happen to me today, who will I be talking to, what will they ask me, and how long will all this take? However, if you are clear about the content and purpose of the session, you will reduce your client's anxiety and increase his/her ability to focus on the session.

*Notice the use of the cue cards on the counselor's lap. Nothing else. (Refer cue cards for the VCT component 1)*

**Component 2: Risk Assessment**

In assessing the client's risks, the questions asked by the counselor are directed at eliciting the entire range of factors that may have contributed to the risk behavior. A discussion of the most recent risk behavior may help the client clarify how the risk behavior occurs. The counselor should be aware of the client's emotions, recent life events, alcohol and drug use, self-esteem, and other issues that might influence a particular risk incident or pattern of risk behavior. The aim of this exploration is to help the client gain an understanding of the complexity of factors that influence his/her risk behavior.



*Figure: Analogy of conditions of client HIV concerns or risk, identifies during VCT initial session.*

*This figure illustrates that as the counselor asks questions to assess the client's risk, the client begins to think about her risk, maybe for the first time. VCT offers your client an opportunity to take time to reflect on and begin to understand his/her personal risks.*

#### Risk Assessment and exploration of recent risks

- ◆ Risk assessment is the exploration of the factors that influence the client's behaviors that place him/her at risk for HIV infection. This exploration of risk helps the client understand his/her risk behavior. During risk assessment, the counselor seeks to understand the client's HIV concerns and develop an understanding of the client's risk. The questions asked are intended to clarify how risk behavior occurs and identify client characteristics, issues, and circumstances that leads to risk behavior. The counselor should explore the most recent risk behavior that the client encountered to gain an understanding of how he/she gets into risky situations to begin to reduce the risk.
- ◆ This exploration of risk helps the client understand his/her risk behavior.
- ◆ During risk assessment, the counselor seeks to understand the client's HIV concerns and develop an understanding of the client's risk.
- ◆ The questions asked are intended to clarify how risk behavior occurs and what client characteristics, issues, and circumstances lead to risk behavior.

From this point forward, the counseling session will be more interactive.

- ◆ The client will be talking more than the counselor.
- ◆ The counselor will actively engage the client in exploring his/her risk behavior and understand the factors that influence his/her risk behavior.

### Component 3: Explore Options for Reducing Risk

The component of the session is intended to be very interactive and meant to engage the client in a focused exploration of risk reduction and support options. This session will encourage the client to reflect and examine his/her strengths, resources and options. The counselor's aim is to have the client fully engaged in the session and invested in reducing his/her HIV risk.

The counselor is expected to:

- ◆ Explore any efforts and intention initiated by the client to reduce his/her HIV risk(s)
- ◆ Elicit obstacles encountered by the client in attempting behavior change
- ◆ Acknowledge that behavior change is a complex, difficult and challenging process

This component will help to address client's HIV risk reduction efforts through:

- ◆ Enhancing self-perception of risk.
- ◆ Addressing disagreement (examples when beliefs and behavior are at odds) and ambivalence (mixed feelings) about risk reduction.
- ◆ Increasing self-efficacy (belief in one's power or ability to do something).
- ◆ Identifying peer pressure and community norms.
- ◆ Exploring and identifying support resources.

What are some examples of possible Risk Reduction Options? High Risk Behaviors?

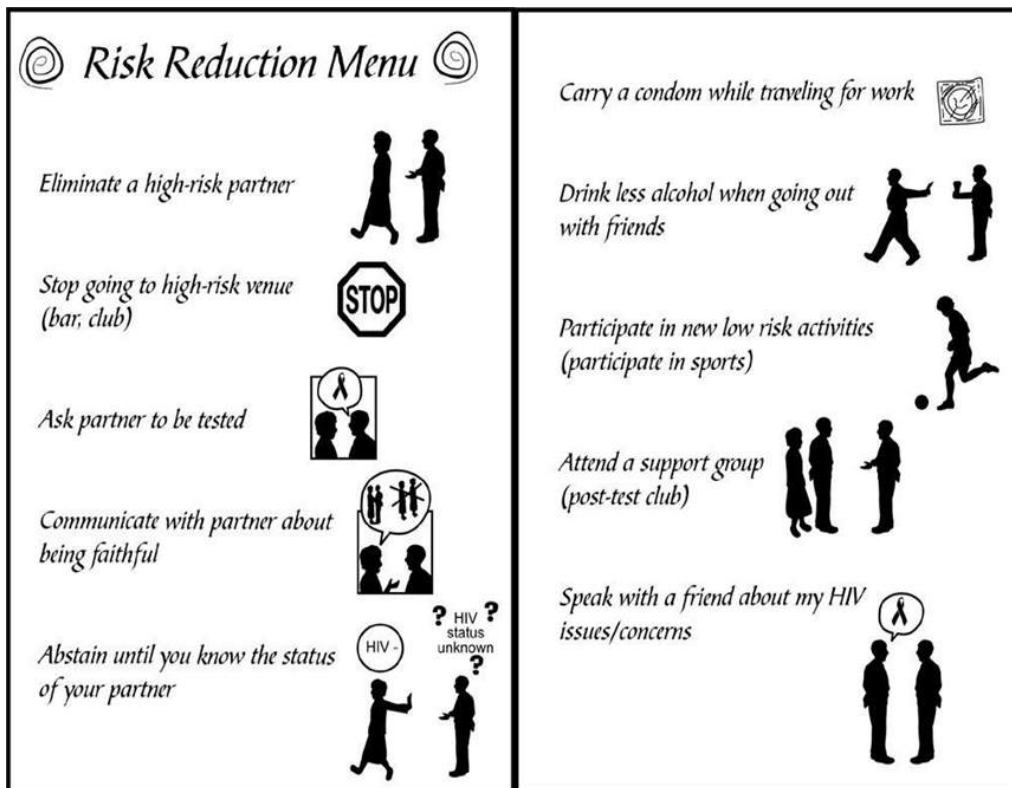


Figure: Options / Menu of HIV Risk reduction

#### Component 4: HIV Test Preparation

In this component of the session, it is essential for the counselor to explore the client's understanding of the meaning and implications of the HIV test result. The counselor should communicate the benefits of knowing one's serostatus. A client who is aware of his/her HIV status can protect partners and children from HIV and protect his/her health.

#### Role-Play Number 1

COMPONENT 1: Introduction and orientation to VCT session

COMPONENT 2: Risk assessment

COMPONENT 3: Explore options for reducing risk

COMPONENT 4: HIV test preparation

#### General directions for conducting role-plays

You will be partnered with two other people for the role-play. Your instructor will assign each of you to conduct a role play as a counselor, a client, or an observer. Your group will sit together



and conduct the role-play.

Directions for each role counselor:

- ◆ Quickly review the main points of the counseling protocol section using cue cards before the role-play begins.
- ◆ Take your time.
- ◆ Use the questions that are clearly stated in you cue cards.
- ◆ Stay organized.

Client:

Before the role-play, read through the client scenario. No need you to have cue cards. Refer to the scenario when responding to the counselor. Although the information given in the scenario does not cover all the questions you may be asked, try to make an appropriate response that does not contradict the facts outlined for you. Try to be a very reasonable and uncomplicated client; this is a learning experience not a test of the counselor's skills and abilities. So be simple and cooperative.

Observer:

Before the role-play, read through the observation checklist. Also read the client scenario. No need to have cue cards. During the role-play, quietly observe "do not interfere while he/she is conducting a role play" and make notes but, if the counselor is having difficulty or is not using the protocol, you may offer suggestions to the counselor. You may also offer suggestions to the client if his or her responses do not follow the client scenario. At the end of the role play you will give feedback to the counselor using the checklist.

The role paly will be conducted from component 1 to 4. After playing one round of role play you will rotate clockwise to change your role and will continue conducting the role play till your facilitator inform you to be back for a large group processing.

*(Please refer the VCT cue cards, VCT case scenarios, & observer checklist)*

## CHAPTER 3: THE HIV NEGATIVE TEST RESULT

Learning Objectives: By the end of this session the participants will be able to:

- ◆ Provide an HIV negative test result clearly and simply with an emphasis on the need for the client to initiate risk reduction in order to remain negative.
- ◆ Develop a realistic risk-reduction plan that addresses the high risk behaviors
- ◆ Help the client to identify resources for support with his/her risk reduction plan.
- ◆ Encourage the client to discuss his/her HIV status with his/her partner/s

Contents

Component 5: Provide HIV Negative Test Result Component 6: Negotiate a Risk Reduction Plan Component 7: Identify Support for Risk Reduction Plan

Component 8: Negotiate Assisted Partner Disclosure and Referral

Reasons for providing an HIV-negative test result counseling in the VCT protocol

- ◆ It helps to Empower them to remain HIV Negative and practice behavioral change

Component 5: Provide HIV Negative Test Result

The client may be very relieved to receive the negative test result. The counselor should allow the client to experience his/her reaction at not being infected while gently emphasizing the need for behavior change for the client to remain negative. The counselor should explore feelings and beliefs the client has about his/her negative test result, particularly in the context of the risk behavior(s) the client has described thus far in the session. The counselor should be alert to the possibility that the client may feel more inclined to engage in risky behavior in response to the negative result. It is often helpful for the counselor to underscore the fact that the negative test result does not indicate that the client's sex partner(s) is not infected.

There is a slight possibility that a recent risk behavior (especially in the last month) may have resulted in the client becoming infected without the infection being indicated in this test result. Counselors must be very careful with their "retest message." If there is no significant risk in the previous 6 weeks no additional test is indicated.

*(Refer the VCT HIV Negative Session, Component 5)*

N: B- Avoid Technical jargons in disclosing the HIV test results.

- In case the client wants to see the actual test result (test kit), show the test result.

## Component 6: Negotiate a Risk Reduction Plan

The risk reduction plan is a fundamental component of the prevention counseling session. The counselor should assist the client in identifying a behavior corresponding to his/her risk and that he/ she is invested in changing risky behavior. It is essential that the plan match the client's skills and abilities with his/her motivation to change a specific behavior. The counselor should challenge the client to go beyond what he/she has previously attempted in terms of risk reduction. The plan must be specific in that it describes who, what, when, where and how the risk reduction process is applied. It must be concreted in that it details the successive actions required of the client to implement and complete the risk reduction plan.

Global risk reduction messages such as "always use condoms," "remain monogamous," or "abstain from sex" do not meet the criteria for an appropriate risk reduction plan. The counselor should ensure that the client agrees with the plan and is committed to its implementation. The client should be asked to critique the plan and identify problems with the plan. The counselor may even quiz the client on the plan or provide plausible examples of obstacles the client may encounter in initiating the plan. These obstacles should be problem-solved with the client and may require revising the plan.

The process of developing a plan represents the client's movement toward risk reduction. In fact, it is the second step in reducing risk (the first being the client's decision to come for counseling and testing), for which he/she should be provided encouragement and considerable Client must be able to visualize in specific and detailed terms his/her plan to change behavior to reduce his/her HIV risk.

*(Refer the VCT HIV Negative Session, Component 6)*

## Component 7: Identify Resources to Support for Risk Reduction Plan

This step is critical because there is no second session for the counselor to review with the client his/ her experience in implementing the plan. The priority for this component of the session is to identify a specific friend or relative with whom the client trusts and will discuss his/her risk reduction plan and report to regarding the implementation and completion of the plan. The process of the client checking in with someone about the plan is important because it gives enhanced meaning to the plan and increases the client's personal expectations about completing the plan. The counselor should discuss the process of confiding the risk reduction plan with a similar level of detail as that devoted to developing the plan. The counselor and client should establish a time frame during which this will occur. When will the client disclose the plan to this person? When will the client report the progress or completion of the plan to this person?

*(Refer the VCT HIV Negative Session, Component 7)*

#### Component 8: Negotiate Assisted Partner Disclosure and Referral

HIV status disclosure is the process of informing one's HIV status to others. It is the base for accessing HIV testing, prevention, care and treatment services. . All clients positive or negative should be empowered to inform their sexual partner/s of their test result. The counselor should provide additional counselling to help the client to disclose the test result and bring the partner/s for testing. The client should be reminded that in order to remain negative he/she must be confident that his/her partner is uninfected or always use condoms correctly and consistently.

*(Refer the VCT Negotiate disclosure and partner referral: HIV Negative Session, Component 8)*

#### Essential Messages to Convey when Counseling an HIV Negative Client

- ◆ Reinforce that the client's test result does not indicate the HIV status of his/her sexual partner(s), it is also common for sexual partners to have different HIV test results
- ◆ HIV negative individuals with a HIV positive partner or partner of unknown status are at high risk for becoming infected with HIV.
- ◆ Prioritize assisted disclosure of the client's HIV status to partner(s) and referral of his/her partner(s) to HIV testing and counseling services.
- ◆ Address communication issues, engage in skill building and role-play approaches to partner disclosure and referral.
- ◆ Emphasize that assisted disclosure of HIV status to partner enhances the client's ability to negotiate risk reduction with partner(s).

#### Role-Play: 2 (Component 1 to 8)

Component 1: Introduction and Orientation to Session

Component 2: Risk Assessment

Component 3: Explore Options for Reducing Risk

Component 4: HIV Test Preparation

Conduct Test

Component 5: Provide HIV Negative Test Result Component 6: Negotiate a Risk Reduction Plan Component 7: Identify Support for Risk Reduction Plan

## Component 8: Negotiate Assisted Partner Disclosure and Referral

### General directions for conducting role-plays

You will be partnered with two other people for the role-play. Your instructor will assign each of you a role – as a counselor, as a client, or as observer. Your group will sit together and conduct the role-play. The role play will be conducted from component 1 to 8. After played one round of role play you will rotate clockwise to change your role and will continue conducting the role play till your facilitator inform you to return to your place for a large group processing.

### Directions for each role Counselor:

- ◆ Quickly review the main points of the counseling protocol section before the role-play begins.
- ◆ Take your time.
- ◆ Use the questions.
- ◆ Stay organized

### Client:

Before the role-play, read through the client scenario. Refer to the scenario when responding to the counselor. Although the information given in the scenario does not cover all the questions you may be asked, try to make an appropriate response that does not contradict the facts outlined for you. Try to be a very reasonable and uncomplicated client; this is a learning experience not a test of the counselor's skills and abilities.

### Observer:

Before the role-play, read through the observation checklist. Also read the client scenario. During the role-play, quietly observe and make notes but, if the counselor is having difficulty or is not using the protocol, you may offer suggestions to the counselor. You may also offer suggestions to the client if his or her responses do not follow the client scenario.

### For this Role-Play

For this role play, you will begin with the section "Introduction and Orientation to the Session" and immediately follow with "Risk Assessment" "Explore Options for Reducing Risk," "HIV Test Preparation," conduct simulated rapid test and then you will move on to "Provide HIV Negative Test Result", "Negotiate a Risk Reduction Plan", "Identify Support for Risk Reduction Plan", "Negotiate Assisted Partner Disclosure and Referral" and end with "Risk Reduction Issues" if applicable.

*(Please Refer to VCT Cue cards, VCT Negative session case Scenarios, & Initial with negative sessions observer checklists)*

## CHAPTER 4: THE HIV POSITIVE TEST RESULT

Learning Objectives: By the end of this course, participants will be able to:

- ◆ Provide the client with an HIV-positive test result in a clear, compassionate, and supportive manner
- ◆ Provide the HIV positive client with linkages to essential preventative health, clinical care and treatment services and to identify appropriate support services
- ◆ Assist the client to inform partners about his/her HIV status and arrange assisted partner referral to VCT
- ◆ Assist the client in exploring his/her feelings about telling friends and family about his/her test result
- ◆ Address any other risk reduction issues that the client may need to discuss

Contents:

Component 9: Provide HIV Positive Test Result

Component 10: Provide Linkages to Care, Treatment and Support Services  
Component 11: Negotiate Assisted Partner Disclosure and Referral  
Component 12: Risk Reduction Issues

Component 9: Provide HIV Positive Test Result

The priority for this component of the session is to ensure that the client understands the test result, expresses his/her feelings about being infected with HIV, receive empathy and compassion from the counselor, and is supported to cope. The counselor should provide the test result in simple terms, avoiding technical jargon. A simple statement such as, "The test indicates that you have been infected with the HIV virus." will provide the essential information. Showing the client his/her code number and then indicate the test result using the lab request. The counselor should allow for silence in the session to provide the client with time to absorb the test result. The counselor should acknowledge that receiving this result can be difficult, elicit feedback from the client as to how he/ she is feeling about the result and provide appropriate support.

*(Refer the VCT HIV Positive Session, Component 9)*

Component 10: Provide Linkages to Care, Treatment and Support Services

Linkage is defined as a process of actions and activities that support people testing for

HIV and people diagnosed with HIV to engage with prevention, treatment, and care services as appropriate for their HIV status. For people with HIV, it refers to the period beginning with HIV diagnosis and ending with enrolment in care or treatment. It is critical for people living with HIV to enroll in care as early as possible. This enables timely initiation of ART as well as access to interventions to prevent the further transmission of HIV, prevent other infections and co-morbidities and thereby to minimize loss to follow-up.

HIV positive clients should have access to clinical care and treatment using a test and treat approach, including other prevention services (TPT, CCX..). It is essential that the counselor ensure that HIV infected client understands the benefits of accessing medical care and other services. The counselor should help client to understand the need of informing his/her HIV status to other health professionals who will evaluate or treat him/her for any other HIV related medical conditions. The counselor should discuss family planning and antenatal care intervention options, if needed. If the client is not emotionally prepared for a comprehensive discussion on these issues, a follow-up appointment or referral to care and treatment services need to be arranged.

For the HIV positive client, it is essential that he/she identify at least one person with whom he/ she can share the test result and receive support. Isolation and loneliness in dealing with HIV is detrimental to the client. The client's health and emotional wellbeing is enhanced proportionate to the extent he/she is accepted by family and friends, continues to live an active and productive life and is integrated into the community. However, the client and counselor should anticipate that there may be negative consequences associated with disclosure of his/her HIV status. It is the role of the counselor to help the client weigh and assess where and how to obtain support. It is helpful if the client can identify a close family member or friend to help him/her through the process of dealing with his/her HIV infection. This person can assist the client in planning for the future, initiating positive living and completing medical follow-up. In addition, HIV positive persons often find support and fellowship through association with other positive persons. The counselor should encourage the client to attend at least one support group, posttest club or other organization who provide psychological support to the HIV infected persons.

*(Refer linkage to care, treatment and support Session, Component 10)*

Essential care and treatment services for HIV infected persons

- ◆ Package of HIV positive living, including HIV care follow up,
- ◆ Safe water precautions
- ◆ Practicing safe sex
- ◆ Malaria prophylaxis- insecticide-treated bed netting (especially for pregnant women and young children) and treatment

- ◆ Address PMTCT and family planning services
- ◆ Evaluation, diagnosis and treatment, or prophylaxis for tuberculosis (TB)
- ◆ Nutritional support and vitamin supplements
- ◆ Personal hygiene/skin care,
- ◆ Up to date immunizations (especially for children)
- ◆ Screening, diagnosis and treatment of STI's, and referral of partners
- ◆ Treatment/ managing for prevention and treatment opportunistic infections like
- ◆ Oral thrush, fungal infections, vaginal candidacies, herpes zoster)

#### ARV treatment service and essential messages

- ◆ Treatment is initiated immediately after adherence preparation and exclusion of OI's or any other medical reason without considering WHO HIV clinical stage Or CD4 levels.
- ◆ ARVs help prolong quality of life by significantly reducing the viral load.
- ◆ ARVs do not cure HIV and must be taken for life long
- ◆ A person taking ARVs is still infected and can transmit the virus to others.
- ◆ It is essential that a patient should take his/her medication every day as directed

#### Component 11: Negotiate Assisted Disclosure and Referral for HIV testing

Disclosure and referral service should be offered as part of comprehensive package of testing service to be provided to an individual diagnosed with HIV.

- ◆ Assisted disclosure or partner notification improves uptake and diagnosis of HIV positive individuals.

However, an HIV infected client may have numerous concerns about the potential repercussions of partner getting information about his/her HIV status. These include IPV, anger, blame, rejection, and abandonment. The counselor must explore these concerns with the client. It is the role of the counselor to work through the client's concerns and develop a plan that maximizes the quality of partner disclosure. Together the counselor and client should identify at least one person, other than a partner, the client can tell about the test result and receive comfort and support. This person can assist the client in planning for the future, initiating positive living and completing medical follow-up. In addition, HIV positive persons often find support through association with other positive persons. The counselor should encourage the client to attend at least one support group, posttest club or other organization who provide psychological support to the HIV infected persons.

*(Refer the VCT HIV Positive Session, Component 1)*



## Component 12: Risk Reduction Issues

The counselor has three responsibilities in addressing risk issues:

1. To ensure access to HIV prevention, care and treatment services
2. To make assisted disclosure, notification and referral for HTS
3. To address the immediate need of the client and to give appointment for the client who may not be prepared for further behavior change and risk reduction discussion

*(Refer the VCT HIV Positive Session, Component 12)*

ROLE-PLAY: 3

Component 1: INTRODUCTION AND ORIENTATION TO SESSION

Component 2: Risk Assessment

Component 3: Explore Options for Reducing Risk

Component 4: HIV Test Preparation

Conduct Test

Component 9: Provide HIV Positive Test Result

Component 10: Provide Linkages to Care, Treatment and Support Services  
Component 11: Negotiate Assisted Disclosure or Partner Notification and Referral  
Component 12: Risk Reduction Issues

General directions for conducting role-plays

You will be partnered with two other people for the role-play. Your instructor will assign each of you a role – as a counselor as a client, or as observer. Your group will sit together and conduct the role- play. The role paly will be conducted from component 1 to 4 and 9 to 12 After played one round of role play you will rotate clockwise to change your role and will continue conducting the role play till your facilitator inform you to back to your place for a large group processing.

Directions or each role Counselor:

- ◆ Quickly review the main points of the counseling protocol section before the role-play begins.
- ◆ Take your time.
- ◆ Use the questions.
- ◆ Stay organized.

Client:

Before the role-play, read through the client scenario. Refer to the scenario when responding to the counselor. Although the information given in the scenario does not cover all the questions you may be asked, try to make an appropriate response that does not contradict the facts outlined for you. Try to be a very reasonable and uncomplicated client. This is a learning experience not a test of the counselor's skills and abilities.

Observer:

Before the role-play, read through the observer checklist. Also read the client scenario. During the role-play, quietly observe and make notes but, if the counselor is having difficulty or is not using the protocol, you may offer suggestions to the counselor. You may also offer suggestions to the client if his or her responses do not follow the client scenario.

This Role-Play

For this role-play, you will begin with the section "Introduction and Orientation to the Session" and immediately follow with "Risk Assessment", "Explore Options for Reducing Risk", "HIV Test Preparation", Conduct Simulated Rapid Test, and you will move on to "Providing Client with HIV Positive Test Result", "Provide Linkages to Care, Treatment and Support Services", "Negotiate Disclosure and Partner Referral" and end with "Risk Reduction Issues" if applicable.

## CHAPTER 5. OVERVIEW OF COUPLE HIV COUNSELING AND TESTING

Learning objectives: By the end of this course, Participants will be able to:

- ◆ Define couple HIV counseling and testing, and describe the advantage
- ◆ Describe preconditions to receive CHCT
- ◆ Discuss the roles, responsibilities, and expectation of couples
- ◆ Describe how to deliver HIV test result to couples
- ◆ Provide discordant test result
- ◆ Discuss disclosure

Content

- ◆ Definition of couple HIV counseling and testing
- ◆ Advantage of couple HIV counseling and testing
- ◆ Describe preconditions to receive CHCT
- ◆ Couple roles, responsibilities, and expectations
- ◆ Tips for counselors
- ◆ How to deliver HIV test result to the couples
- ◆ Provide discordant test result
- ◆ Discuss coping and mutual support
- ◆ Discuss family planning and PMTCT options for discordant couples
- ◆ Discuss protecting the negative partner from HIV
- ◆ Discuss window period
- ◆ Discuss disclosure

Definition

Couple counseling is when a couple are counseled, tested, and receive their results together. When couples receive their results together, there will be mutual disclosure of HIV status, and the couple can receive appropriate support and be linked to follow-up services by a health care worker.

Advantage

- ◆ Partners hear information and messages together, enhancing likelihood of a shared understanding.
- ◆ Counselor could minimize tension and diffuse blame.
- ◆ Counseling messages are based on the results of both individuals.
- ◆ Individual is not burdened with the need to disclose results and persuade partner to be tested.
- ◆ Counseling facilitates the communication and cooperation required for risk reduction.
- ◆ Treatment and care decisions can be made together.
- ◆ Couples can engage in decision-making for the future.

Pre-conditions for receiving CHCT services.

There are several conditions the couple should agree upon, to receive couples HIV counseling and testing services. These conditions include:

- ◆ Partners agree to discuss HIV risk issues and concerns together.
- ◆ Couples are willing to receive results together. This means that the couple will know each other's test results.
- ◆ Couple commits to shared confidentiality. The couple should make decisions together about sharing their test results with other people.
- ◆ Disclosure decisions are made mutually. The couple should agree not to tell anyone their test results unless both partners agree.

Couple roles, responsibilities, and expectations

- ◆ Each partner participating equally in the discussion
- ◆ Listening carefully and responding to each other
- ◆ Treating each other with respect and dignity
- ◆ Being as open and honest as possible
- ◆ Providing understanding and support to each other

These roles, responsibilities, and expectations are addressed in the initial session when the counselor introduces the couple to CHCT and obtains their concurrence to receive couple services.

Tips for counselors: -

- ◆ Should focus on solutions—not problems.

- ◆ Must assist in diffusing blame and tension.
- ◆ Should focus on the present and the future.
- ◆ Remember that the past is in the past and cannot be changed.

How to deliver HIV test result to the couples

If the couple is concordant, the counselor should say: First, “Your test result is same”; Then, either “Both of you have tested HIV-positive” OR, “Both of you have tested HIV-negative.”

- ◆ If the couple is discordant, the counselor should say: First; “Your test results are different.”

Then, provide the HIV-positive result to the infected partner first then HIV-negative partner next.

Providing discordant test results

- ◆ It is important to understand the different types of HIV test results that are possible during a couples counseling session. (The woman is HIV-positive, and the man is HIV-negative, or the man is HIV-positive, and the woman is HIV-negative).
- ◆ Counselors should support discordant couples to focus on coping and providing each other support, positive living, care, and treatment, risk reduction, family planning, disclosure and getting support.

Counselor responsibilities during discordant test result counseling

Because couples may have difficulty in understanding their discordant results, counselors need to be very clear. Their messages should emphasize the risk of the HIV-negative partner becoming infected, unless the couple adopts behaviors to protect him/her.

It is extremely important that counselors fulfill the following responsibilities:

- ◆ Facilitate understanding and acceptance of results.
- ◆ Provide clear and accurate explanation of discordance.
- ◆ Correct any beliefs that might undermine prevention. For example, the HIV negative partner might believe that he/she will no longer be infected with HIV and might be discouraged to access prevention services.
- ◆ Empower the couple to commit to risk reduction behavior. Provide them knowledge and skills to prevent transmission from the positive partner to the negative one. This will empower them to stay healthy.

When couples are discordant, infection could have occurred in different ways:

- ◆ The positive partner may have been infected before they became a couple.

- ◆ The positive partner may have other partners outside the relationship
- ◆ Transmission risk through sex is high among steady discordant couples if treatment is not initiated, adherence is poor and if HIV prevention methods are not applied (condoms and PrEP)
- ◆ Discuss mutual disclosure decisions. Couples need to be careful about to whom they disclose their results. This should be a mutual decision.
- ◆ Help the couple develop adaptive coping strategies as discordant results are stressful. Your counseling will involve helping these couples cope with this stress.
- ◆ Encourage the positive partner to start ART and properly take the medication and the negative partner to receive PrEP services.

#### Discuss coping and mutual support strategies

- ◆ Counselor should carefully balance the couple's expression of feelings with supportive encouragement and demonstrate genuine optimism about the couple's ability to adapt to and cope with the results.
- ◆ The counselor should refrain from labeling the couple's feelings for them. For example, the counselor should avoid saying, "You must be upset," or "This is difficult for you."
- ◆ The partners should first be supported to define the meaning of the results for themselves and identify their own thoughts, reactions, feelings, and emotions. The counselor can then supportively reflect and normalize the couple's experiences.
- ◆ Counselor may remind the couple of their resources and strengths, which they identified earlier in the session.
- ◆ The partners should be encouraged to be supportive of each other. At the same time, the counselor should help the couple recognize the potential need for additional support from others.

#### Discuss children, family planning, and PMTCT options

Unintended pregnancies should be prevented to reduce the risk of HIV transmission to infants born to infected mothers. The counselor should support the couples to make informed reproductive choices and then their choices should be respected.

Counselor's aim is to make sure that the couple understands PMTCT, has access to family planning services, and understands the importance of accessing PMTCT services if the woman is currently pregnant or if the couple conceives in the future.

The counselor should aim at least to address the essential information and to provide

appropriate referrals. If the couple is interested and time permits, the counselor can discuss their choices more fully.

#### Discuss protecting the negative partner from HIV

- ◆ The negative partner can be a source of support for the positive partner, both emotionally and with HIV care and treatment.
- ◆ Should the HIV-positive partner become ill or die, having an HIV-negative, healthy partner can help ensure the well-being of any children or the household.
- ◆ Couples may remain discordant for a long time without knowing their HIV status or reducing their risk. However, the counselor should inform the couple that if they do not take steps to protect the negative partner from HIV, that partner is at very high risk of being infected.
- ◆ By taking steps to protect the negative partner, using condoms during sex, the couple should be able to remain discordant for much longer. It is important to inform the couple about PrEP services for the HIV negative partner and ART for the HIV positive partner.
- ◆ Helping discordant couples protect the negative partner from HIV is among the most important goals of CHCT.
- ◆ Counseling greatly reduces the transmission of HIV within discordant couples by delivering risk reduction messages and discussing the couple's choices.

#### Discuss "Window Period"

- ◆ Counselors should tell couples that a recent exposure to HIV may not be detected by the HIV antibody test.
- ◆ If either partner has had a recent exposure that they are concerned about, then the provider should inform them about the importance of re-testing within 4-6 weeks after the last risk exposure to an HIV-infected person or someone with unknown status.

#### Discuss disclosure

It is important for the couple both to understand the benefits of disclosing their HIV status to friends, family, and community members who will support them. It is also important for the couple to understand how to approach disclosing their status.

#### Benefits of disclosure to infected person

- ◆ Allowing the individual to acknowledge HIV status and plan for the future.

- ◆ Build a network of social and emotional support and reduce sense of isolation and anxiety.
- ◆ Enhance opportunities for HIV-infected person to receive support in obtaining proper medical care and treatment openly and properly.

Potential benefits of disclosure to sex partners:

- ◆ Allows sex partner to know about exposure risk, to seek testing and to reduce his/her risk of acquisition or transmission of HIV.
- ◆ Enhances the sex partner's ability to understand and support the behavior changes needed to reduce risk.

Potential benefits of disclosure to family

- ◆ Helps infected family to prepare for the future.
- ◆ Allows an opportunity to address children's fears and anxieties.
- ◆ Provides a role model to friends, family, and community.
- ◆ Allows health care providers to take appropriate precautions.

Potential benefits of disclosing to children:

- ◆ Being secretive/ undisclosed can be stressful for children. Because children are highly observant. (Especially older ones) often know something is wrong even if the parent has not disclosed.
- ◆ Parents should be the ones to disclose their status. It is best for children to learn about their parents' HIV status from the parents themselves.
- ◆ Disclosure opens communication between parents and children and allows the parents to address the children's fears and misperceptions.
- ◆ Disclosure lowers parents' stress. Parents who have shared their HIV status with their children tend to build trust, experience less depression than those who do not.

Considerations for disclosing to children:

- ◆ The decision to tell a child that parent{s} are HIV-infected should be individualized to the child's age, maturity, family dynamics, social circumstances, and health status of the parent.
- ◆ How a child reacts to learning that parent{s} have HIV usually depends on the child relationship to the parent.
- ◆ Young children should receive simple explanations about what to expect with their



parent's HIV status. The focus should be on the immediate future and addressing fears and misperceptions.

- ◆ It is possible that in some cases, disclosure may initially cause stress and tension. Parents should anticipate that their child might need time to adjust to and accept their parents' HIV status.
- ◆ If a parent discloses his/her HIV status but requires the child to keep it a secret from others, it can be stressful to the child.
- ◆ Parents should consider disclosing their status to other adults who are close to their children. This creates a support network of adults who can help the child cope with and process their feelings.
- ◆ Parents who are experiencing intense feelings of anger or severe depression about their HIV infection may want to wait to disclose to their child until they have learned to cope with their status.
- ◆ HIV-affected children and families need ongoing support beyond disclosure for coping with HIV and planning for future.

#### Approaches of disclosure

- ◆ Find a private and quiet place and time for the discussion.
- ◆ Inform clearly that the discussion points are all be confidential.
- ◆ Develop a script of what to say and how and when to say it.
- ◆ Be clear and specific about what support is needed and what would be helpful.
- ◆ When finished, review the experience; revise the approach as necessary for disclosure to the next person.
- ◆ When deciding which sex partners to disclose, prioritize those who may have been exposed to HIV (if the HIV-positive person feels it is safe to disclose to that person).

Once couples and individuals decide to disclose and decide practicing the four "W" and one "H" strategies for disclosure is a useful way to make the process easier. (Whom, What, Where, When, and How).

## CHAPTER 6. PROVIDING DISCORDANT RESULTS

Learning objectives: By the end of this session the participants will be able to:

- ◆ Describe the factors Influencing the Transmission of HIV
- ◆ Explain essential counselor responsibilities to disclose test result
- ◆ Provide discordant test result
- ◆ Discuss risk reduction

Content

- ◆ Factors that influence the transmission of HIV
- ◆ Key counselor responsibilities
- ◆ Provide discordant test result
- ◆ Discuss coping and mutual support
- ◆ Discuss positive living and HIV care and treatment
- ◆ Discuss risk reduction
- ◆ Discuss family planning and PMTCT options for discordant couples
- ◆ Discuss Disclosure

This chapter clarifies the implications of couple's HIV discordant result and will explain procedure for counseling discordant couples. There are six components in providing couple's discordant result

Component 1: Provide discordant test result

Component 2: Discuss coping and mutual support

Component 3: Discuss positive living and HIV care and treatment

Component 4: Risk Reduction

Component 5: Discuss family planning and PMTCT options for discordant couples

Component 6: Discuss disclosure and getting support

N.B:

1. For both concordant Negative and positive result please follow PITC and /or ICT cue card
2. Please use/refer the couple HIV counseling and testing cue card for discordant HIV

test result counseling to perform the task

Factors that influence the transmission of HIV

Sexually transmitted infections

HIV-infected persons with STIs are more likely to transmit HIV than people without STIs. Sexual partners are more likely to acquire HIV if they have STIs.

Viral Load

If the high viral load amount of HIV-positive person has in his or her body, the more likely it is that he or she will pass HIV to a sexual partner. When individuals develop AIDS, they are ill because they have very high levels of HIV in their body and low numbers of immune system cells. Patients who take their ARVs as directed will have a lower level of virus but are still able to transmit the virus.

Recent infection with HIV

When someone is recently infected with HIV, he or she will initially have a higher amount of virus in his or her body. This increases the chance of passing HIV to others.

Frequency of sexual exposures

Each time an HIV negative person has sex with someone who has HIV, he or she is at risk of getting HIV. The more exposure to HIV he or she has, the more likely it is that he or she will become infected.

Injury of the genital tract

Partners with cuts or abrasions of the membranes of the genital track are more likely to acquire HIV than partners with intact membranes.

Key Counselor Responsibilities to disclose test result

Couples may have difficulty understanding their discordant results, counselors need to be very clear. Their messages should emphasize the very high risk of the uninfected partner becoming infected unless the couple adopts behaviors to protect the uninfected partner. It is important that counselors fulfill the following responsibilities:

- ◆ Facilitate understanding and acceptance of results.
- ◆ Provide clear and accurate explanation of discordance.
- ◆ Correct any beliefs that might undermine prevention. For example, the HIV negative partner might believe that he/she will no longer be infected with HIV, and might be discouraged to access prevention services.
- ◆ Help the couple develop adaptive coping strategies as discordant results are stressful.

Your counseling will involve helping these couples cope with this stress.

- ◆ Empower the couple to commit to risk reduction. During your counseling session, you will be giving couples the knowledge and skills to prevent transmission from the positive partner to the negative one. This will empower them to stay healthy.
- ◆ Discuss mutual disclosure decisions. Discrimination and stigma are unfortunately very common. Couples need to be careful about to whom they disclose their results. This should be a mutual decision.

The counselor has a crucial opportunity to help discordant couples deal with their results and, most importantly, take steps to reduce the risk of transmission.

Myths or Misconception regarding Discordant

Belief #1: One partner has been unfaithful and deserves to be abandoned or punished.

Answer: The infected partner could certainly have acquired HIV well before the partners became a couple.

Belief #2: The couple believes the virus is sleeping and cannot be transmitted.

Answer: HIV-infected persons can transmit the virus at any time, even if they have no signs or symptoms of the disease.

Belief #3: There has been a mistake in the lab.

Answer: While this is a possibility, it is very rare, and the lab has many procedures in place to prevent any mistakes.

Belief #4: We have been having sex all this time and never transmitted the virus. Why do we need to take precautions now?

Answer: HIV may be transmitted in the future, particularly as the person gets sicker and has higher levels of the virus.

Component 1: PROVIDE DISCORDANT TEST RESULTS

The aim of this component is to emphasize that the counselor is responsible for providing results to the couple in a simple and clear description. It is essential for the counselor to help discordant couples accept the accuracy and reality of their test results. Discordance must be explained in simple terms that clearly address any misconceptions the couple may have. The following five tasks guide counselors through this portion of the post-test session: Remember that the words a counselor chooses to say in the session affect each client in different ways and on many levels.

Words, information, and explanations can have several meanings and interpretations. A counselor should listen carefully to his or her own choice of words and phrases and assess how

the messages may be heard, perceived, and interpreted.

First, the counselor should provide the couple with a summary of both of their test results by saying, “Your results are different.” This should be immediately followed by, Man or Woman “Your test results are HIV-positive, which indicates that you are infected with HIV.” And Man or Woman “Your test results are Negative”, which indicates that you are not infected with HIV.” This approach reaffirms that the partners have sought to learn their HIV status as a couple and that they will be coping with their shared test results together.

The counselor should allow a moment of silence in the session to provide the couple with time to absorb the meaning of the test results. The counselor should make sure that the couple clearly understands the test results. As much as possible, the counselor should diffuse any discussion about one partner being unfaithful or bringing HIV into the relationship. The counselor may need to assist the couple in understanding that it is not possible to determine when or by whom either partner became infected, and in reality, this is neither relevant nor helpful. The counselor should attempt to focus the partners on how they can support each other and cope with their discordant results.

#### Component 2: DISCUSS COPING AND MUTUAL SUPPORT

In this component, the counselor should balance the couple’s expression of feelings—often of distress and loss—with supportive encouragement and understated but genuine optimism about the couple’s ability to adapt to and cope with the results. The counselor’s behavior should be gentle yet supportive. The counselor should refrain from labeling the couple’s feelings for them. For example, the counselor should avoid saying, “You must be upset,” or “This is difficult for you.” The partners should first be supported to define the meaning of the results for themselves and identify their own thoughts, reactions, feelings, and emotions. The counselor can then supportively reflect back and normalize the couple’s experiences.

As appropriate, the counselor may remind the couple of their resources and strengths, which they identified earlier in the session. The partners should be encouraged to be supportive of each other. At the same time, the counselor should help the couple recognize the potential need for additional support from others.

#### Component 3: DISCUSS POSITIVE LIVING AND HIV CARE AND TREATMENT

The goal is to motivate and empower the couple to understand and value the importance of accessing appropriate prevention and care. To do this, the counselor should provide information at the couple’s level of understanding to educate them about the importance of early/timely initiation of HIV care and treatment.

#### Component 4: DISCUSS RISK REDUCTION

For HIV-infected couples, the issue of risk reduction may be delicate and complex, especially when talking about outside sexual partner/s. Discussing the risks of having partners outside the relationship should be handled diplomatically and in general terms or by providing example as a third person.

Reasons to talk about outside partners include:

- ◆ Outside sexual partner/s could be HIV-negative.
- ◆ Outside sexual partner/s could have STIs that would make the couple sicker.
- ◆ Individuals in the couple are HIV-positive and need to use condoms with outside partners.

Using of third person technique or in abstract way in this protocol component is basic the counseling skill. Example we can use some words such as in some married couples, in some relationship, polygamy. The counselor should emphasize the importance of reducing the risk of acquiring STIs.

If there is any sexual exposure outside of the relationship, condoms must be used to protect the couple from STIs and to prevent the transmission of HIV.

The following four tasks and objectives outline how to discuss risk reduction effectively with discordant couples:

- ◆ Discussing the Likelihood of an HIV Test Not Detecting Recent HIV Infection “Window Period” Issues of “Window Period” will or may come up in discordant CHCT sessions. The window period describes the period when an HIV test does not detect HIV infection because the body has not yet produced antibodies to a very recent infection. This briefing paper should assist the trainer in facilitating discussion on this issue and dispelling myths.
- ◆ Explain to participants that as counselors they should try to avoid using the term “window period” when explaining HIV test results to clients. The phrase is misleading, poorly understood, and essentially jargons. Instead, counselors should tell couples that a recent exposure to HIV may not be detected by the HIV antibody test. If either partner has had a recent exposure that they are concerned about then they should consider re-testing 4-6 weeks or more after the last risk exposure to an HIV-infected person or someone with unknown status.
- ◆ Explain to participants that they should be careful when explaining the likelihood of being in the window period to couples. The actual likelihood of being in the window period is quite low. The counselor therefore has an ethical responsibility to mention the risk but should also emphasize their confidence in the negative test result(s) and convey this to the couple.

- ◆ Some participants may believe that discordant couples are actually concordant positive, and that one partner is in the window period. If so, explain to the participants that this is not likely. Remind them that discordance is not only possible, but that it is also fairly common in Africa, occurring in about 13%-30% of couples, whereas the risk of being in the window period is very small (<3%).

#### Component 5: DISCUSS CHILDREN, FAMILY PLANNING, AND PMTCT OPTIONS

There are several issues to address regarding the couple's family planning and reproductive choices to prevent unintended pregnancies and to reduce the risk of transmission of HIV to infants born to infected mothers.

When discussing family planning and reproductive health issues with the couple, the counselor's aim is to make sure that the couple understands the importance of accessing PMTCT, family planning services,

#### Component 6: DISCUSS DISCLOSURE AND GETTING SUPPORT

It is important for the couple both to understand the benefits of disclosing their HIV status to friends, family, and community members who will support them. It is also important for the couple to understand how to approach disclosing their status.

N.B. For detail providing discordant test result please refer CHCT cue card.

#### Module Three Summary

- ◆ VCT is one of the models of HTS serving as "an entry point" for HIV prevention, care and support services. The WHO 5C's (Consent, confidentiality, counseling, correct test result and connection to care) should be followed in the implementation of VCT.
- ◆ VCT Has a total of 12 component, which comprises of 4 initial, 4 Negative Sessions and 4 positive sessions
- ◆ HIV Risk Reduction Options Includes: (Abstinence, having only one partner whose HIV status is known, consistent and appropriate condom use)
- ◆ Positive living means taking care of client's health and emotional well-being to enhance his/her life and stay well longer. It involves having positive attitude, sense of optimism and well-being, understanding the disease, and follow prescribed nutrition, and medications. And follow-up medical care, and advice
- ◆ When providing HIV Positive test results, Counselor should allow a brief period of supportive silence and acknowledge the difficulty of receiving it and should focus the need to have focused and brief medical care follow up.

- ◆ Counselors should clearly describe to couples about preconditions to receive CHCT and inform them that the couple should agree to participate on the CHCT.
- ◆ Understanding the couple roles, responsibilities, and expectations are very much crucial to make the the CHCT session a success
- ◆ Counselors MUST clearly inform the HIV testing result delivery options to the couples



## ANNEX: 1

### Scenario 1: Initial / Pre-test counseling

#### Male Client: Role Play – Protocol Components 1, 2, 3 and 4

Duguma, who is 23 years old, moved to the city from his village about two years ago. He works very hard at his teaching job and coordinates a boy's football club's games after work and weekends. Until he met his girlfriend, Elfness, he and his friends used to have fun, especially on pay day, hanging out at clubs, drinking a few beers, dancing, and meeting girls. Sometimes he would have sex with these girls, but he usually would wear condoms. A couple of times he had too many beers and forgot to use a condom. Then about six months ago Duguma began dating Elfness, who is 21 years old and a teacher. He quickly fell in love with Elfness, and felt the relationship was getting serious. Because he felt in "love and committed" to Elfness, he did not use a condom when they first had sex four months ago. As time went on and Duguma thought about his past and the future he was imagining with Elfness, he became terrified that he may have exposed himself and Elfness to HIV. As a youth in his village, he had a couple of girlfriends. Duguma was not too worried about these girls as he knew them and their families all his life and he usually used condoms to prevent pregnancy. But he was very concerned about the two club girls he had sex with without condoms. The more he thought about it, he realized he did not know if Elfness has had sex with anyone else. They have never talked about HIV/AIDS, but he has talked with his brother about getting tested and may talk with Elfness after he finds out his HIV test result.

#### Female: Role Play – Protocol Components 1, 2, 3 and 4

Elfness is 21 years old and a teacher. She loves working with children and hopes to have a family of her own someday. When Elfness was in teacher's training, she dated a nice man for over a year. They stayed together often, and usually used condoms to prevent pregnancy. She thought he would someday become her husband. Their relationship ended after his father died in an accident and he needed to return to his village to care for his brothers and sisters. After finishing her training, Elfness moved to the city to find a teaching position. She was new to the city and lonely. She eventually made some friends and would go out with them. Once she met a man, she thought was nice and she dated him a few times. They eventually had sex, but she ended the relationship because he usually drinks too much. He refused to wear a condom whenever he drinks, and she was frightened she might get pregnant.

She was transferred to a new school and met Duguma, a teacher at the same school. Duguma is a wonderful man, a fine teacher and wonderful with the children. He even coaches a boy's football club on the weekends. They began dating about six months ago and first had sex about four months ago. He has told her he loves her and is committed to her. They are

talking about their future together. When they first had sex, they did not use a condom. Elfresh thinks this was because it was a way to be intimate and demonstrate their mutual love. As they have begun to talk about their future together, Elfresh has been thinking about her past and wonders about Duguma' past. They have never talked about their previous partners. She wants to get herself tested for HIV before she asks him to be tested.

#### Scenario 2: Initial and Negative post-test counseling Female Client: Role Play 2 – Protocol Components 1 - 8

Mebrat is 22. She moved from her village to the city for work about one year ago. She stays with her aunt and her family. She had a steady boyfriend in her village, but they both went different directions after completing school. She and the boy from her village had sex, but they almost always used condoms to prevent pregnancy. When she first came to the city, she was lonely and went out most weekends with the other young people from her work. They would drink and dance. About four months ago, she had sex two times with a friend from work who went to the club with her.

They did not use condoms the first time they had sex because they had both been drunk. The second time she insisted he better use condom. She soon found out this man had another girlfriend and stopped dating him.

About three months ago, Mebrat became close to a man named Ayalew. He works with her cousin. Ayalew is a very serious person and has a good job with the government. They have begun to talk about having a future together. Recently, they began having sex and use condoms each time, but he really does not like using condom and is pressuring her to let him stop use it. She knows little about his previous partners.

Mebrat and Ayalew have never really talked about HIV, AIDS or STIs. They have not talked about other people they have had sex with.

#### Male Client: Role Play 2 – Protocol Components 1 - 8

Ayalew is a 24-year-old who recently graduated from the university and now has a good position in the government. He has recently started dating a very nice girl who just moved from her village to the city about a year ago. This girl, Mebrat, is 22 years old and is also very serious about her work. Ayalew and Mebrat have recently started having sex. They have used condoms every time because Mebrat has insisted. Ayalew does not like the condoms and is trying to convince Mebrat that since they have a serious relationship, they can stop using condoms. Ayalew had several girlfriends at the university, but he had no serious relationship with anyone of them. He sometimes used condoms with these girls but not always. He sometimes reluctant to use condom, assuming that the girls are from good families or when he had too much to drink. Now he is committed to Mebrat however, occasionally he goes out with his old friends and has sex with a bar girl, but he usually uses condoms with these women. However, about two months ago he was celebrating his new-job post, had too much to

drink and forgot to use a condom.

He has never really thought about his past partners until recently. Mebrat's insistence that they should always use condoms has made him begin to wonder about his and her previous partners. He thought maybe he should get an HIV test before he goes any further in this relationship.

### Scenario 3: Initial and Positive post- test counseling

#### Female Client: Role Play 3 – Protocol Components 1-4 and 9-12

Mihiret is 26 years old and has two children (4-year-old twins, girls). Her husband Dawit was a businessman and died in an automobile accident three years ago. He used to be away from home for several weeks at a time on business trips. She believes that he may have had sex with other women while away on these trips. This always concerned her.

Mihiret is thinking more and more about all this because she has been seeing a man named Yohannes for about six months. She met Yohannes at the church she is attending, and they both sing in the choir. Yohannes is 30 years old and works for a company that repairs computers. She and Yohannes have always used condoms. They are getting serious, and Yohannes has suggested that they better stop using condoms. Yohannes is a very good man, he helps her with school fees, and he is kind to the children. His wife died almost two years ago from pneumonia. Yohannes has one 3-year-old son, who is very close to Mihiret's twins. She is not sure if Yohannes is having sex with anyone else, as they did not talk of such things.

#### Male Client: Role Play 3 – Protocol Components 1-4 and 9-12

Yohannes is a 30-year-old man whose wife died two years ago from what the doctors said was pneumonia. Yohannes has a three-year-old son. Yohannes works for a company that repairs computers. Yohannes is seeing a woman named Mihiret; he met her about six months ago at the church he is attending. This woman's husband, a businessman, died in an automobile accident a few years earlier. He is very fond of this woman, and she is very good to his son. Mihiret is 26 years old and has 4-year-old twins (girls).

Yohannes and Mihiret started having sex but have always used condoms. He would rather not use condoms, but he is very much concerned because during the first year after his wife's death he was in deep grief and feels lonely, and sometimes he used to go to clubs and occasionally have sex with women he would meet at the club. He usually, but not always used condoms with these women. Yohannes didn't have sex with another woman since he met Mihiret. Yohannes would like a future with Mihiret. He wants to ask Mihiret and the two little girls to live with him and his son. He would first like to get himself tested for HIV because he loves Mihiret but does not know what he will do if he is infected. He and Mihiret have not yet talked about this, but he senses it is weighing on both of their minds.

VCT Observer Check list

Observer Checklist Role Play 1

Introduction and Orientation to the Session		
Key counselor tasks	Task addressed?	Comments and recommendations
Introduce self to client.		
Describe your role as counselor.		
Explain confidentiality.		
Explain Benefits of VCT		
Review the rapid test process: <ul style="list-style-type: none"> <li>• Detects HIV infection</li> <li>• Accurate</li> <li>• Negative – not infected</li> <li>• Positive – infected with HIV</li> <li>• Same day test result</li> </ul>		
Outline content of session: <ul style="list-style-type: none"> <li>• Explore HIV/STI risks</li> <li>• Address options for reducing risk</li> <li>• Provide test</li> <li>• Develop risk reduction plan</li> <li>• Provide referrals to care and Support</li> </ul>		
Review “map” of client stops/activities during this counseling and testing visit.		
Address immediate questions and concerns.		

General comments:

Observer Checklist (continued), Role plays 1

Risk Assessment		
Key counselor tasks	Task addressed?	Comments and recommendations
Assess client's reason for coming in for services.		
Assess client's level of concern about having/acquiring HIV.		
Explore most recent risk exposure/behavior <ul style="list-style-type: none"> <li>• When?</li> <li>• With whom?</li> <li>• Under what circumstances?</li> </ul>		
Assess client's feelings about his/her risk behaviors		
Assess pattern of risk (e.g., happening regularly, occasionally, due to an unusual incident) <ul style="list-style-type: none"> <li>• Number of partners?</li> <li>• Type of partners?</li> <li>• Frequency of new/different partners?</li> <li>• Condom use?</li> </ul>		
Identify risk triggers, vulnerabilities, and circumstances		
Assess partner's risk		
Assess communication with partner(s)		
Assess for indicators of increased risk		

Summarize and reflect client's story and risk issues		
<ul style="list-style-type: none"> <li>• Risk pattern</li> <li>• Prioritize risk issues</li> </ul>		
<ul style="list-style-type: none"> <li>• Risk triggers and risk vulnerabilities</li> </ul>		

General comments:

Observer Checklist Role Play 1

Explore Options for Reducing Risk		
Key counselor tasks	Task addressed?	Comments and recommendations
Explore client's communication with friends about risk reduction.		
Review previous risk reduction attempts.		
Identify successful experiences with practicing safer sex.		
Identify obstacles to risk reduction		
Explore triggers and situations which increase the likelihood of high-risk behavior.		
Place risk behavior in the larger context of client's life.		
Assess condom skills.		
Identify entire range of options for reducing risk.		
Role play, skill build, problem solve.		

Address examples when client's beliefs and behavior are at odds or when feelings are mixed about changing behavior.		
Summarize risk reduction options/discussion.		

General comments:

Observer Checklist (continued), Role Play 1

HIV Test Preparation		
Key counselor tasks	Task addressed?	Comments and recommendations
Explore with whom client has shared his/her decision to come for VCT services. <ul style="list-style-type: none"> <li>Partners, family and friends</li> </ul>		
Discuss the client's understanding of the meaning of positive and negative HIV test results.		
Assess client's response to the potential results. <ul style="list-style-type: none"> <li>Positive result</li> <li>Negative result</li> </ul>		
Assess who will provide the client support if he/she is infected.		
Discuss the importance of follow-up health care and positive living: <ul style="list-style-type: none"> <li>Medical care and follow-up</li> <li>Staying well living longer</li> <li>Obtaining support</li> </ul>		

Review the benefits of knowing your serostatus (knowledge is power).		
Affirm client's test decision.		
Describe the tests and the interpretation/reading of the test.		
Direct client to lab to receive test and instruct him/her to return to the counselor or where to wait should the counselor be with another client		

General comments:

Observer Checklist Role Play 2

Introductions and Orientation to the Session		
Key counselor tasks	Task addressed?	Comments and recommendations
Introduce self to client.		
Describe your role as counselor.		
Explain confidentiality.		
Explain benefits of VCT		
Review the rapid test process: <ul style="list-style-type: none"> <li>• Detects HIV infection</li> <li>• Accurate</li> <li>• Negative – not infected</li> <li>• Positive – infected with HIV</li> <li>• Same day test result</li> </ul>		



<p>Outline content of session:</p> <ul style="list-style-type: none"> <li>• Explore HIV/STI risks</li> <li>• Address options for reducing risk</li> <li>• Provide test</li> <li>• Develop risk reduction plan</li> <li>• Provide referrals to care and support</li> </ul>		
<p>Review “map” of client stops/activities during this counseling and testing visit.</p>		
<p>Address immediate questions and concerns</p>		

General comments:

Observer Checklist (continued). Role plays 2

Risk Assessment		
Key counselor tasks	Task addressed?	Comments and recommendations
Assess client’s reason for coming in for services.		
Assess client’s level of concern about having/acquiring HIV.		
<p>Explore most recent risk exposure/behavior</p> <ul style="list-style-type: none"> <li>• When?</li> <li>• With whom?</li> <li>• Under what circumstances?</li> </ul>		
Assess client’s feelings about his/her risk behaviors		

<p>Assess pattern of risk (e.g., happening regularly, occasionally, due to an unusual incident)</p> <ul style="list-style-type: none"> <li>◆ Number of partners?</li> <li>◆ Type of partners?</li> <li>◆ Frequency of new/different partners?</li> <li>◆ Condom use?</li> </ul>		
Identify risk triggers, vulnerabilities, and circumstances		
Assess partner's risk		
Assess communication with partner(s)		
Assess for indicators of increased risk		
<p>Summarize and reflect client's story and risk issues</p> <ul style="list-style-type: none"> <li>◆ Risk pattern</li> <li>◆ Prioritize risk issues</li> <li>◆ Risk triggers and risk vulnerabilities</li> </ul>		

General comments:

Observer Checklist (continued). Role plays 2

Explore Options for Reducing Risk		
Key counselor tasks	Task addressed?	Comments and recommendations
Explore client's communication with friends about risk reduction.		

Review previous risk reduction attempts.		
Identify successful experiences with practicing safer sex.		
Identify obstacles to risk reduction.		
Explore triggers and situations which increase the likelihood of high-risk behavior.		
Place risk behavior in the larger context of client's life.		
Assess condom skills.		
Identify entire range of options for reducing risk.		
Role play, skill build, problem solve.		
Address examples when client's beliefs and behavior are at odds or when feelings are mixed about changing behavior.		
Summarize risk reduction options/ discussion.		

General comments:

Observer Checklist (continued). Role plays 2

HIV Test Preparation		
Key counselor task	Task addressed?	Comments and recommendations
Explore with whom client has shared his/her decision to come for VCT services. • Partners, family, and friends		
Discuss the client's understanding of the meaning of positive and negative HIV test results.		
Assess client's response to the potential results. • Positive result • Negative result		
Assess who will provide the client support if he/she is infected.		
Discuss the importance of follow-up health care and positive living: • Medical care and follow-up • Staying well living longer • Obtaining support		
Review the benefits of knowing our serostatus (knowledge is power).		
Affirm client's test decision.		
Describe the tests and the interpretation/reading of the test.		
Direct client to lab to receive test and instruct him/her to return to the counselor or where to wait should the counselor be with another client.		

General comments:

Observer Checklist (continued), Role plays 2

Provide HIV Negative Test Result		
Key counselor tasks	Task addressed?	Comments and recommendations
Inform client that the test result is available.		
Provide result clearly and simply (show the client his or her result).		
Explore client's reaction to the result.		
Note the need to consider the test result in relation to most recent risk exposure.		
If client has ongoing risk, convey concern and urgency about client's risks (as appropriate).		

Role plays 2

Negotiate a Risk Reduction Plan		
Key counselor tasks	Task addressed?	Comments and recommendations
Identify priority risk-reduction behavior.		
Explore behavior(s) that the client will be most motivated about/ capable of changing.		

Identify a reasonable yet challenging incremental step toward changing the identified behavior.		
Break down the risk reduction action into specific and concrete steps.		
Identify supports or barriers to the risk reduction step.		
Problem-solve issues concerning the plan.		
Role-play the plan.		
Confirm with the client that the plan is reasonable and acceptable.		
Ask the client to be aware of strengths and weaknesses in the plan while trying it out.		
Recognize the challenges of behavior change.		
Document the risk reduction plan with a copy to counselor.		

Observer Checklist (continued), Role plays 2

Identify Support for Risk Reduction Plan- HIV Negative		
Key counselor tasks	Task addressed?	Comments and recommendations
Emphasize the importance of the client discussing with a trusted friend or relative the intention and content of the plan.		
Identify a person to whom the client feels comfortable disclosing the plan.		
Establish a concrete and specific approach for the client to share the plan with his or her friend or relative.		
Convey confidence in the client's ability to complete the plan.		

Role Play 2

Negotiate Assisted Disclosure and Partner Referral		
Key counselor tasks	Task addressed?	Comments and recommendations
Explore client's feelings about telling partner(s) about his/her HIV negative test result.		
Remind the client that his/her result does not indicate partner's HIV status.		

Support client to refer partner for testing.		
Anticipate potential partner reactions.		
Practice and role-play different approaches to disclosure.		
End session, providing the client with motivation and encouragement.		

Observer Checklist for Role Play Number 3

Introduction and Orientation to the Session		
Key counselor tasks	Task addressed?	Comments and recommendations
Introduce self to client.		
Describe your role as counselor.		
Explain confidentiality.		
Explain Benefits of VCT		
Review the rapid test process: <ul style="list-style-type: none"> <li>• Detects HIV infection</li> <li>• Accurate</li> <li>• Negative – not infected</li> <li>• Positive – infected with HIV</li> <li>• Same day test result</li> </ul>		



<p>Outline content of session:</p> <ul style="list-style-type: none"> <li>• Explore HIV/STI risks</li> <li>• Address options for reducing risk</li> <li>• Provide test</li> <li>• Develop risk reduction plan</li> <li>• Provide referrals to care and support</li> </ul>		
Review “map” of client stops/ activities during this counseling and testing visit.		
Address immediate questions and concerns.		

General comments:

Observer Checklist (continued), Role play 3

Risk Assessment		
Key counselor tasks	Task addressed?	Comments and recommendations
Assess client’s reason for coming in for services.		
Assess client’s level of concern about having/acquiring HIV.		
<p>Explore most recent risk exposure/behavior</p> <ul style="list-style-type: none"> <li>• When?</li> <li>• With whom?</li> <li>• Under what circumstances?</li> </ul>		

Assess client's feelings about his/her risk behaviors		
<p>Assess pattern of risk (e.g., happening regularly, occasionally, due to an unusual incident)</p> <ul style="list-style-type: none"> <li>• Number of partners?</li> <li>• Type of partners?</li> <li>• Frequency of new/different partners?</li> <li>• Condom use?</li> </ul>		
Identify risk triggers, vulnerabilities, and circumstances		
Assess partner's risk		
Assess communication with partner(s)		
Assess for indicators of increased risk		
<p>Summarize and reflect back client's story and risk issues</p> <ul style="list-style-type: none"> <li>• Risk pattern</li> <li>• Prioritize risk issues</li> <li>• Risk triggers and risk vulnerabilities</li> </ul>		

General comments:

Observer Checklist (continued) Role play 3

Explore Options for Reducing Risk		
Key counselor tasks	Task addressed?	Comments and recommendations
Explore client's communication with friends about risk reduction.		
Review previous risk reduction attempts.		
Identify successful experiences with practicing safer sex.		
Identify obstacles to risk reduction.		
Explore triggers and situations which increase the likelihood of high risk behavior.		
Place risk behavior in the larger context of client's life.		
Assess condom skills.		
Identify entire range of options for reducing risk.		
Role play, skill build, problem solve.		

Address examples when client's beliefs and behavior are at odds or when feelings are mixed about changing behavior.		
Summarize risk reduction options/ discussion.		

General comments:

Observer Checklist (continued), Role play 3

HIV Test Preparation		
Key counselor tasks	Task addressed?	Comments and recommendations
<p>Explore with whom client has shared his/her decision to come for VCT services.</p> <ul style="list-style-type: none"> <li>Partners, family and friends</li> </ul>		
<p>Discuss the client's understanding of the meaning of positive and negative HIV test results.</p>		
<p>Assess client's response to the potential results.</p> <ul style="list-style-type: none"> <li>Positive result</li> <li>Negative result</li> </ul>		
<p>Assess who will provide the client support if he/she is infected.</p>		

Discuss the importance of follow-up health care and positive living: <ul style="list-style-type: none"> <li>• Medical care and follow-up</li> <li>• Staying well living longer</li> <li>• Obtaining support</li> </ul>		
Review the benefits of knowing your HIV status (knowledge is power).		
Affirm client's test decision.		
Describe the tests and the interpretation/reading of the test.		
Direct client to lab to receive test and instruct him/her to return to the counselor or where to wait should the counselor be with another client.		

General comments:

Observer Checklist (continued), Role Play 3

Provide HIV Positive Test Result		
Key counselor tasks	Task addressed?	Comments and recommendations
Inform client that the test result is available.		
Provide result clearly and simply.		

Allow the client time to absorb the meaning of the result		
Review the meaning of the result		
Explore client's understanding of the result.		
Assess how client is coping with result.		
Acknowledge the challenges of dealing with positive result and provide appropriate support.		

### Role play 3

Provide Linkages to Care, Treatment and Support Services		
Key counselor tasks	Task addressed?	Comments and recommendations
Discuss living positively.		
Identify current access to health care services.		
Address the need for the health care provider to know about the HIV positive test result.		

<p>Address the need for preventative health care:</p> <ul style="list-style-type: none"> <li>• STI exam/treatment</li> <li>• Prevention of opportunistic infections</li> <li>• Environmental precautions <ul style="list-style-type: none"> <li>• Safe water</li> <li>• Mosquito netting</li> </ul> </li> <li>• Nutritional support and vitamin supplements</li> </ul>		
<p>Determine if immediate referral for TB treatment is needed.</p>		
<p>(If available) Explain basic information about ARV treatment.</p>		
<p>Address client's questions and concerns about ARV treatment.</p>		
<p>Address PMTCT and family planning services.</p>		
<p>Identify needed medical referrals.</p>		
<p>Assess whom the client would like to tell about his/her positive result.</p>		
<p>Identify a family member or friend to help the client through the process of dealing with HIV</p> <ol style="list-style-type: none"> <li>A. Coping and support</li> <li>B. Planning for the future</li> <li>C. Positive living</li> </ol>		

Assess the client's willingness to seek support, complete a referral.		
Discuss options of support groups (Posttest Club).		
Evaluate what types of referral the client would be most receptive to.		
Provide appropriate referrals.		

Observer Checklist (continued), Role play 3

<b>Negotiate Assisted Disclosure, Partner Notification and Referral</b>		
Key counselor tasks	Task addressed?	Comments and recommendations
Explore client's feelings about telling partners about his/her HIV positive test result.		
Remind client that his/her result does not indicate the partner's HIV status.		
Identify partners that are at risk and need to be informed of their risk for HIV infection.		
Discuss possible approaches to disclosure of HIV status to partners.		
Practice and role-play different approaches to disclosure.		



Anticipate potential partner reactions.		
Support client to refer partner for testing		
Identify other friends/family members the client might want to disclose his/her result to.		
Discuss situations in which the client may want to consider protecting his/her own confidentiality.		

Observer Checklist (continued), Role play 3

Risk Reduction Issues		
Key counselor tasks	Task addressed?	Comments and recommendations
Elicit transmission risks the client may need/want to address.		
Address issues raised by the client		
Recognize the important risk reduction issues already addressed in the session.		
Remind client of need to re-visit risk reduction issues in the future		
Explore client's immediate plans after leaving the test site		
Inquire as to additional issues the client may like to address		

Annex 2:

Role Play—Discordant

Yohannes: 28 year's old, computer technician

Eyerusalem: 25 years old, secretary

Married: 3 years

Children: 3-year-old twins (one girl and one boy)

Yohannes and Eyerusalem met a little over 4 years ago when they travel 500km.by public transport to visit their family. They met for lunch a few times and found they had quite a lot in common. Soon they were seeing each other regularly and it was clear that they had a strong bond and similar dreams. When they first had sex they used condoms but as their relationship became more committed and as their wedding plans moved along they became more relaxed. They never really talked about it but somehow they simply stopped using condoms. Not long after the wedding they found out that they were having twins. This news was exciting to their families and brought them closer. With the help of her mother-in-law, who lives nearby and cares for the twins while she is at work, Eyerusalem returned to work when the twins were 1 year old.

Yemane and Eyerusalem are dedicated to each other and happy together. Eyerusalem sister lives close by and they are best friends. They both listen to a radio drama while at work and talk and laugh endlessly about the characters. Recently a couple in the drama has been considering going for an HIV test. Eyerusalem decided she was going to talk to Yemane about getting a test. Yohannes too had been thinking about HIV as a friend and co-worker has been ill and the rumor was that he had HIV. His friend really looked bad for a while but lately he had been looking better. Yohannes heard he was taking some new medications to treat HIV. Yohannes and Eyerusalem both have their worries but decided to go ahead and go for couple HIV counseling and testing.

Although Yohannes and Eyerusalem never talked specifically about it, they both knew there may have been other partners in their pasts. In fact, Yohannes knew that Eyerusalem went with someone from her work for a while when she first moved to town. Eyerusalem knows Yohannes is a handsome man and he must have had girlfriends while at the university. Her only hope is that he had been careful. What is important is that she knows that he is now committed to her and their family and she is proud to have such a handsome and responsible husband.

You are Eyerusalem:

When Eyerusalem was young and lived in the village she had a boyfriend for a brief time. He persuaded her that he loved her and convinced her to have sex. The first time he used a condom; the second time he did not. She was so relieved not to become pregnant that she stopped seeing him. Eyerusalem was eager to find a career, so 6 years ago she moved to the city to live with her sister. Eyerusalem went to technical school to become a secretary. After her training, she found a good job in a large company. She and her co-workers would go out evenings to dance and have fun. An older supervisor from another unit took an interest in her. They saw each other for a while and then he seemed to lose interest. They had sex a few times and he used a condom every time except once. Six months later she felt for Yohannes. In him she found a companion, a supportive husband, and a dedicated father.

You are Yohannes:

Yohannes has some concerns about HIV as he had a few girlfriends while in training at the university. That was a carefree time in his life and he often went out to clubs with friends. There was one girl he was a bit serious about for a while, but as time went on it was clear they were not meant to be together. She later moved to another country to pursue an advanced degree. Of course, as a boy in secondary school he had also played with a couple of girls. He usually used condoms but not always; he wasn't perfect. Besides he really didn't like condoms that much as it didn't seem as close or pleasurable.

Once he met Eyerusalem he knew he met the woman who would be his wife. Although he has at times been tempted, he has been faithful to Eyerusalem. He cherishes their beautiful children and the life they share together.

Couple HIV testing and counseling cue card for Discordant HIV test Result counseling:

<b>Component -1: Provide Discordant Test Results</b>				
	<b>Not Achieved</b>	<b>Partially Achieved</b>	<b>Well Achieved</b>	<b>Comment</b>
Inform the couple that their results are available				
State that the couple's test results are not the same/shared				
Provide a simple summary of the				

couple's results – one test results are positive, indicating the one is infected and the other is Negative or not infected				
Allow the couple to absorb the meaning of their results				
Inquire as to the couple's understanding of their results				
Encourage mutual support and avert blame				
<b>Component 2: Discuss Coping and Mutual Support</b>				
Invite both partners to express their feelings and concerns				
Validate and normalize the couple's feelings and acknowledge the challenges of dealing with a positive result				
Inquire as to how the couple could best support each other				
Recall couple's strengths and convey optimism that the couple will be able to cope and adjust to living with HIV				
Address the couple's immediate concerns				
<b>Component -3: Discuss Positive Living and HIV Care and Treatment</b>				
Discuss positive living.				
Address the need for preventive health care. <ul style="list-style-type: none"> <li>◆ Encourage immediate visit to the Care and treatment clinic/ ART</li> </ul>				

Dispel myths about treatment eligibility				
Encourage the couple to access appropriate care and treatment services.				
Provide needed referrals to the Care and treatment clinic/ART and other services.				
Identify and problem-solve obstacles.				
Discuss with the couple the need to live a healthy lifestyle. Discuss things that they can do right away to keep healthy.				
Discuss the importance of having safe drinking water to prevent diarrhea.				
Inform the couple about where to get more information or obtain supplies.				
Discuss the importance of using bed nets to prevent malaria (when applicable).				
Inform couple about where to get more information or obtain supplies.				
Discuss the importance of good nutrition.				
Inform couple about where to get more information.				
<b>Component -4: Discuss Risk Reduction</b>				
Discuss the importance of being faithful and not having sex with outside partners.				

Inform couple of the need to protect partners if they choose to have sex outside their relationship.				
Provide condom demonstration.				
<b>Component -5: Discuss about Children, Family Planning and PMTCT Options</b>				
Discuss the issue of HIV testing of children				
Revisit the couple's intentions concerning having children.				
Discuss the couple's reproductive options				
Prevent unintended pregnancies – family planning – dual contraception				
Limit the number of children				
When pregnant access antenatal and PMTCT services				
Describe PMTCT programs and services and identify where the couple can access services.				
Address the couple's questions and concerns regarding PMTCT services.				
Provide needed referrals.				
Family planning				
ANC clinics (if woman is pregnant)				
MCH clinic (if woman has young children and/or if he is breastfeeding)				

**Component -6: Discuss Disclosure and Getting Support**

Explain the benefits for the couple to disclose their HIV status to others.				
Explore the couple's feelings about sharing their results with a trusted friend, relative, or clergy.				
Discuss disclosure basics.				
Reinforce that the decision to disclose is mutual.				
Explore the possibility of participating in a support group and additional counselling sessions.				
Answer remaining questions and provide support.				

**Module Four**  
**Provider Initiated Testing**  
**and Counseling**



## **CHAPTER1: PROVIDER-INITIATED HIV TESTING AND COUNSELING FOR ADULTS**

Learning objectives:

By the end of this session the participants will be able to:

- ◆ Perform initial provider-client encounter
- ◆ Understand HIV risk screening tool utilization and risk-based testing
- ◆ Provide HIV negative test results
- ◆ Provide HIV positive test results

### CONTENTS

Component 1: Introduce the Topic of HIV and inform client of the need to test for HIV

Component 2: Provider recommends and offers HIV test

Component 3A: If the Patient Refuses the Test

Component 3B: Patient Agrees to an HIV Test

Component 4: Providing HIV test result to the patient: Negative result

Component 5: Provide Prevention Messages for HIV-negative

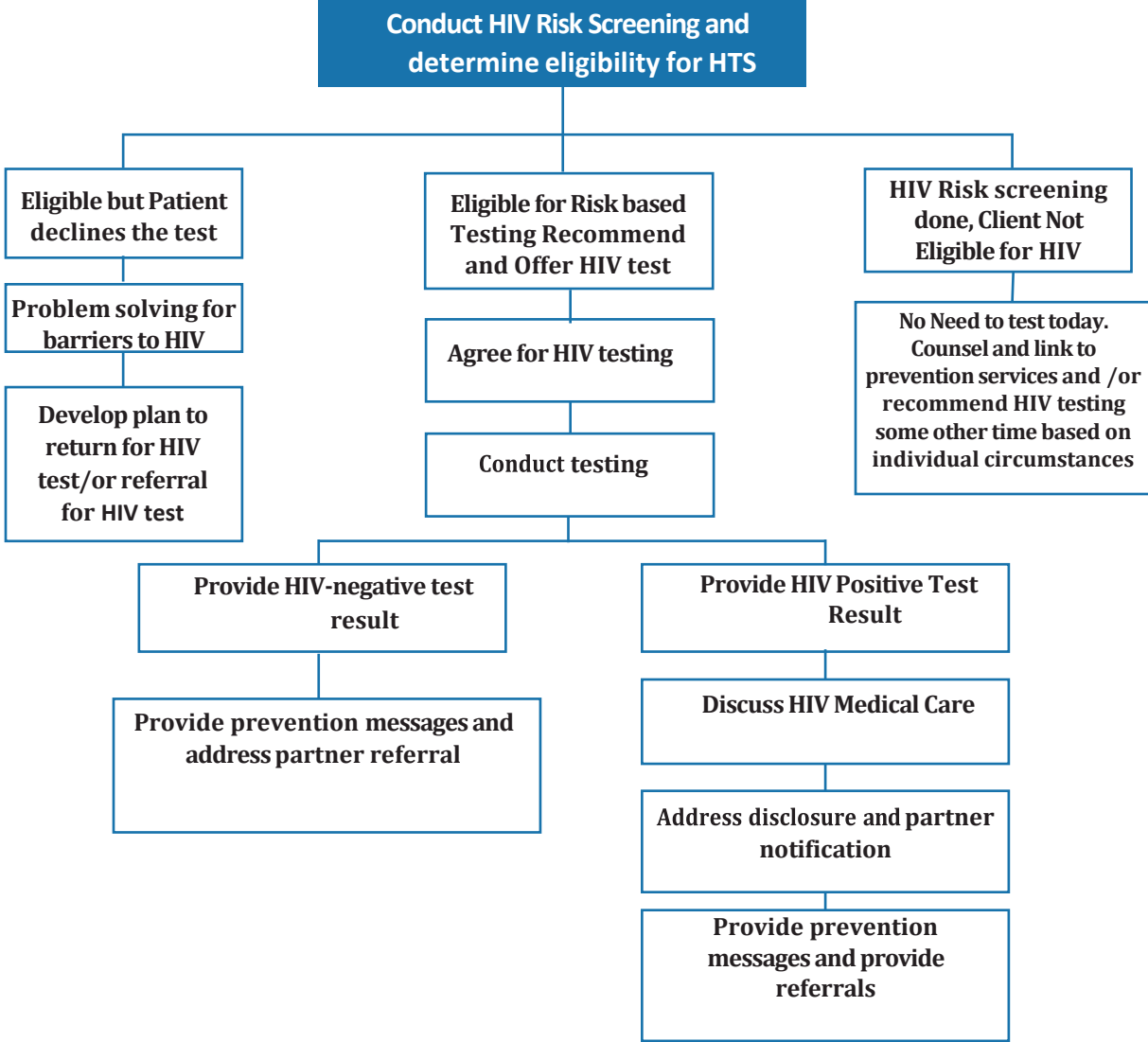
Component 6: Providing HIV test result to the patient: Positive result

Component 7: Discuss medical care and provide HIV clinical care recommendations

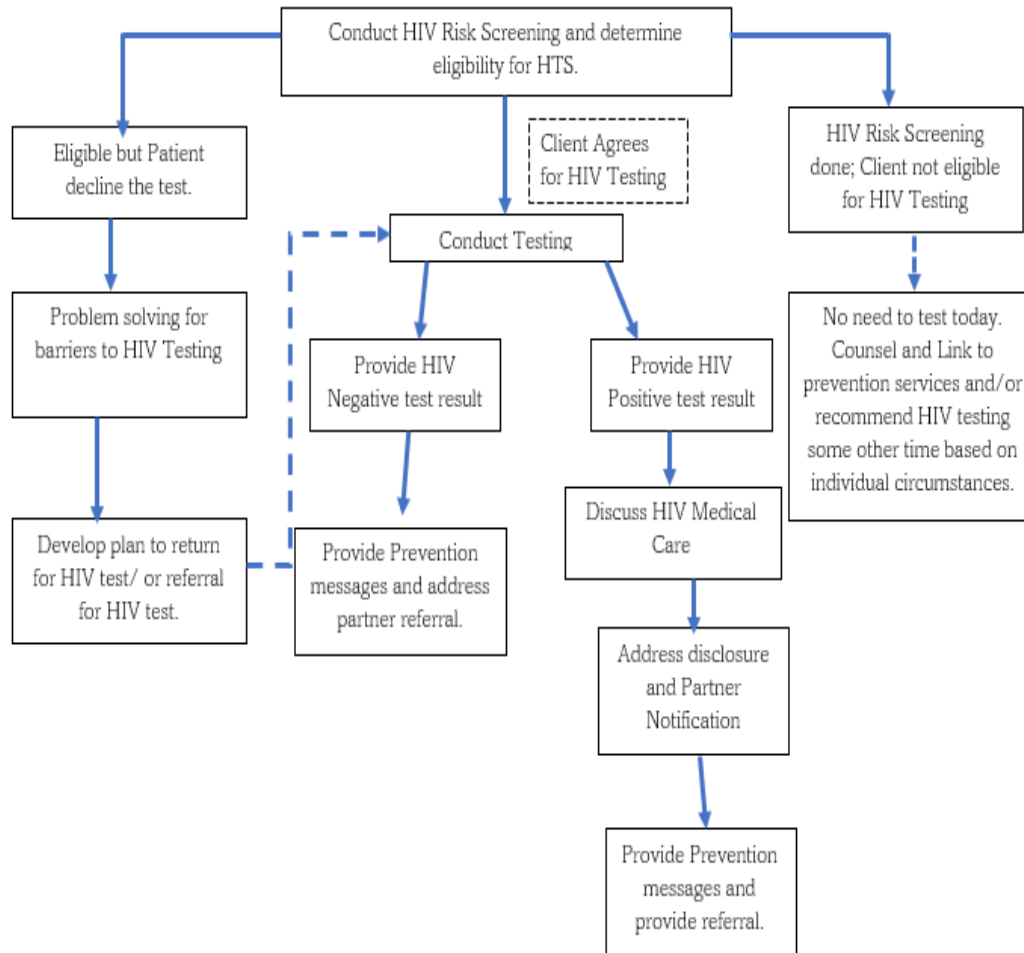
Component 8: Address assisted disclosure, partner notification and referral

Component 9: Please refer provide preventive message and referral on component 5

**RISK BASED PROVIDER-INITIATED HIV TESTING AND COUNSELING PROTOCOL FOR ADULTS**



**RISK BASED PROVIDER INITIATED HIV TESTING AND COUNSELING PROTOCOL FOR ADULTS**



*Figure: PITC Adult Protocol*

**INITIAL PROVIDER-CLIENT ENCOUNTER**

The Provider’s Initial Encounter with the Patient

All Eligible patients should undergo testing unless they refuse. They have the right to refuse. Testing is not mandatory.

The best time to talk to new patients about the HIV test is usually after the provider discusses the patient's current condition.

In the first part of the script, you will help patients understand:

- ◆ That people in the community may have HIV infection.
- ◆ That some people admitted to the hospital may have HIV infection
- ◆ The importance of treatment for HIV-infected patients

Component 1: Introduce the Topic of HIV and inform client of the need to test for HIV

Once you have introduced the topic of HIV and explained the importance of knowing one's HIV status, you should tell the patient;

- ◆ It is recommended that all eligible patients be tested for HIV.
- ◆ The patient will be tested today if he is willing to be tested. Unless he or she refuses.
- ◆ The patient will receive the result of their HIV test today.

Once the provider introduces the topic of HIV the provider should conduct risk assessment using HRST. HIV risk screening tool is a tool, with a standard set of questions, used to screen high risk clients for HIV testing.

HIV Risk screening should be done to optimize HIV case finding through the PITC modality. HIV risk screening tool enables service providers to identify high risk clients for HIV. It gives opportunity for targeted HIV testing and enhance case finding.

HRST helps to determine a client's HIV risk and whether the client is eligible for HIV testing or not based on the below category:

- ◆ Client's HIV status (is the client a known HIV positive case or not?)
- ◆ HIV risk behavior (practicing unprotected sex, having concurrent multiple sexual partners, etc.)
- ◆ Clinical symptoms or signs of HIV
- ◆ Occupational risk
- ◆ Marital risk

HRST reduces over testing, improves case finding and subsequently increase yield. Risk screening tool helps to identify clients who need to be tested, maximize HIV case detection and increase efficient utilization of resources including RTKs. In our setup, risk screening tool can be applied at all service delivery points with the exception of first ANC/labor/postpartum visit, high risk pregnant women, and VCT clinics. (Refer annex). Maintaining the privacy of the client and building rapport and trust will have beneficial

effect for effective risk screening to optimize PITC and targeted testing.

#### Component 2: Provider recommends and offers HIV test

Providers should not ask the patients directly if they want to be tested. Instead, they should use the recommended script, “For these reasons, we advise that all target patients/clients be tested for HIV. “HIV testing is among the services we provide in this facility and I advise you to be tested today”

“Opt out” approaches.

Patients have the right to refuse the test. But the primary task of the provider is to help the patient understand that knowing his/ her HIV status will help for better health care service provision.

#### Component 3A: If the Patient Refuses the Test

Explain to the patient that knowing the complete medical condition of the patient including HIV status determination will help the providers to give optimal health care service. If the client comes to the clinic with HIV-related disease or symptoms of HIV, explain to them that they are eligible for HIV test. Ask patients if they have additional questions or concerns that you can address for them.

Acknowledge patients’ fears or concerns.

However, you should focus on reminding patients of the benefits of knowing their HIV status, including:

- ◆ They can be treated for their possible HIV infection.
- ◆ Treatment for HIV will make the treatment for other illnesses more effective.

If the patients say they have had a recent negative HIV test, encourage them to repeat the test so the clinic will have a record of it.

If patients continue to refuse, repeat the reasons to be tested and give them the following option: You can give patients a referral to another HIV testing site if they do not want to be tested in the clinic.

#### Component 3B: Patient Agrees to an HIV Test

- ◆ Explain the procedure of the HIV test.
  1. The HIV test will be done in the clinic by a trained health care provider.
  2. A blood sample may be sent to the lab unit to be tested.
  3. The patient will go to the lab unit, give blood sample and get tested.
- ◆ To determine the HIV test result, a nationally approved testing algorithm of 3 different test kits will be used. To declare a positive result, one must pass through all the 3 test

kits and procedures. (Refer Annex of testing algorithm)

#### Component 4: PROVIDING HIV TEST RESULT TO THE PATIENT: NEGATIVE RESULT

##### Inform Patient of the Negative HIV Test Result

Once you have finished testing the blood or the lab has given you the result of the patient's HIV test, you will give the result to the patient.

When giving the patient an HIV-negative result, there are two important issues you need to discuss:

- ◆ Repeat testing and prevention.
- ◆ First you will tell the patient that the test result is negative; this means that the test did not detect HIV in the patient's blood. At this point, you should pause for a moment to let the patient absorb what you have said.
- ◆ It is very important that you inform your HIV-negative patients about HIV prevention messages.

#### Component 5: Provide Prevention Messages for HIV-negative

Partner testing: The patient should ask his or her partner to be tested for HIV. It is possible that the patient's sex partner is positive even though the patient is negative. The Sexual partner/s of HIV positive client should be tested to know their HIV test status

**If one partner in a couple is negative and the other is positive, we say the couple is discordant.**

Being faithful: If the patient's partner does not have HIV, both partners can protect each other from getting HIV by being faithful and not having any other partners.

Abstaining from sex/use condom: Its recommended to abstain until the partner knows his/her status. If not use condom properly and consistently

Using condoms: Consistent and appropriate use of condom protect the transmission of HIV from one partner to another. It also helps prevent transmission of a different strain of HIV incase both partners are tested Positive.

#### Component6: PROVIDING HIV TEST RESULT TO THE PATIENT: POSITIVE RESULT

##### Inform the Patient of the Positive HIV Test Result

Reminder;

- ◆ You must remember to focus on their understanding the situation while disclosing a positive result.
- ◆ You should acknowledge that these results may be difficult to hear, but express confidence in their ability to adjust and cope.
- ◆ You should ask if there is someone, they can talk to..

If your clinic has an on-site counsellor offer them the opportunity to talk with that person. If not, you will give them information about support from organizations in the community.

- ◆ You will give the patient a referral to the HIV care clinic. If you are working in an in-patient ward at a health facility that has an HIV care clinic on-site, you will try to arrange for a HIV care clinic counsellor to come to the ward and meet with your patient for additional supportive counselling and to talk more specifically about treatment options.
- ◆ You will advise the patient that if she (or a male patient's partner) is pregnant or planning to get pregnant that they should consult the health care provider at the HIV care clinic so that they can talk about how to protect the unborn child from HIV.

Confidentiality is particularly important at this time. Patients will be very concerned about others knowing about their HIV status, and they will need time to figure out for whom to disclose and how to manage their situation. You can help in two ways:

1. Ensure clients that their medical information is secure, and no one will know their result unless they ask to tell them
2. Advise the patient to keep their referral form in a private place until they take it to the HIV care clinic.

#### Prevention Messages for HIV-positive Patients

Finally, it is very important to talk with the patient about preventing transmission of HIV to the patient's partner or partners and preventing the patient from getting other STIs and/or re-infection with different strains of HIV.

It will be important that you make sure the patient understands that HIV can be spread through sex and that his or her partner may not have the same HIV status. The prevention messages for HIV- positive patients are similar to those for HIV-negative patients. (See Above)

#### Component 7: Discuss medical care and provide HIV clinical care recommendations

Linkage to HIV treatment, care, support and other relevant services is the primary responsibility of HTS testers and providers. The provider should inform the client that HIV clinical care is needed to maintain their health. The provider should ensure that clients are

linked to ART or refer the client to HIV care and treatment providing facility, as early as possible (for early ART initiation).

The provider should also assess if there are additional HIV cares and treatment needs of the client, if the client and his/her partner are pregnant or planning to get pregnant. In this case, the provider should inform the client about protecting the unborn child from HIV infection and link/refer to PMTCT services.

Component 8: Address assisted disclosure, partner notification and referral

Please refer to Assisted Disclosure or Partner Notification Service and Referral in VCT (component 11).

Component 9: Provide preventive message and referral

Please refer provide preventive message and referral on component 5 above in the VCT, HIV negative section



## **CHAPTER 2: PROVIDER-INITIATED HIV TESTING AND COUNSELING FOR INFANTS, CHILDREN AND ADOLESCENTS**

Learning objectives: By the end of this session the participants will be able to:

- ◆ Describe the different approaches needed for testing infants, children, and adolescents.
- ◆ Utilize recommended counseling scripts for the different target groups
- ◆ Describe the significance of HIV antibody-based test results in infants under 18 months of age
- ◆ Describe HIV risk screening tool utilization and risk-based testing
- ◆ Conduct Pediatric PITC using cue card.
- ◆ Address disclosure issues related to the HIV status of children.

### **CONTENTS**

- ◆ Rationale for testing infants, children and adolescents
- ◆ PITC Protocol for Pediatric clients
- ◆ HIV Risk screening tool for pediatric
- ◆ Testing of Adolescents
- ◆ Testing Infants and Children
- ◆ Disclosing Children their HIV Status

### **RATIONALE FOR TESTING INFANTS, CHILDREN AND ADOLESCENTS**

WHY DIFFERENT APPROACH, IF THE PATIENT IS AN INFANT, CHILD OR ADOLESCENT?

Why Different Approach for Children

If your patient is an infant, child or adolescent, you will need to contextualize what you say and do in this situation. For example:

Diagnosis of HIV in young children less than 18 months of age presents unique challenges

- ◆ If young children test HIV-positive, it is very likely that their mothers are also infected and Need to be tested.
- ◆ Children and adolescents below the age of 15, unless they are “mature minors” between the age of 13–15, are not responsible for making decisions about medical treatment or procedures for themselves; their parents or guardians will be responsible for refusing the test for their children.

Because issues related to HIV testing differ between young children and adults, this training discusses each of these age groups separately.

Introduce the Topic of HIV and inform the need to test for HIV to the parent or guardian.

The provider should introduce the topic of HIV and explain the importance of knowing a child's HIV status, you should tell the parent/guardian:

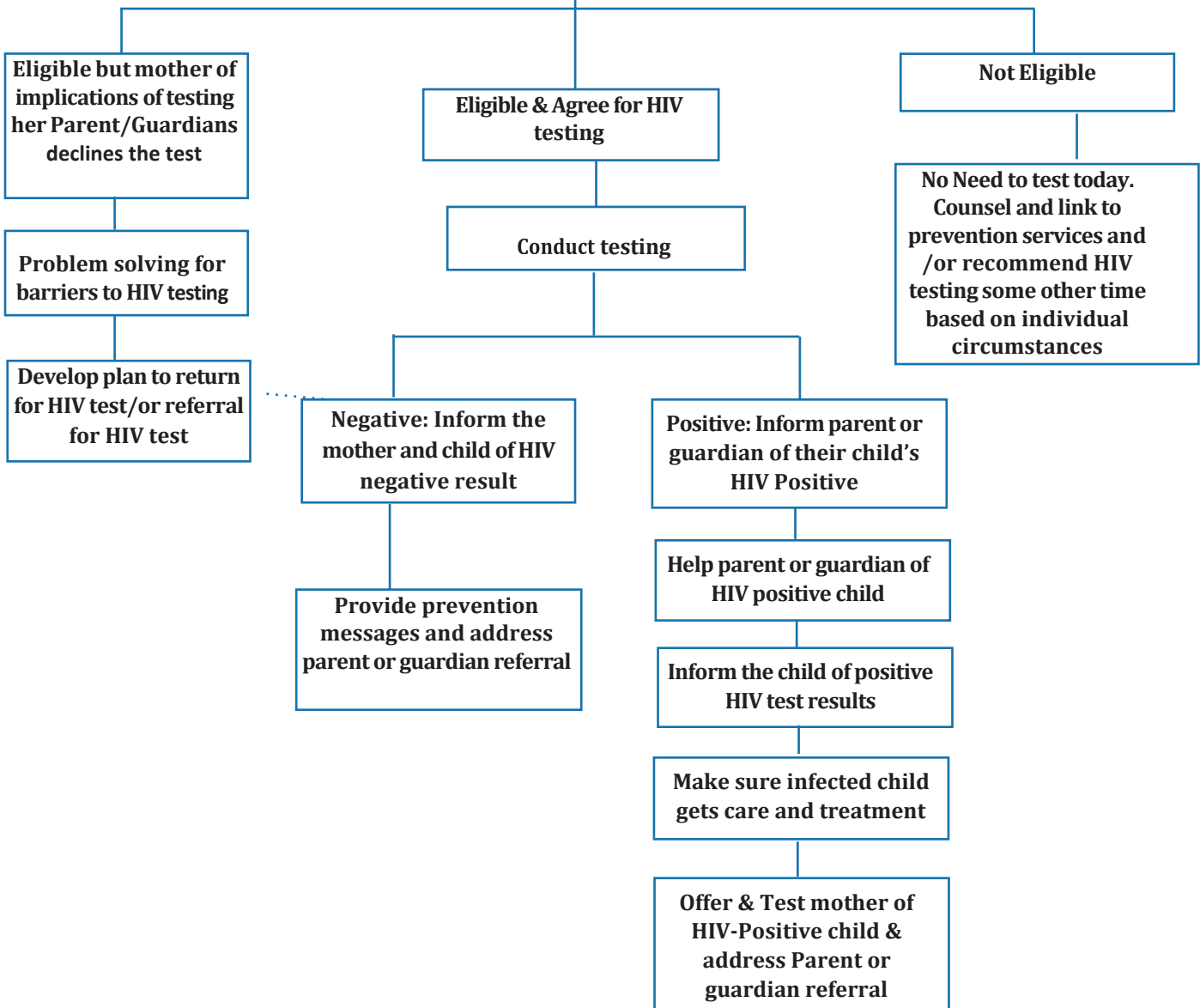
- ◆ It is recommended that all eligible children be tested for HIV.
- ◆ The child will be tested today if the parent/guardian is willing to get them tested.
- ◆ The test result of the child will be received today.
- ◆ After the provider introduces the topic of HIV the provider should conduct risk assessment using HRST. HIV risk screening tool is a tool, with a standard set of questions, used to screen high risk clients for HIV testing. HIV risk screening tool (under 18 months and 18 months or older) enables service providers to identify high risk children. It gives opportunity for targeted HIV testing. HRST helps to determine a client's HIV risk and whether the client is eligible for HIV testing or not. The risk screening tool has 6 categories. These are: Mother's HIV status (HIV status unknown or known HIV positive?) [if the child <18 months]
- ◆ Child's HIV status [if unknown]
- ◆ Vulnerability assessment (Orphan, street children etc...)
- ◆ Clinical symptoms or signs of HIV
- ◆ Health status, growth status, history of repeated admission etc.
- ◆ Sexual activity status (for adolescents 10-14 years)

NB: HIV Risk Screening Tool (HRST) should be implemented for all individuals (children, adolescents, and adults) at service delivery units to minimize missed opportunities, improve HIV case detection and yield.

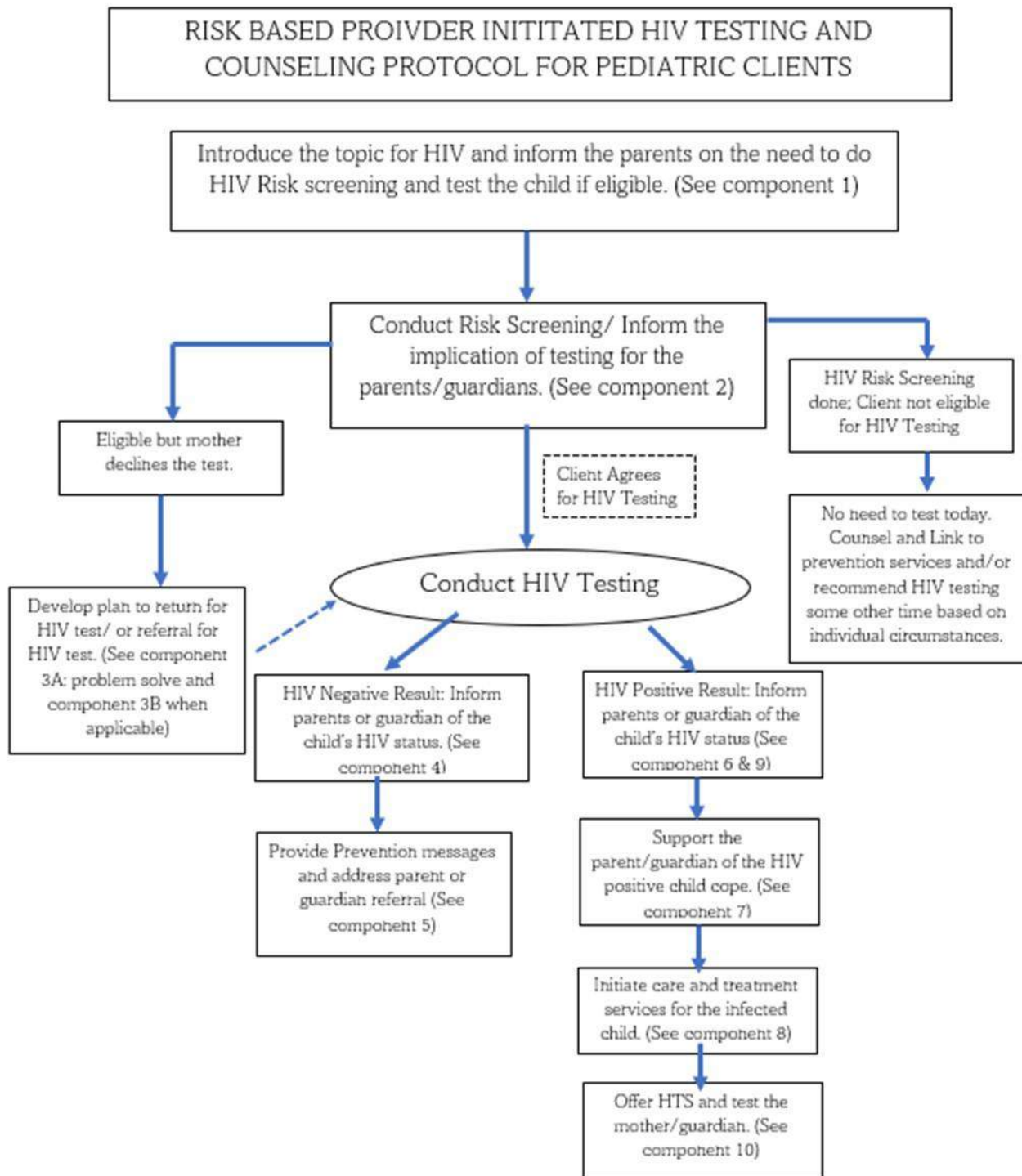
# HIV RISK SCREENING & PROVIDER-INITIATED HIV TESTING AND COUNSELING PROTOCOL

**Introduce the topic for HIV and inform the parent on the need to do HIV risk screening and Test the child if eligible**

**Conduct Risk screening/ inform the implication of testing for the parents/ guardians**



*Figure: PICT Protocol and Cue Card Components*



*Figure: PITC Pediatrics Protocol and Cue Card Components*

## TESTING OF ADOLESCENTS

As children become adolescents, many of them may become sexually active. Once this happens, adolescents can acquire HIV the same ways as adults, which is primarily through sexual contact with an infected partner. For this reason, the script for adolescents is similar to the script used for adults.

However, you may need to speak with the adolescent's parents or guardians about HIV testing recommendations or guidelines because it may be the parents' or guardians' responsibility to make decisions regarding testing for the adolescent. Let's talk about this situation.

At What Age Adolescents Legally Responsible for Their Own Health Care Decisions?

In Ethiopia, the legal age at which an adolescent may be considered as an adult is 18.

1. However, adolescents 15 years and older are allowed to make their own decisions regarding HIV testing.
2. Adolescents, aged 13–15, who are married, pregnant, commercial sex workers, street children, heads of households or sexually active are referred to as emancipated or mature minors.

For Adolescents 15 Years of Age or Older

Adolescents who meet these criteria also do not need parental permission for HIV testing and counseling but can make this decision on their own. In this case, use the same script as you are using for adults.

Involving the Under-Age Adolescent

Adolescents younger than the age of 15 must have permission from their parents or caregivers to undergo HIV testing, unless they are considered independent from their parents/caregivers.

If the under-age adolescent does not meet these criteria, you will need to speak to his/her parent or caregiver about the recommendations regarding HIV testing, in addition to discussing this with the adolescent.

Involving the Under-Age Adolescent in Health Care Decisions

- ◆ If the parent or guardian is not present, do not introduce PITC.
- ◆ If the adolescent patient requires parental consent for HIV testing, have the parent/guardian present when introducing PITC. Although the parent has responsibility for deciding whether HIV testing can be done, the adolescent should be able to voice an opinion about his/ her health care

Ideally, the adolescent should participate in the decision making about HIV testing even though the final decision rests with the parent.

For the adolescent to be able to participate fully, he/she must be educated along with the parents about the need for HIV testing as part of their diagnostic work-up, the benefits and so on. Being active participants in their own care may support the adolescents' better decision making in the future. In addition, open communication may build trust between the adolescent and the health care provider, which may lead to the adolescent patient's better adherence to future treatment.

For these reasons, it is better to involve both the parent and adolescent in the PITC process. The script advises that you speak primarily to the adolescent while acknowledging the role of the parent.

It is best if the adolescent and parent can sit next to each other so you can look at both of them while you are talking.

You may want to explain to the parent first that you will be talking to the adolescent so that you do not seem disrespectful.

#### Why Parents Refuse

1. Parents may refuse because they think their child is not at risk or is too young. Acknowledge this, but remind the parents that it is recommended to test all patients with their son or daughter's condition, even if they are at low risk for HIV.

You could say something like, "We want to be absolutely sure about the HIV status of all our patients because this is very important for their health, particularly because there are several treatment options that are used to prevent other infections and treat HIV that were not available before."

2. Some parents may want to consult the other parent.

Acknowledge that this is not legally required. If the parent insists on getting permission, encourage the parent to bring the other parent in as soon as possible if your clinical judgment suggests that the adolescent patient needs a test immediately. If the adolescent patient's medical condition is not life-threatening, encourage the parent to bring the other parent along when the adolescent returns to the clinic.

3. The other important reason why parents refuse HIV testing for children is a fear that will indicate their HIV status as well.

## Why Adolescents Refuse

Reasons why adolescents may refuse HIV testing include:

- ◆ Being embarrassed
- ◆ Feeling guilty about sexual activity
- ◆ Fearful of needles
- ◆ Fear of incorrect test result
- ◆ Feeling unable to cope with the result.
- ◆ Worried about stigma/discrimination from peers and others in the community

Providers can reassure adolescents who are refusing a test by:

- ◆ Reassuring adolescents about the confidentiality of the result
- ◆ Asking parents' permission to speak to the adolescent alone.
- ◆ Reassuring adolescent that the needle pain is minimal.
- ◆ Ensuring availability of treatment for HIV and for preventing other infections

In the event that the HIV test is positive, you may encounter parents who are quite upset, or even crying. Some parents may be angry and disappointed in their adolescent. Adolescents are also likely to be upset and may feel ashamed. The provider should understand their reactions are expected and should try to console both the parents and adolescents before pursuing to the next step.

## Handling the Reactions of Parents and Adolescents

Providers can handle the reactions from parents and adolescents by:

- ◆ Reassuring adolescents and parents that this does not mean that their life is over. With treatment, HIV-positive persons can live long and lead productive lives.
- ◆ Reassuring the adolescents that while their parents may be visibly upset, their reaction is normal because they are worried about their children. Have the parents acknowledge that they will be supportive to the adolescent.
- ◆ Reassuring the parents that the HIV test does not indicate HOW a person got HIV only that they have the virus. Remind the parent that their support of their adolescent is critically important at this time.
- ◆ Reminding adolescents and parents that there are community resources that can help the family deal with the situation.

- ◆ Referring the adolescent and parent(s) to local support groups or youth friendly services that may be available in the community.

In rare cases, parents may abandon their adolescent or even throw him or her out of the home to live on the street; this happens especially when the parent is not around and the adolescent is accompanied by guardians.

It will be important to make sure that the adolescent knows that they can come to the clinic at any time to address concerns or questions.

## **TESTING OF INFANTS AND CHILDREN**

Children can acquire HIV from: infected mothers during pregnancy, labor and delivery; breastfeeding; blood transfusions with HIV-infected blood; HIV-contaminated medical injections or harmful traditional practices; and, on occasion, through sexual abuse.

The most common way that children get HIV is from their mothers during pregnancy, labor and delivery, or through breastfeeding. Thus, the mothers of children who have HIV should be tested for HIV.

If the mother tests HIV-positive, then the child became infected through exposure to the virus at some point during pregnancy, labor and delivery, or through breastfeeding.

If the mother is HIV-negative, the child most likely contracted HIV from a blood transfusion, breastfeeding from another HIV-positive woman (wet nursing), medical injection, harmful traditional practices, or sexual abuse.

### **Meaning of the HIV Test Results in Infants**

All HIV-infected mothers will pass their antibodies to their babies during pregnancy. Thus, all babies born to HIV-infected mothers will have antibodies and will test positive using the antibody test for several months since the HIV test kits that are being used detect HIV antibodies

Remember that not all babies born to an HIV-infected mother will become infected; this is true even if the mothers do not receive ARV treatment during pregnancy, labor or delivery.

In the event that the infant is sick or appears ill, and the antibody test is positive, it will be important for the health care provider to conduct other tests (DNA PCR) to define the status of HIV in the infant as soon as possible.

### **Counselling Parents and Children about PITC**



In giving the baby's result to the mother, you will need to be able to explain the meaning of a positive result.

Because parents make the decisions about health care for their children, you will be discussing the testing of the child with the parent/guardian.

You will also need to talk to the child who is being tested, but this must be done in a developmentally appropriate manner; this means that what we say and how we say it when talking to a three-year-old will be quite different from when we are talking to a 10-year-old.

### What Can Children Understand?

As with adolescents, some older children may be able to understand what you are saying to their parents about HIV testing and the results of their tests.

The age at which children are likely to be able to understand most of the words you are saying is probably around four to five years of age. Although children at this age may understand the words, they may not grasp the significance or meaning. However, younger children, while not understanding all your words, can be very good at reading your tone and feelings on a subject.

Children older than 4–5 years may understand more of the meaning of the words but lack the maturity to understand the significance of HIV testing and HIV test results.

Most adults will keep the HIV status of the child private to protect the child's confidentiality and to prevent discrimination.

Children may not understand the concepts of confidentiality or discrimination and may freely share their HIV-positive status, which can harm themselves and their family.

Regardless of the child's age, most children are keenly aware of the emotions and actions of the adults around them, particularly the parent.

### THE INITIAL PITC DISCUSSION

#### What Is the Process for Providing PITC to Paediatric Patients?

To facilitate the discussion with both the parent and the child, ideally you should first talk with the parent about the need for HIV testing without the child being present.

Children older than five years of age should be able to wait in a separate area of the clinic or the ward while the provider discusses PITC with the parent.

However, children five years of age and younger should not be left unattended. If the parent has come alone to the clinic and there is no responsible attendant, then the young children can remain with their parent during the PITC discussion, as they are not likely to understand or be interested in the discussion.

Young children will likely be reactive to the emotions of the adults in the room, particularly the parent. Parents may be upset when they are told their children need an HIV test.

#### TAKING THE BLOOD SAMPLE

If the parent agrees to an HIV test for his or her child, you may then bring the child into the exam room/area to discuss the need for drawing blood. Most children are afraid of pricks and needles, so you will need to reassure the child by telling him/her that his/her parent will be close by.

#### INFORMING THE PARENT OF THE CHILD'S RESULTS

Once the result is back, you will be discussing the child's HIV test result to the parent only, again without the child being present (if the child is 6–12 years). If the child's result is HIV-negative, you may have the child return to the exam room/area and reassure him/her that the blood tests were "normal." The parent may never have a reason to tell the child that he/she was tested for HIV.

If the child's test result is HIV-positive, you may need to give the parent some time to adjust before bringing the child back into the room. The parent may be upset when given the news that his/her child has been exposed to HIV or is HIV-positive. Thus, the provider should support the parent gain emotional control.

It will be the parent's responsibility to decide when to tell the child about his/her result. Providers should not tell children less than 12 years of age their HIV diagnosis unless specifically requested by the family.

#### DISCLOSING CHILDREN THEIR HIV STATUS

##### Informing Children of Their HIV-positive Results

Because telling a child about his/ her HIV status is likely to be very difficult for parents, assistance from trained counselors in the HIV clinic can be very helpful. Since HIV is a life-long infection, at some point (age) the child will need to know his/ her HIV-positive status. Although there is no exact "right" time to tell children, most parents and professionals feel that children need to know at least by 10–11 years or sooner if the child is very sick, requires a lot of medical care or ARVs, or is very curious about his or her condition. If the child asks questions about their illness, the responses should always be truthful and age- appropriate.

## How Should Children be informed of their HIV status?

In addition to using language and words that children of different ages will understand, we must also consider what information children need to know and the appropriate times and settings to share that information with.

It is important to note that telling a child about their HIV status is a process that does not need to be done immediately after testing but can be done over time. In general, an initial understanding between the health care provider and the parents about how and when to disclose a child's HIV status can be defined.

Settings where HIV testing occurs (out-patient departments, pediatric in-patient wards) may not be the best setting for disclosure. Usually, disclosure of a child's HIV status to the child will be done over time in the clinic where they receive their HIV care and treatment.

A good general rule is to respond truthfully to the questions a child may ask about their illness in an age-appropriate manner.

Children should be given information about issues that will affect their lives and should be able to voice their opinions. They need information and support to understand the things that are happening to them; this approach is important to minimize fear.

Children need to be told their diagnosis, but it is important to share information with them:

- ◆ In an age-appropriate manner,
- ◆ At the appropriate time
- ◆ In a supportive environment or setting where they can be emotionally reassured
- ◆ As part of a process that will begin in the clinic where they will receive HIV care and treatment

While parents have the responsibility to provide both information and support to their child, they may need the assistance from professionals in helping to know what to say and when to say it. Providers working in busy clinics or wards may have limited time to provide counseling to parents. It is important to keep this in mind as we consider how best to provide PITC to our pediatric patients.

Within the context of PITC, the information that is shared with children during the initial encounter is best limited to inform them that they need a blood test because you are trying to find out why they are sick. If the child tests HIV-negative, they can simply be told that the blood test was "normal" or "okay."

Parents can decide when and if they want to tell the child that they were tested for HIV and found to be negative. If the child asks specifically about his/her HIV or other test results, answer them simply and truthfully.

### What Information Should Children be given About Their HIV Status?

It is suggested that providers limit the information given to young children about testing because they can easily misunderstand what you are saying about HIV. Many children will not be HIV-infected, so providers do not want to cause unnecessary emotional distress.

The situation of a child who tests positive is more difficult. In a busy clinic, where the parent is first learning the child's HIV diagnosis, is not the appropriate time or setting to properly inform a child about his/her HIV status.

The parent needs the time to adjust to this information before he/she is able to properly inform the child and provide the necessary support. The parent may also want time to discuss the diagnosis with the other parent or family members for support or guidance.

The child who tests HIV-positive can be informed that the blood test showed they have a germ in the body, and that the parent will be taking the child to another clinic where he/she will receive special care and treatment. When the parents and the HIV-infected child are followed in the HIV clinic, the issue of when to inform the child of their HIV diagnosis can be discussed. Some parents may want to inform their children within the setting of the home. Others may need assistance from the providers or counselors.

Since you will provide acute medical care and HIV diagnoses, you will likely not be the health care provider responsible for in-depth family counseling. Parents will be able to access supportive counseling for themselves and their children at the HIV clinic.

### Advantages of Telling Children Their HIV Diagnosis

Some advantages to telling children their HIV diagnosis include:

- ◆ To help children cope with their illness, addressing their fears, concerns and questions in an honest and supportive manner, and allowing them to participate in support groups or other coping activities.
- ◆ To facilitate involvement of children in their care (preventive therapy and ARVs), especially the issue of adherence.

If children are not told about their HIV status, they may be more anxious and depressed about their illness. And if children are not told the truth, they may become angry and resentful. They may be relieved to find out the cause of their illness, even if it is HIV. Children also need to know their HIV status as they may become sexually active adolescents. It is imperative that they know how to prevent spreading HIV to others.

Issues to consider during disclosure of HIV diagnosis to children and adolescents:  
Inadvertent disclosure to the parents etc

- ◆ Emotional

#### Disadvantages of Telling Children Their HIV Diagnosis

Some disadvantages to telling the children about their HIV diagnosis include:

- ◆ Children may not fully understand the situation and become emotionally distressed.
- ◆ Children may reveal their status without realizing the possible negative consequences. Although most children will be told about their HIV diagnosis at the HIV care clinic, it might still be beneficial for us to think about children's feelings during this time.

## CHAPTER 3: SOCIAL NETWORK STRATEGY (SNS)

**Chapter objective:** To build the capacity of HCWs on social network strategy.

### **Learning activities:**

- ◆ Define social network strategy.
- ◆ Describe each Phases of SNS
- ◆ Describe the implementation approach.
- ◆ Describe recruiter coaching guide

### **Content:**

- ◆ Introduction and rationale to SNS
- ◆ Implementation approach and phases of SNS
- ◆ Recruiter coaching guide

### **Introduction**

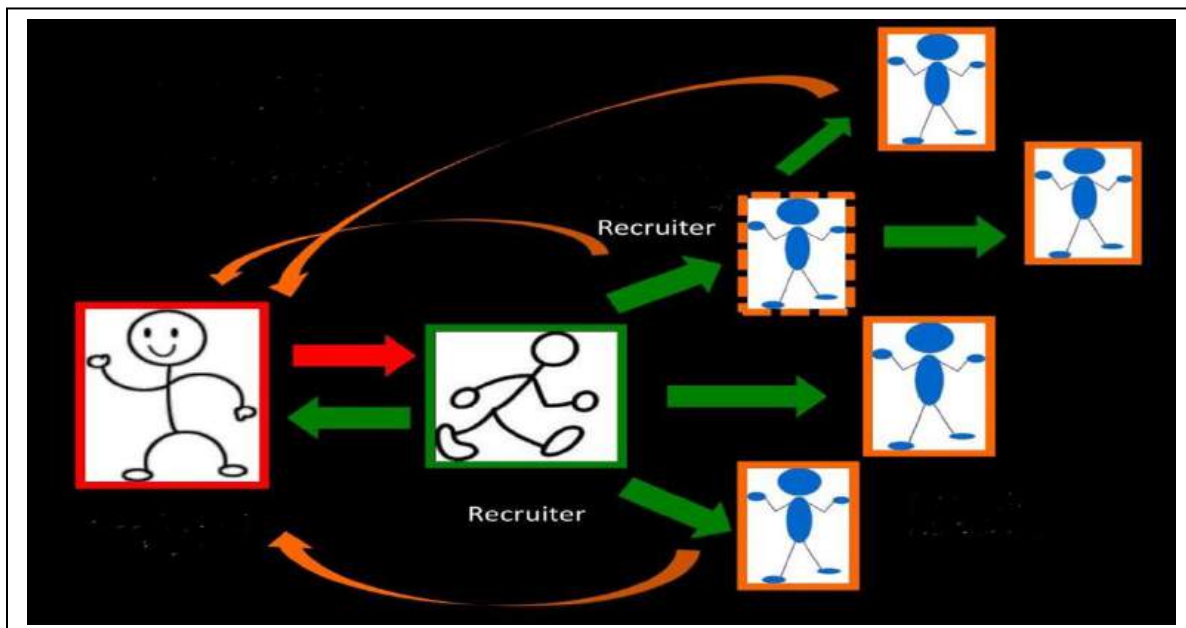
SNS is a peer-driven recruitment strategy for reaching and providing HIV counseling, testing, and referral services (HTS) to persons who are unaware of their HIV infection by using social network connections to locate individuals at the highest risk for HIV. The strategy is founded on the notion that people are connected to one another in broad social networks and that infectious diseases frequently spread across these networks. Although similar in some aspects, ICT and risk reduction counselling are not intended to be replaced by SNS. This strategy works by regularly identifying newly diagnosed and known HIV positives and high-risk HIV negative recruiters and offering HIV testing to social network members.

SNS can be very helpful in identifying KPs and other people at risk for HIV who do not have easy access to HIV testing, under the fundamental premise that similar risk behaviors for HIV are shared by individuals in the same social network. Messages about HIV testing from someone they know and trust are more likely to be received favorably by people.

### **Implementation approach and phases of SNS**

SNS use a strategy to enlist HIV-positive and high-risk HIV-negative persons (recruiters) to identify individuals from their social network for HTS.

Pic.1: Recruitment approaches



## Four Phases of SNS

SNS is implemented in four phases.

- ◆ Identify initial recruiters/seed
- ◆ Instruct and coach recruiters
- ◆ Recruitment of network members
- ◆ Provide HTS to network members & invite them to become a recruiters as needed

### Phase 1: Identify Initial Recruiters (Seeds).

The first phase of SNS implementation is to identify initial recruiters (seeds) to start the recruitment process. Selected seed need to be HIV positive and/or high-risk HIV negative who are willing to refer network members to HTS, comfortable talking about HIV and knowledgeable about HTS and testing locations.

Generally, there are two methods of finding effective seeds:

- ◆ Service providers can identify a newly diagnosed person (or high-risk HIV-negative person) at an HTS location who might be a recruiter.
- ◆ Service providers can use a peer/outreach member to refer social network members who may not normally attend HTS facilities.

### Phase 2: Instruct and coach recruiters

The second phase is to instruct the recruiter on who to recruit and provide coaching on the best practices for recruitment. Instruction includes, brief orientation to SNS, explanation of their role as a recruiter that include written description of role, discussion about their social network and coaching on how to approach their peers for HTS.

### **Recruitment Instruction Steps**

Step 1: Identify people in your social networks who may be at risk of HIV infection.

Step 2: Consider if these network members may be interested in receiving an HIV test.

Step 3: You will receive referral to give to them to direct them to a friendly and confidential HIV testing location.

Step 4: Tell your network member that the results of his/her HIV test will never be shared with you.

Step 5: A friendly healthcare provider can be reached by the phone number for any questions about HIV testing location or about their test results.

Step: 6: Refer to the SNS Coaching Guide for detailed coaching techniques to improve recruitment.

### **Phase 3: Recruitment of Network Members**

Phase 3 is the recruitment of network members by the recruiter. The recruitment networks that are created with SNS can be visualized in schematics that help show the success, or lack thereof, of the current SNS strategy.

Network members should present referral form upon testing.

### **Phase 4: Provide HTS to network members & invite them to become recruiters as needed**

The fourth and final phase involves testing network members and offering them the opportunity to recruit members of their network for HTS. This phase includes conducting HIV testing, if negative, offer HIV counseling and prevention services as indicated (e.g. condoms, risk reduction counseling, PrEP, etc.) and if positive, linking to HIV care and treatment is very important. Consequently, HIV positive and high-risk HIV negatives members should get an opportunity to recruit their social network members for HTS.

## **Recruiter Coaching Guide**



The coaching guide have major 4 components which is used by service provider to coach selected recruiters.

- A. Introduce the coaching Session
- B. Identify network members
- C. Develop a plan
- D. Summarize and close your plan with the recruiter

### **A. Introduce the Coaching Session**

What is your understanding of what I am asking you to do?

Let's talk about confidentiality. None of the information you have told me will be shared with any other person. The notes I have taken will be kept in a locked file cabinet and will be used only as a reminder on what the plan was for each person.

### **B. Identify Network Members**

- ◆ Next I would like for us to talk about someone you know who you think should test for HIV and who you would be willing to have a conversation with.
- ◆ What would you like to call this person? You don't have to say their name.
- ◆ How would you describe your relationship to this person?
- ◆ Please describe this person. (If necessary to assist with coaching, probe to get information on age, gender, etc.)
- ◆ Why do you think this person could be at risk for HIV?
- ◆ Do you believe this person has ever tested for HIV before?

### **C. Develop a Plan**

- ◆ When and where would you bring up the subject of HIV testing?
- ◆ How would you bring up the subject of testing for HIV with this person? What will you say about it?
- ◆ How do you think this person would react to you bringing up the subject of testing for HIV?
- ◆ How would you respond to those reactions?

- ◆ Do you think there is any possibility this person would react in a violent way?
- ◆ Do you think the person will ask you about your HIV status? If so, how would you respond?
- ◆ How would you disclose your HIV status? How comfortable are you with disclosing your status and your decision to test? (Discuss approaches for disclosing their own HIV status their network members, should they choose to do so.)
- ◆ If you are not comfortable disclosing your status, how can you discuss (the importance of) testing without revealing your HIV test results/status? (Discuss approaches to raising the topic of HIV counseling, testing, and referral to network members without revealing their own status)
- ◆ Here are the locations where we can provide testing: [A, B, C]. Where do you think this person is most likely to test?
- ◆ Do you prefer to refer this person to testing (refer), come in with him/her (escort), or meet in an agreed upon location where testing can be provided (coordinate)?
- ◆ Let's talk about how to respond to any additional questions from network members about HIV transmission risks, available support services, confidentiality or privacy, or any other issues/questions your friends might have.

#### **D. Summarize and close your plan with the recruiter**

- ◆ Let me summarize your plan for your network members.
- ◆ Does anything about this plan make you uncomfortable?
- ◆ How confident do you feel that you can carry out this plan with your friend/relative/associate?
- ◆ I will want to follow up with you to see how things went. Let's talk about our plan for that follow up.
- ◆ What final questions or concerns do you have?

## Chapter 4. HIV SELF TESTING

### OVERVIEW AND STRATEGIES OF HIVST

#### Learning activities

- ♦ Explain the rationale of HIVST.
- ♦ Explain the HIVST approaches.
- ♦ List the target population groups
- ♦ Describe the demand creation for HIVST
- ♦ Explain the QA of HIVST kit
- ♦ Short video of HIV self-test procedures
- ♦ In person demonstration of HIVST procedures by trainees

#### Content:

Introduction and rationale of HIVST

Approaches for HIV self-test distribution

Target population groups for HIVST kit distribution

Demand creation strategy for HIVST

#### Caregiver assisted HIVST in children 2-15 years old

Quality assurance of HIVST

Video Show/demonstration of HIVST procedures

In person demonstration/performance of ORA quick HIV self-test

#### Introduction

HIV Self-Test (HIVST) is an innovative approach to deliver HIV testing services and contribute more for the national case finding efforts. HIV self-testing should be offered as an additional approach to HIV testing services. As with all approaches to HIV testing, HIVST should always be voluntary, not coercive, or mandatory([WHO, 2016](#)). It is one of the best approaches helps increase knowledge of HIV status and has the public health benefits that may significantly reduce the risk of HIV transmission.

## **Rationale**

In Ethiopia, present trend indicates that there is still gap in fully accessing key and priority populations by the existing HTS. To close the testing gap and reach high-risk individuals not accessing conventional HTS, HIVST is one of the recommended innovative case detection strategies which is effective in identifying HIV infection among key and priority populations to bridge the HIV testing gap of the first 95%.

## **Definition of HIVST**

- ◆ A process, in which a person collects his or her own specimen (oral fluid/blood), performs HIV test and interprets the result, often in a private setting, either alone or with someone he or she trusts.
- ◆ It is an innovative approach that provides an opportunity for people to test themselves discreetly and conveniently, thereby empowering those who may not otherwise test, particularly among key and priority populations to know their HIV status.

### **4.1. APPROACHES FOR HIV SELF TESTING**

HIVST can be delivered through two distinct approaches. The approaches vary in terms of the level and type of support provided. Both approaches build public trust and mitigates issues related to stigma and discrimination.

#### **Standards and procedure**

##### **A. Directly assisted HIVST**

Refers to trained/oriented providers, or peers giving individuals an in-person demonstration before or during HIVST on how to perform the test and interpret the test result. HIVST must be conducted using the nationally approved HIV self-test kit(s). The kit(s) will include instructions in English and local language as well as pictorial diagrams to aid ease of use and correct interpretation of results. All HIVST kits distributed must also be accompanied with client education material. All service delivery points where HIV self test is conducted should display illustrations or instructions on HIVST procedures should a tester require further explanation or testing support. In addition, all outlets must have a separate, private space to perform the test. The assistant will provide pretest information, demonstration and interpretation of the result. If the HIVST test result is reactive, the assistant should link the self tester to conventional HIV testing for confirmation, where the approved national HIV testing algorithm is utilized. And the assistant will also follow

whether the confirmatory test is performed and the client is enrolled to ART if test result turns out to be positive. For individuals with non-reactive self-test results, the assistant should advise the self-tester to retest as per their risk to HIV infection as outlined in the national Comprehensive prevention, care and treatment guideline on repeat testing recommendations.

## **B. Unassisted HIVST**

Refers to when individuals self-test for HIV using only a self-test kit that includes manufacturer-provided instructions for use. As with all self-testing, users will be provided with links or contact details to access additional support, such as telephone hotlines or instructional videos.

The kit will include instructions in local languages and pictorial diagrams to aid simplicity of use and correct interpretation of result. It is recommended that all the unassisted HIVST kits distribution points be accompanied with client education material. All distribution points should display illustrations or instructions on HIVST procedures.

### **Both directly assisted and unassisted HIVST may include additional support tools:**

- ◆ Manufacturer’s instructions and brochures.
- ◆ Brief in-person demonstration (one-on one) before testing.
- ◆ Demonstration HIV Self-test video
- ◆ In-person assistance during procedure.
- ◆ 952 Hotline contacts for HIVST information.

## **TARGET POPULATIONS FOR HIVST KIT DISTRIBUTION**

HIV self-testing (HIVST) should be highly targeted to individuals and 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:

- ◆ Improve access for people with high HIV risk and vulnerability, identified as key and priority populations.
- ◆ 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.
- ◆ Improve testing coverage by integrating it into clinical services where testing is needed but not routinely accessed or where testing is poorly implemented.

## **Target populations for HIVST:**

- ◆ FSW and their partners,
- ◆ Sexual partners and children of HIV Positive patients
- ◆ Long distance truck drivers and their assistants
- ◆ Daily Laborer, mobile workers
- ◆ Widowed/ divorced/ remarried
- ◆ Partners of PMTCT/ANC clients
- ◆ Sexual partners of STI patients
- ◆ Prisoners

## **HIVST guiding principles and its benefit**

### Guiding Principles

- ◆ HIVST should adhere to the following WHO 5 Cs:
  - o Consent
  - Confidentiality
  - o Counseling
  - Correct test results and
  - Connection (linkage to prevention, care and treatment services)
- ◆ HIVST should always be voluntary, not coercive or mandatory
- ◆ Whether that coercion comes from a health-care provider or from a partner, family member, or any other person, Coerced or mandatory testing is never appropriate

### **4.1.1. DEMAND CREATION STRATEGY OF HIVST**

To create awareness and increase uptake of HIVST, advocacy and communication strategies should aim to emphasize:

- ◆ Correct usage of the self-test kits, and ensure correct interpretation of results and linkage to confirmatory testing for self test reactive results
- ◆ Demand creation should be tailored to high-risk target populations. It will be most successful when developed with communities in local setting.

- ◆ Demand creation will be conducted at health facility and community platforms. Clients should get adequate information to increase their knowledge and decision-making ability to test themselves, their peers, sexual partners, and children.
- ◆ Clear messages are needed to ensure that users understand what to do after a reactive self-test result, including where to go to access conventional HTS for confirmation of results, treatment, care, and other support. The messages can be delivered through:
  - One to one (health care providers, health extension professionals, peer educators, volunteers).
  - Print media (banners, poster, fliers)
  - Audio visual.

Integrated in the daily Health Education platform of health facilities.

- Networks of people living with HIV
- Community-based organizations
  
- Adapt /customize messaging in local languages to disseminate HIVST in children.

**NB:** Providers and users should be aware that HIVST is not recommended for people with a known HIV status, as this may lead to an incorrect self-test result.

List of target population	Distribution Channel	SDP from where kits are distributed and documentation and follow up is done.	Distribution Model	Distribution Strategies	Data source for reporting
FSW	Community based	DIC	Secondary distribution through FSWs to their peers	<ul style="list-style-type: none"> <li>- Oriented service providers will demonstrate the procedures of HIVST in person, using HIVST leaflet &amp; HIVST video and distribute HIVST kit for FSWs who visited facility to reach their peer FSWs who are not able to access health facilities.</li> <li>- Provide follow up support and encouragement to FSWs to ensure their peers are self-tested by the kit and accessed different service based on their test result.</li> <li>- Document their test result and the service they accessed on community distribution logbook.</li> </ul>	Community distribution logbook
FSW and their sex partners	Community based	Hot spot / venue based	Secondary distribution through FSWs to their peers and sex partners	<ul style="list-style-type: none"> <li>- Oriented peer navigators/volunteers/peer educators/ service providers will collect HIVST kit from health facilities.</li> <li>- Peer navigators/volunteers/peer educators/ service providers will demonstrate the procedures of HIVST and distribute for those FSWs who not able access health facilities for HIV testing with Information card.</li> <li>- Transcribe distributed HIVST kit for target clients to facility HIVST register once per week.</li> <li>- Provide follow up support and encouragement to ensure they are self-tested by the kit and accessed different service based on their test result and document their test result and accessed service on</li> </ul>	Customized PNs /Community HIVST distribution register



				both PN register and facility HIVST register.	
FSW	Community based	Hot spot / venue based	Primary distribution through PNs, PE to FSWs	<ul style="list-style-type: none"> <li>- Oriented peer navigators/volunteers/peer educators/ service providers will collect HIVST kits from health facilities</li> <li>- Peer navigators/volunteers/peer educators/ service providers will demonstrate the procedures of HIVST and distribute for those FSWs who prefer not to go to health facilities for HIV testing with an Information Card.</li> <li>- Transcribe distributed HIVST kit for target clients to facility HIVST register once per week.</li> <li>- Provide follow-up support and encouragement to ensure they are self-tested by the kit and access different service based on their test result and document their test result and access service on both PN register and facility HIVST register.</li> </ul>	Customized PNs /Community HIVST distribution register
Widowed and Divorced	Community Based	Community level	Primary distribution through community health workers (peer educator)	<ul style="list-style-type: none"> <li>- Oriented community health worker will demonstrate the procedures of HIVST in person, using HIVST leaflet &amp; HIVST video and distribute HIVST kit for Widowed and Divorced at community level with Information card.</li> <li>- Community health worker follows up support and encouragement to widowed/Divorce as they are self-tested by the kit and accessed different service based on their test result</li> <li>- Document their test result and accessed service using community distribution logbook.</li> </ul>	Community distribution logbook
FSW	Facility based	KP Friendly clinic	Secondary distribution	<ul style="list-style-type: none"> <li>- Oriented service providers will demonstrate the procedures of HIVST in person, using HIVST leaflet &amp; HIVST video and</li> </ul>	Endorsed HIVST register

			through FSWs to their peers	<p>distribute HIVST kit for FSWs visited health facilities for other peer FSWs who are not able to access health facilities for HIV testing with Information card.</p> <ul style="list-style-type: none"> <li>- Provide follow up support and encouragement to FSWs to ensure their peers are self-tested by the kit and accessed different service based on their test result and document their test result and accessed service on facility HIVST register.</li> <li>- Conduct biweekly Facility level review and performance monitoring</li> </ul>	at KPP & OPD
FSW partners	Facility based	KP Friendly clinic	Secondary distribution through FSWs to their customers and “Baluka”	<ul style="list-style-type: none"> <li>- Oriented service providers will demonstrate the procedures of HIVST in person, using HIVST leaflet &amp; HIVST video and distribute HIVST kit for FSWs visited health facilities for their sex partners with Information card.</li> <li>- Provide follow up support and encouragement to FSWs to ensure their partners are self-tested by the kit and accessed different service based on their test result and document their test result and accessed service.</li> <li>- Conduct biweekly Facility level review and performance monitoring</li> </ul>	Endorsed HIVST register at KPP clinic
Sexual partners and networks of HIV positive index cases	Facility based	ART/PMTCT/KP friendly Clinic	Secondary distribution through index cases to their sexual partners and networks	<ul style="list-style-type: none"> <li>- Oriented service providers will demonstrate the procedures of HIVST in person, using HIVST leaflet &amp; HIVST video and distribute HIVST kit for index patients visited health facilities for their sex partners with Information card.</li> <li>- Provide follow up support and encouragement to Index to ensure their partners are self-tested by the kit and accessed different service based on their test result and document their test result and accessed service.</li> </ul>	Endorsed HIVST register at ART

				- Conduct biweekly Facility level review and performance monitoring	
Long distance truck drivers (LDTD) and their assistances	Facility based	OPDs, VCT, ART and others	Secondary distribution through LDTD patients from OPD to their other peers and sexual partners and who are (LDTD)	<ul style="list-style-type: none"> <li>- Oriented service providers at OPDs &amp; VCT clinic will demonstrate the procedures of HIVST in person, using HIVST leaflet &amp; HIVST video and distribute HIVST kit for LDTD visited health facilities for their sex partners and peers who are LDTD with Information card.</li> <li>- Provide follow up support and encouragement to LDTD to ensure their peers &amp; assistance are self-tested by the kit and accessed different service based on their test result and document their test result and accessed service.</li> <li>- Conduct biweekly Facility level review and performance monitoring</li> </ul>	Endorsed HIVST register at OPD
Workers in hot spot areas	Facility based	OPDs, VCT, ART clinic and others	Secondary distribution through Workers in hot spot areas patients from OPD to their peers (Workers in hot spot areas) and Partners (Workers in	<ul style="list-style-type: none"> <li>- Oriented service providers at OPDs will demonstrate the procedures of HIVST in person, using HIVST leaflet &amp; HIVST video and distribute HIVST kit for Workers in hot spot areas visited health facilities for their sex partners and peers who are Workers in hot spot areas with Information card.</li> <li>- Provide follow up support and encouragement to Workers in hot spot areas to ensure their peers/sexual partners who are Workers in hot spot areas are self-tested by the kit and accessed different service based on their test result and document their test result and accessed service.</li> <li>- Conduct biweekly Facility level review and performance monitoring</li> </ul>	Endorsed HIVST register at OPD

			hot spot areas)		
Workers in hot spot areas	Community based	Community level	Primary distribution through community health workers to Workers in hot spot areas (Volunteers)	<ul style="list-style-type: none"> <li>- Oriented community health worker will demonstrate the procedures of HIVST in person, using HIVST leaflet &amp; HIVST video and distribute HIVST kit for Workers in hot spot areas working at construction area with Information card.</li> <li>- Community health worker will provide follow up support and encouragement to Workers in hot spot areas to ensure that they are self-tested by the kit and accessed different service based on their test result</li> <li>- Document their test result and accessed service using community distribution logbook.</li> </ul>	Community distribution logbook
Partners of ANC clients	Facility based	MCH/ANC	Secondary distribution through ANC mothers to their sexual partners	<ul style="list-style-type: none"> <li>- Oriented PMTCT/ANC service providers will demonstrate the procedures HIVST in person, using HIVST leaflet &amp; HIVST video and distribute HIVST kit for all pregnant &amp; breast-feeding clients visited health facilities for their sex partners with Information card.</li> <li>- Provide follow up support and encouragement to ANC/BF women to ensure their partners are self-tested by the kit and accessed different service based on their test result and document their test result and accessed service.</li> <li>- Conduct biweekly Facility level review and performance monitoring</li> </ul>	Endorsed HIVST register at ANC/L&D & PNC/PMTCT
Sexual partners and peers of STI patients	Facility based	OPD/STI Standalone clinic	Secondary distribution through patients	<ul style="list-style-type: none"> <li>- Oriented service providers at OPDs will demonstrate the procedures of HIVST in person, using HIVST leaflet &amp; HIVST video and distribute HIVST kit for patients diagnosed with STI visited health facilities for their sex partners and peers who share same risk</li> </ul>	Endorsed National HIVST register

			<p>diagnosed with STI at OPD / STI standalone clinic to their sexual partners, networks, and at-risk peers,</p>	<p>behaviors with Information card.</p> <ul style="list-style-type: none"> <li>- Orientation training to providers on consistently offering HIVST to STI patients and their sexual partners who may not be tested through PITC modality at the SDP</li> <li>- Provide follow up support to STI diagnosed patients to ensure their sexual partners, peers are self-tested by the kit and accessed different service based on their test result and document their test result and accessed service.</li> <li>- Biweekly Facility level review and performance monitoring</li> </ul>	
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## Caregiver assisted HIVST in children 2-15 years old

Caregiver assisted HIVST for children 2-15 years implementation was found feasible and acceptable for testing children 2-15 years with improved pediatric case finding. Currently it is accepted as one of the modalities of pediatric HIV case detection nationally.

### Rationale:

- ◆ There is a need to bridge the gap in HIV testing for children if we are to reach the global targets for children in Ethiopia HIV program implementation.
- ◆ Barriers to HIV testing among children include fear of stigma and discrimination, parents' lack of knowledge of the need to test children for HIV, lack of transportation to bring children to facility for testing, inopportune service hours and long waiting times at health facilities.
- ◆ Parents and guardians are reluctant to take their children to health facilities because of fear of COVID-19 exposure.
- ◆ Provision of HIV-ST for index caregivers to test their children is an innovative strategy to overcome some of these barriers while complementing other testing strategies available at the HF therefore, HIV self-testing could address testing barriers through added privacy and parents /caregivers' control over other people's knowledge of their and their child's HIV status.

### Guiding Principle of HIVST in children

The guiding principles include:

- ◆ Informed Consent
  - *Mature minors (13-15 years old) who are married, pregnant, FSW, head of families or who are sexually active can give verbal consent by themselves for testing.*
- ◆ Confidentiality
- ◆ Pre-test information, posttest counseling, and referrals to appropriate services
- ◆ Respect for social and cultural dynamics in the community, family dynamics, norms, beliefs, values, and administrative structures.
- ◆ IPV/ Social Harm risk screening and AE monitoring.

### Who are Eligible?

- ◆ Biological children of PLHIV aged 2 to 15 years with unknown HIV status.
- ◆ Non-biological children 2-15 years of age whose biological mother is HIV-positive, deceased, or whose HIV status is unknown.
- ◆ Children 2-15 years of age who are siblings of CLHIV.
- ◆ Biological Children of FSW mother who is HIV-positive, deceased or HIV status is unknown, and aged b/n 2-15 years of age whose HIV status is unknown.

### Service Delivery Points

- ◆ Access to the service will be limited to index client testing (ICT) implementing service delivery outlets, such as ART and PMTCT clinics of the selected HFs.
- ◆ Other service delivery points, such as the under-five OPDs can identify eligible children and refer them to an ART or PMTCT clinic within the same health facility.

### **HIVST Kit Distribution Procedures**

The HIVST test kit will be distributed after a trained provider gives information on how to use the kit, interpret the result, and demonstrates use before giving it to the parent/guardian. When distributing HIVST kits to Parents/guardians the following issues need to be addressed with the caregiver.

- ◆ It should be shown that it is in the **best interest** of the child.
- ◆ Pre-test and posttest counselling Should be provided to the caregiver/ parent
- ◆ Psychosocial support services will be made available to Parents/guardians either face to face or via cell phones, depending on their preference.
- ◆ HIVST kits will be distributed for **each biologic children** with unknown HIV status
- ◆ They will be informed that all positive or indeterminate tests will be confirmed by finger prick blood test at the health facility as per national guidelines.
- ◆ Caregivers will also be given contact number of the health facility to ask if they have any concerns or questions during the testing process.
- ◆ All caregivers will receive follow-up phone call within one week of receiving the tests kits to verify that tests have been done and confirm results.
- ◆ Any caregiver who reports a reactive or indeterminate result will be asked to bring the child (ren) to the health facility for confirmatory testing.
- ◆ The guardians/ caregivers with a reactive child, will be provided follow up counseling and additional HIVST kits to the siblings of the child, if any.
- ◆ Based on the Parents/ caregiver's consent conventional test can be conducted at community testing points or approaches.

### **Facility Based Distribution Model:**

- ◆ Instructional leaflet in local language and video shall be shared with caregivers' that supports the use and interpretation of the results.

### **Use of Partner Violence Screening Tool: (Social harm risk screening) for the provision of HIVST among Children 2-15**

1. Has your partner ever hit, kicked, slapped, or otherwise physically hurt you?
2. Has your partner ever threatened to hurt you, your children, or someone close to you?
3. Has your partner ever forced you to do something sexually that made you feel uncomfortable?

4. Has your partner ever used “harassment”, “threat of imminent harm”, “intimidation” or “physical, mental, social or economic abuse” against you?
5. Do you think that taking a test kit home and/or performing the test on your child might result in your partner physically harming you or the child?

If the Parent/caretaker answers “yes”, “maybe” or “I don’t know” to any of the above questions, the client could be asked to bring the child to the facility to test the child. The Parent / caretaker and the provider will determine if a referral is warranted to gender-based violence (GBV)/IPV support services. If the Parent / caretaker answers “no” to all the above questions, they may take home the HIV Self-testing kit. Follow-up Assessment of the occurrence of adverse events following the distribution of HIV self – testing shall be conducted within 3 – 7 days after distributing the kit. The provider may ask the questions below.

- ◆ Did the child experience any harm from using the Ora-Quick screening kit? (Please specify)
- ◆ Did the parent / caretaker experience any adverse event because of using the kit? (Please specify).

### **Social Harm risk screening and ensuring the suitability of Parent / caregiver**

The provider should look for child abuse in history and physical examination and if there is any suspicion of child abuse the kit shall not be distributed to the parent/caregiver. Some of the signs of child abuse include, but are not limited to:

- ◆ Bruises,
  - ◆ Difficulty connecting with others
  - ◆ Avoiding a specific person or place
  - ◆ Difficulty walking or sitting,
  - ◆ Feeling of shame or guilt.
  - ◆ Disclosure of abuse by child
  - ◆ Exposure to family violence
- ♣ Job aids like HIVST SOP, social harm screening tool and Child friendly communication tools should be distributed and availed to all implementing sites.

### **Quality assurance of HIVST**



An effective Quality Assurance (QA) program is one that is integrated into routine practices in the country. This section aims to provide guidance on how to ensure the quality of HIV self-testing test kits and testing processes.

- ◆ Monitor the quality of HIVST and the various activities in the QA program
- ◆ Mentoring and supportive supervision need to be conducted at periodic interval to ensure the quality of HIVST implementation.
- ◆ HIVST support tools including how to conduct HIV self-test and results interpretation should be readily available to all clients.
- ◆ Adequate and locally translated clear instructions with pictorial illustrations on how to conduct self-testing should be provided with the test kits to ensure a person obtains the correct results.
- ◆ Clients should follow manufactures instructions in the test kits insert.
- ◆ All clients must also be aware of correct practices to minimize biosafety risks the need to confirm any reactive test results as per the national HIV testing algorithm.
- ◆ The safety, quality and performance of HIVST should be further verified upon delivery and before distribution to the target groups
- ◆ Each rapid SELF-testing device is equipped with an *“internal” control device that consists of a line* that appears next to the “C” in the device window when a valid result is obtained. This control verifies that enough sample was applied, and that the sample and reagent migrated through the device properly.
- ◆ Adequate orientation and demonstration should be given to the clients to verify the presence of control line irrespective the result.
- ◆ WHO recommends HIV self-testing requires self-testers with a reactive result to receive further testing with conventional testing algorithm by a trained provider to confirm the result.
- ◆ HIV self-testers receive clear communication and client education on how to interpret test results and can easily access health services for follow-up testing and subsequent treatment, if needed.

HIVST Video Demonstration and practice:

- ◆ Your facilitator will show the demonstration video on HIVST.

- ◆ The facilitator will provide you HIVST kits, follow the procedure you observed from the video demonstration and conduct the self-test
- ◆ Share your experience to the group. How was it? Easy? Difficult? Why?

- ◆ Self-Test (HIVST) is an innovative approach to deliver HIV testing services and contribute more for the national case finding efforts.
- ◆ As with all approaches to HIV testing, HIVST should always be voluntary, not coercive, or mandatory
- ◆ HIV self-testing (HIVST) refers to a process in which a person collects his or her own 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
- ◆ HIVST will be provided through assisted and unassisted approach which represents another forward step to HTS in line with efforts to increase patient autonomy, decentralization of services and create demand for HIV testing among those unreached by existing services.
- ◆ An effective Quality Assurance (QA) program is one that is integrated into routine Practices in the country focusing on how to ensure the quality of HIV

ANNEX; PEDIATRIC HIV RISK SCREENING TOOL (HRST)

HIV Risk assessment tool for children <15 years of age

Name \_\_\_\_\_ Age \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

<b>For a child &lt;18 months of age</b>	
<b>A. Mother's HIV status Known:</b>	If Negative..... No action If Positive.....Test child unless mother is on PMTCT care and child/infant is on follow up.
<b>B. Mothers HIV status Unknown</b>	<b>Test mother and decide according to the above options ("A")</b>
<b>C. If Child is orphan</b>	<b>Test the child</b>
<b>For a Child &gt; 18 months of age</b>	
<b>Step 1. Assess for Child's HIV Status</b>	1. Unknown 2. Known Positive & on ART 3. Negative
<b>Step 2. If Child's HIV status is unknown, assess for the criteria below: If "Yes" to one of them, Child is eligible for HIV testing. Test the child.</b>	
1. Are child's biological parents living with HIV?	Y <input type="checkbox"/> N <input type="checkbox"/>
2. Is the child Orphan or vulnerable with unknown parental HIV status?	Y <input type="checkbox"/> N <input type="checkbox"/>
3. Is the child diagnosed to have ANY ONE of the following? (If Yes tick) (√) <ul style="list-style-type: none"> <li>• Confirmed or suspected TB ( )</li> <li>• Recurrent lower respiratory infections(pneumonia)of &gt; 2 in the past 6 months ( )</li> <li>• Prolonged fever (&gt; 2 weeks) ( )</li> <li>• Chronic ear discharge ( )</li> <li>• Chronic or recurrent diarrhea ( )</li> <li>• Recurrent or extensive skin lesion ( )</li> <li>• Severe malnutrition or failure to thrive ( )</li> <li>• Developmental delay / regression ( )</li> </ul>	
4. Unexplained poor-health in the last three months.	Y <input type="checkbox"/> N <input type="checkbox"/>
5. History of repeated admissions to hospital for medical illnesses.	Y <input type="checkbox"/> N <input type="checkbox"/>
<b>If the child is older than 10 years of age (10 to 14 years)</b>	
6. Is the child having ANY ONE of the following? (If Yes tick) (√) <ul style="list-style-type: none"> <li>• Is the child sexually active or sexually exploited? ( )</li> <li>• Is the child living on street? ( )</li> <li>• Is the child leading a family? ( )</li> <li>• Does the child use substance or alcohol? ( )</li> <li>• Is the child out of school or missed schools repeatedly? ( )</li> <li>• Does the child have history of STI? ( )</li> </ul>	
If Yes or (√) to any one the above, child is Eligible for HIV testing. Test the child.	<b>Eligible</b> <input type="checkbox"/> <b>None Eligible</b> <input type="checkbox"/>
HIV test result	Positive <input type="checkbox"/> Negative <input type="checkbox"/>

## Annex: 1

### ROLE PLAY SCENARIOS

#### Role Play Scenario 1

Aster is a 32-year-old secretary working in one of the shoe factories in Addis. She has two children and her husband died two years ago. Three days before she was feeling chest pain, this became severe last night. Girma has diagnosed her and put her on a treatment. While Girma is offering her an HIV test she was very surprised and asked him several times why he wants her to have an HIV test. Girma continues explaining the need of having the test.

#### Role Play Scenario 2

It has been around 30 minutes since Bekele sat in a waiting area waiting to hear his HIV test result. He was very anxious and cannot imagine what his HIV test result could be. The provider called and gave him his HIV test result. Bekele became very happy when he received his HIV- negative result and want to hear what the provider will say next.

#### Role Play Scenario 3

Sr. Senait called one of her clients, Fatima, who was tested for HIV 30 minutes ago. Sr. Senait told Fatima that the result is available and was positive. This was shocking news for Fatima; she was silent for several minutes and started to deny the result. Sr. Senait helps Fatima to cope and continues the post-test counseling and provides her information on where she can get care and support.

#### Role Play Scenario 4

Abebech has a 14 month old baby that has had a fever and cough for four days. She took leave form her work place and took her child to a private clinic. The doctor in the clinic has managed all the acute problems and wants to test the baby for HIV.

But the mother was not well convinced with the need of testing her if the baby is HIV positive. The provider is explaining the need for testing the baby and it's relation to the HIV status of the mother.

#### Role Play Scenario 5

After getting appropriate pre-test information, Chaltu was very happy when she received HIV-negative result for her three year old son. The provider is expressing the need to test Chaltu for HIV in another testing center and partner referral. Chaltu thinks she will have difficulty with bringing her husband to a counseling and testing site. The provider is explaining to her the importance of partner referral along with other prevention messages.

## Role Play Scenario 6

Meselech was very angry when Dr. Abebe politely informed her that it is good to test mothers of HIV- positive children. Meselech was very worried that she will be HIV-positive if she gets tested. The test for the baby was done and turned out to be positive. The provider continued explaining how to cope with the baby's HIV-positive result and the need of testing the mothers of HIV- positive children.

## Annex: 2

### CHECKLIST: INITIAL PROVIDER ENCOUNTER FOR ADULTS

Key counselor tasks	Task addressed	Comments and recommendations
Introduce the topic of HIV		
Inform patient/client of need to test for HIV		
<b>Recommend and Offer HIV Test</b>		
Recommend and offer HIV test		
Explain procedure to safeguard confidentiality		
<b>Patient Declines or Defers Testing</b>		
Problem solve barrier to testing		
Develop plan to return for HIV test or referral for HIV test		
<b>Patient Agrees to be Tested</b>		
Explain the process of getting the HIV test		
Prepare patient for HIV testing		

### CHECKLIST: HIV-POSITIVE RESULT, ADULT

Key counselor tasks	Task addressed	Comments and recommendations
<b>Initial Provider Encounter</b>		
Introduce the topic of HIV		

Inform patient/client of need to test for HIV		
<b>Recommend and Offer HIV Test</b>		
Recommend and offer HIV test		
Explain procedure to safeguard confidentiality		
<b>Patient Declines or Defers Testing</b>		
Problem solve barrier to testing		
Develop plan to return for HIV test or referral for HIV test		
<b>Patient Agrees to be Tested</b>		
Explain the process of getting the HIV test		
Prepare patient for HIV testing		
<b>Post-Test Counseling Session: HIV-Positive</b>		
Inform HIV tests results is positive		
Provide support		
<b>Discuss Medical Care and Provide HIV Clinical Care Recommendation</b>		
Provide HIV clinical care recommendation		
<b>Address assisted Disclosure or assisted Partner notification and referral</b>		
Address assisted disclosure		
Discuss assisted partner notification		
<b>Provide preventive messages and referrals</b>		
Provide preventive message for HIV-positive patients		

Provide referral



## Module Four Summary

- ◆ Use of HIV Risk screening tool in Adult and Pediatric health service delivery points is key to optimize PITC.
- ◆ Target Clients will undergo testing unless they refuse.
- ◆ It is recommended that all target clients/children tested for HIV.
- ◆ Giving HIV-negative test result is simple, but it is necessary to raise issues of retesting and future prevention.
- ◆ Partner testing, being faithful, abstinence and using condoms are important preventions messages in HIV for both HIV negative and positive clients.
- ◆ Providers of PITC must be aware of the legal age and criteria that allow adolescents to make their own health care decisions.
- ◆ Diagnosis of HIV infection in children less than 18 months of age may require further testing.
- ◆ All HIV-infected children will need to be told about their HIV status before adolescence and readiness ongoing counseling is needed, as disclosure of HIV is a process.
- ◆ Mothers of children less than 12 years of age who test positive should also be offered for an HIV test.
- ◆ Providers need to be sensitive to the emotional needs of infants, children, and adolescents, as well as adults, during the PITC process.

**MODULE 5**  
**INDEX CASE TESTING**  
**SERVICES**

## CHAPTER 1: OVERVIEW OF INDEX CASE TESTING

**Learning Objectives:** By the end of this session the participants will be able to:

- ◆ Define Index case testing.
- ◆ Describe Goal of ICT
- ◆ List out the rational of index case testing
- ◆ List out the benefits of index case testing
- ◆ Describe the principles of index case testing
- ◆ Describe contact categories for elicitation to conduct ICT

### Contents

- ◆ Definition of Index case testing
- ◆ Goal
- ◆ Rationale
- ◆ Benefits
- ◆ Principles

### Definition of ICT

#### Index case:

An individual newly diagnosed as HIV-positive and/or an HIV-positive individual who enrolled in HIV treatment services

When counsellors identify index cases whose sexual partners or eligible biological children are not tested for HIV, they should immediately provide ICT services including notification and contact tracing.

#### Index case testing

Voluntary process where the service provider asks index clients to list all biological children and all sexual partners within the past year(s), then offer, and conduct HIV testing for all elicited contacts ICT is a high yield, targeted testing approach for identifying and linking new HIV infected individuals to treatment services.

### Goal of index testing

The goal of index case testing is to break HIV transmission cycle by offering HIV testing to individuals who were exposed to HIV and linking them to care and treatment in case of HIV positive result and to prevention services if the result is negative.

### **Rationale for index case testing**

- ◆ To provide support to PLHIV to assist them in getting their sexual partners and biological children tested for HIV
- ◆ To maximize HIV positive identification and increase ART uptake
- ◆ To promote safer sexual behavior among sexual partners
- ◆ To enhance HIV prevention among families and community
- ◆ Share the burden of the index client as the only person responsible for the contact notification
- ◆ Allows HIV-positive partners and children to access HIV treatment to reduce HIV-related disease and mortality.

### **Benefit of Index Case Testing**

#### **i. Benefit for Partners of Index Client**

- ◆ Maximize the proportion of partners who were notified about their HIV exposure.
- ◆ Maximize early linkage of partners to HIV/STI testing, medical care, prevention interventions, and other services
- ◆ Provide information about real risk of getting infection.
- ◆ Improved prognosis for extended and better quality of life.
- ◆ Referral and linkage to counseling and other support services.
- ◆ Reduced likelihood of acquiring and transmitting infections.

#### **ii. Benefits for the Community**

- ◆ Reduce future rates of transmission by aiding in early diagnosis and treatment.

## **Principles of ICT**

- ◆ Client centered and focused
- ◆ Confidential
- ◆ Voluntary and non-coercive
- ◆ Non-judgmental
- ◆ Culturally and linguistically appropriate
- ◆ Accessible and available to all
- ◆ Integrated and Comprehensive

## **Contact categories for elicitation to conduct ICT**

- ◆ All sexual partner(s) from current and past year(s)
- ◆ All biological children (<19 years) if the mother is HIV positive OR
- ◆ Biological child (ren) <19 of mother who is HIV Positive, dead or unknown HIV status
- ◆ Father is HIV positive & reports the child's mother is HIV positive, dead, or her status is unknown
- ◆ Biological siblings (brothers and sisters) <19 years old, of HIV positive child if the index case is a child
- ◆ Parent(s) of an index child

## CHAPTER 2: MOTIVATIONAL INTERVIEWING (MI) IN ICT

### COUNSELING

**Learning Objectives:** By the end of this session the participants will be able to:

- ◆ Explore the potential role of MI in facilitating behavior change in ICT.
- ◆ Describe the methods of MI in enhancing patient motivation for behavioral change.
- ◆ Explain the four guiding principles of MI
- ◆ Demonstrate skills of MI through practical session.

### Contents

- ◆ Introduction
- ◆ RULES
- ◆ Key strategies and techniques
- ◆ Phasis
- ◆ Case Studies

### INRODUCTION

One of the biggest challenges that primary care practitioners face is helping people change longstanding behaviors that pose significant health risks. In practical settings, **motivational interviewing (MI)** is a counseling approach developed in part by clinical psychologists William R. Miller and Stephen Rollnick. The concept of motivational interviewing evolved from experience in the treatment of problem drinkers, and was first described by Miller (1983) in an article published in *Behavioral Psychotherapy*. Motivational interviewing is a directive, client-centered counselling style for eliciting behavior change by helping clients to explore and resolve ambivalence.

**Ambivalence is** the state of having mixed feelings or contradictory ideas, attitudes or feelings about something or someone (e.g., HIV status disclosure, Partner referral, diet, losing weight, saving money, working out). MI is a counselling method that involves enhancing a patient’s motivation to change by means of four guiding principles, represented by the acronym “RULE” (Resist the righting reflex, Understand the patient’s own motivations, listen with empathy; and empower the patient)

## COUNSELLING METHOD THAT INVOLVES ENHANCING A PATIENT'S MOTIVATION TO CHANGE

### **R RESIST telling the client what to do/ Resist the righting reflex:**

Avoiding telling, directing, or ordering the client about the right path to notify their partner.

“The righting reflex describes the tendency of health professionals to advise patients about the right path for good health. This can often have a paradoxical effect in practice, inadvertently reinforcing the argument to maintain the status quo. Motivational interviewing in practice requires clinicians to suppress the initial righting reflex so that they can explore the patient’s motivations for change.”

Motivational interviewing emphasizes eliciting reasons for change from the patient, rather than advising them of the reasons why they should change their drinking.

### **U UNDERSTAND their motivations:**

Seek to understand their values, needs, motivations, and barriers to notifying their partner(s) and child(ren)

### **L LISTEN with empathy:**

Put aside your viewpoint and try to see things from the client’s perspective. Seek to understand, before being understood.

### **E EMPOWER the client to take action:**

Work with the client to set achievable goals and to identify techniques for overcoming their perceived barriers and challenges

## **KEYS POINTS ABOUT MOTIVATIONAL INTERVIEWING:**

- ◆ A client centered counseling style for eliciting behavior change
- ◆ Assumes *client* knows what his/her barriers are to changing their behavior
- ◆ Counselors’ role is to help client identify these issues and develop a plan to address them.
- ◆ Creates a cognitive dissonance (or discrepancy) between where **one is** and where **one wants to be**

## **STRATEGIES TO ENHANCE CLIENT MOTIVATION TO PARTICIPATE IN INDEX TESTING SERVICES**

- ◆ Affirming the client's autonomy and capacity for self-direction aligns with our client centered approach
- ◆ Increasing client awareness by exploring and resolving ambivalence helps increase clients' capacity for self-direction by allowing them to make more informed choices.
- ◆ Exploring and resolving any ambivalence or barriers to naming contacts
- ◆ Identifying and encouraging behavior change
- ◆ Going through this exploration and decision-making process is in and of itself a healthy behavioral change for many clients and can be identified and encouraged as an example of progress.

## **MOTIVATIONAL INTERVIEWING IN PRACTICE (THE TWO PHASES)**

The practical application of MI occurs in two phases: building motivation to change and strengthening commitment to change.

**Phase 1- Builds Motivation to change:** The four methods represented by the acronym "OARS" constitute the basic skills of MI. These basic counselling techniques assist in building rapport and establishing a therapeutic relationship that is consistent with the spirit of MI.

- ◆ Open-ended Questions
- ◆ Affirming Statements
- ◆ Reflective Listening
- ◆ Summarize the Conversation

**Phase 2- Strengthening commitment to change:** "This involves goal setting and negotiating a 'change plan of action'. In the absence of a goal directed approach, the application of the strategies or spirit of MI can result in the maintenance of ambivalence, where patients and practitioners remain stuck. This trap can be avoided by employing strategies to elicit 'change talk'. There are many strategies to elicit 'change talk', but the simplest and most direct way is to elicit a patient's intention to change by asking a series of targeted questions from the following four categories:

- ◆ **Disadvantages of the status quo (No Change)**
  - E.g. Ask- What worries you about your HIV status non-disclosure and your sexual partner not tested?
- ◆ **Advantages of change**



- E.g. Ask- What are the advantages of knowing HIV status early?

◆ **Optimism for change**

- E.g. Ask-When have you made a significant change in your life before?

◆ **Intention to change**

- Forget how you would get there for a moment. If you could do anything, what would you change?

**KEY STRATEGIES AND TECHNIQUES FOR MI**

◆ **Ask permission**

- Ask client for permission to talk about index testing
- Clients are more likely to engage in discussion if they agree up front

◆ **O= Use open ended questions to elicit information from the client on perceived challenges/barriers to index testing**

- This will help to make the patient do most of the talking
- Gives the practitioner the opportunity to learn more about what the patient cares (eg. their values and goals)
- Assess client's challenges and barriers with index testing (e.g., naming or informing partners)
- Potential barriers: they are married and have other partners, logistical (such as they are no longer in contact in their partner), or emotional such as not ready to deal with diagnosis or disclose their status
- Example of an open-ended question, *"What concerns do you have about telling your partner about the need to get an HIV test? ..."*

◆ **A= Use affirming statements to normalize the client's challenges:**

- Can take the form of compliments or statements of appreciation and understanding
- Helps to build rapport, validate and support the patient during the process of change
- Most effective when the patient's strengths and efforts for change are noticed and affirmed

*Examples of Affirming statements:*

“A lot of people have difficulty telling their partner about the need to take an HIV test...” I appreciate that it took a lot of courage for you to discuss this with me today

“Many people aren’t quite sure how to tell their partner, especially partners you may not speak to anymore...”

◆ **R= Reflect what client tells you to show you have understood:**

- Involves rephrasing a statement to capture the implicit meaning and feeling of a patient’s statement
- Encourages continual personal exploration and helps people understand their motivations more fully

Examples of reflective statements:

“It sounds like you are not sure how to tell him about your HIV....”

“It sounds like *you are worried that your wife may find out about your other girlfriend...*”

◆ **Help client identify solutions to overcome listed barriers**

For each barrier, ask:

- “*What would help you overcome or get around that barrier?*”
  - “*Who can you call for support or assistance? How can he/she/they help you meet your goal?*”
- Assist client in identifying solutions to address their concerns

**For example,**

- ◆ A client who doesn’t know what to say to their partner will **need assistance in determining the best method for telling their partner** (i.e. client vs provider vs dual method) and may need to **practice** what they should say if they choose the client referral method
- ◆ A client who is concerned about others learning their HIV status will need **reassurance that you will protect their confidentiality by not disclosing their identity or status to anyone.**

◆ **Provide information, advice and feedback as needed**

- Many clients lack basic information such as the different ways in which to alert partners about the need to get tested, the risk of transmission at different stages of HIV infection, benefits of early ART/treatment, etc and need accurate information
- Some clients will need direct advice or information to address issue such as:
- “Do you know that HIV-positive persons who are on treatment can live longer, healthier lives & treatment significantly reduces the risk of passing the virus on to your partner(s) or babies?”
- “Are you aware that your partner can be notified about the need to seek an HIV test without you having to disclose your HIV status to him?”

◆ **Assess readiness for change**

- Ask clients if they are ready to take this step to notify their partner(s) and child(ren) about the need to get an HIV test

*“Now that we have developed a plan for how you will tell your partner about your HIV status, are you feeling comfortable that you will be able to do what we discussed?”*

- Many clients will be ready to move forward with index testing if given the proper information, encouragement and support or assistance.
- Others may not be ready to deal with their situation and may need more time, information, support and encouragement
- Schedule another time to meet with client if they are not able to commit to telling their partners or having you help them tell their partners

*Remember: index testing is NOT a onetime event*

◆ **Reinforce the client’s commitment to take positive steps for their health and the health of others**

- “It takes courage to face your HIV diagnosis and help others to know theirs.”
- “I know it is hard to tell your family you are HIV-positive, but you will feel better once you have their support, and you know they are getting the care they need...”

◆ **S= Summarize the conversation and the client’s plan for notifying their partner**

- Link discussions and ‘check in’ with the patient
- Ensure mutual understanding of the discussion so far
- “To review, you will tell your partner, Yohannis, about your HIV after church on Sunday. Remember to do it just like we practiced. You will also bring your daughter to your next ART appointment so we can test her for HIV. I am here if you need me”

**CASE STUDIES: PROBLEM SOLVING GROUP WORK -**

**Case Study 1:** You are interviewing a woman who has recently tested positive. She indicates that she has had two partners during the interview period. She is willing to talk to you about notifying one partner but does not want to discuss the other at all because “he is married, and his wife is pregnant”.

**Case Study 2:** Sarah is a 34-year-old woman who was recently diagnosed HIV-positive during antenatal care. Her infant is now 14 months, and she has three older children aged 3, 6, and 10 years old. She has been married to her husband, Yohannis, for 12 years

## CHAPTER 3: STEPS OF INDEX CASE TESTING

**Learning Objectives:** By the end of this session the participants will be able to:

- ◆ Explain the 10 steps of index case testing.
- ◆ Demonstrate practical skills on the 10 steps of ICT.
- ◆ Explain approaches for testing sexual partners and biological children of index client

### Contents

- ◆ Steps of index case testing
- ◆ Detail explanation of each steps
- ◆ Case studies

### THE TEN STEPS OF INDEX CASE TESTING

**Step 1:** Introduce the concept of index testing during pretest session at PMTCT/ART and community visit

**Step 2:** Offer index testing as a voluntary service to all clients testing HIV-positive or with high viral load

**Step 3:** If client accepts participation, obtain consent to inquire about their partner(s) and biologic child (ren)

**Step 4:** Obtain a list of sex partners and biological children < 19 with unknown HIV status.

**Step 5:** Conduct intimate partner violence (IPV) risk assessment for each named partner.

**Step 6:** Determine the preferred method of partner notification or child testing for each named partner/child. Offer HIVST if a client prefers HIVST and provide necessary support including provision of HIVST kit. **Step 7:** Contact all named partners in addition to biological children <19 years old using the preferred notification approach and provide conventional HIV testing at the health facility and community level.

**Step 8:** Record outcomes of ICT (partner notification and family testing results)

**Step 9:** Provide appropriate services for children and partner(s) based on their HIV status.

**Step 10:** Follow-up with client to assess for any adverse events associated with index testing

## **Detail description of the 10 steps of index case testing.**

### **Step 1: Introduce the concept of index testing during pretest session at PMTCT/ART and community visit**

- ◆ During pre-testing session, healthcare provider should provide information and counselling on the availability of Index case testing service and its benefits for early diagnosis and treatment, thereby breaking the cycle of HIV transmission to the partner, children, and other family members of the index client. The healthcare provider should mention that these services will be offered if the client tests positive and will be discussed in more depth after the results of the HIV test are available.
- ◆ Index case testing service should be offered by a trained healthcare provider with an emphasis on WHO's "5 Cs" (Consent, Confidentiality, Counselling, Correct test results & Connection to treatment/ prevention services).

### **Step 2: Offer index testing as a voluntary service to all clients testing HIV-positive or with high viral load**

- ◆ When a client has tested positive, healthcare provider should remind the client of the pre-counselling talk about offering ICT in case s/he tested positive, the client should be educated about the risks of infecting others.
  - ◆ ICT should be provided in compliance with safe and ethical principles, which include respect the right to participate or withdrawal at any stage, and the right to be protected from any harm.
- ◆ The healthcare provider should explain the objectives, benefits, risks of ICT, and answer all questions.
  - ◆ Index testing should be client-centered, meet the client's needs, and respect his or her preferred method or modality.
- ◆ The index client may voluntarily choose a contractual, dual, provider, or client referral approach, which should be documented.

While offering ICT, assure the index that:-

- ◆ Partner(s) will not be told the index client's name or test results.
- ◆ Index client will not be told the HIV test results of their partner(s) or whether or not their partner(s) actually tested for HIV.
- ◆ Testing services and results for children will not be shared with others.

- ◆ Providers will not contact elicited partner(s) and child(ren) without their permission.
- ◆ They will continue to receive the same level of care regardless of whether they choose to participate in index case testing services or decline.

Address any questions raised by the index client, obtain verbal consent and fill contact information on ICT register.

It is advisable to enhance index client's motivation to participate in index testing services by:

- ◆ Affirming the client's autonomy and capacity for self-direction.
- ◆ Increasing client awareness about the importance of index case testing.
- ◆ Exploring and resolving any ambivalence or barriers to naming contacts.
- ◆ Identifying and encouraging behavioral change.

The client can choose different options for contacting different partners. The client is also free to change strategies. For example, maybe they initially choose client referral but later can decide that they prefer dual referral.

**Step 3:** If client accepts participation, obtain consent to inquire about their partner(s) and biologic child (ren)

The client should agree verbally to inquire about his or her partner/s and children, which should be documented in the client's file or patient register.

If the client is too overwhelmed by the HIV test result, the health care provider should continue the discussion and follow-up should be made telephonically within one week to continue offering ICT.

**Step 4:** Obtain a list of sex partners and biological children < 19 old with unknown HIV status. **(Elicitation)**

- ◆ Ask index client for permission to talk about index testing. Engage index client in discussion and use open ended questions to elicit information from the client on perceived challenges on naming or informing partner(s) for they are married or no longer in contact or emotionally not ready to deal with diagnosis or disclose their status.
- ◆ Ask the index client to tell the names and contact information of all the persons they have had sex with in the last 12 months. Begin, by asking about the most recent

sexual partner and working backwards. Then ask if there are any other partners that he/she can remember having sex with in the last 12 months like “Who is the last person you had sex with?” “Who was the person you had sex with before that?”

- ◆ During this, encourage the client to list names and contact information for main partner(s) as well as casual partner(s), even if they only had sex once. If there is no one in last 12 months, go for additional 12 months.

**Use affirming statements to normalize the client’s challenges by saying,**

- ◆ “Many people aren’t quite sure how to tell their partner, especially partners you may not speak to anymore...”
- ◆ For clients who have concerns about others learning their HIV status, provide reassurance that their confidentiality is protected. Their identity or status won’t be disclosed to anyone contacted. And provide advice such as:
- ◆ “Are you aware that your partner can be notified about the need to seek an HIV test without you having to disclose your HIV status to him?”
- ◆ “It takes courage to face your HIV diagnosis and help others to know theirs.”

**Regarding children:** elicit all children < 19 years old and siblings despite their testing status.

**Step 5:** Conduct intimate partner violence (IPV) risk assessment for each named partner.

Intimate Partner violence (IPV) is behavior by an intimate partner that causes physical, sexual, or psychological harm, including acts of physical aggression, psychological abuse and controlling behaviors and sexual coercion. Screening for IPV risk is a standard for index testing services.

- ◆ Primary goal of the IPV Risk assessment is to ensure no harm comes to the index client because of index testing services.
- ◆ To protect the safety of the index client, partners who pose higher risk of IPV may need to be excluded from notification and testing services and the index client provided with and referred to appropriate care and support services for IPV.
- ◆ Respond to clients experiencing IPV by listening to the client with empathy and a nonjudgmental attitude and provide available services and refer for appropriate GBV services including psychological, legal support services and GBV prevention.



- ◆ During counseling, determine if the index client is thinking of harming him/ herself or others because of the diagnosis. Use the “snake in the house” analogy.
- ◆ “We do not care how the snake got in the house; we just know we need to deal with it. HIV is like that snake. It does not matter how it entered our life or who infected us. What matters is getting on treatment and taking other positive steps to lead a healthy life.”
- ◆ As a provider, screen all named partners for IPV by using three standard questions and document on ICT register.
  - **Has [partner’s name] ever hit, kicked, slapped or otherwise physically hurt you?**
  - **Has [partner’s name] ever threatened to hurt you?**
  - **Has [partner’s name] ever forced you to do something sexually that made you feel uncomfortable?**

If the client answers “yes” to any of the screening questions, the provider should work with the client to see which notification strategy may be most appropriate. Offer first-line support if the client says ‘YES’ to any of the above 3 questions or discloses any form of violence and refer him/ her to appropriate services

**The provider must offer a first line response**, including a safety check and referrals to support services, and then should work with the client to see which Notification approach may be most appropriate. **Offer First-Line Support if the Client Discloses Violence**

- ◆ *First-line support is a practical, survivor-centered, empathetic counseling approach. It is the immediate care given to an index client who has experienced violence upon their first contact with the health or criminal justice system.*
- ◆ *It responds to the client’s **emotional, physical, safety and support** needs- without intruding on his or her privacy and is also a component of clinical post- violence care.*
- ◆ *Often, first-line support is the most important care that you can provide. Even if this is all you can do, you will have greatly helped your client.*
- ◆ *First-line support has helped people who have been through various upsetting or stressful events, including women subjected to violence.*

◆	Listen: Listen closely with empathy, no judgment.
◆	Inquire: Assess & respond to the client’s needs and concerns. emotional, physical, social, and practical
◆	Validate: Show the client that you believe and understand him/her
◆	Enhance safety: Discuss how to protect the client from harm.
◆	Support through referrals: Help connect the client to appropriate services, including social support.

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- ◆ A client's safety is the most important factor in determining if they should participate in partner services.
  - ◆ Remember that provider referral can be done completely anonymously without the client having to disclose his/ her HIV status to the partner. If the client's safety is at risk, then he/ she may not be able to participate in index partner services. Link or refer the client with IPV to Gender Based Violence (GBV) services.

**Step 6: Determine the preferred method of partner notification or child testing for each named partner/child. Offer HIVST if a client prefers HIVST and provide necessary support including provision of HIVST kit.** The healthcare provider should discuss the options that the client has regarding testing for their sexual partner/s. It is important to emphasize that the client is not forced to disclose his or her status if s/he is not ready.

#### **Approaches of sexual partner & index case testing**

**There are 4 options for notifying and testing index client partner for HIV.**

- ◆ **Client Referral-** the **index client takes responsibility** for disclosing their HIV status to partner(s) and encouraging partner(s) to seek HTS. This is often done using an invitation letter or referral slip.
- ◆ **Contract Referral-** The **index client enters into a "contract" with the counsellor and/or health care provider** whereby he or she agrees to disclose their HIV status to their partner(s) and refer them to HTS within 14 days. If partner(s) do not access HTS within this period, counsellors/providers contact the partner(s) directly and offer them voluntary HTS.
- ◆ **Dual Referral-**A **trained provider sits with the HIV-positive client and his/her partner(s)** to provide support as the client discloses his/her HIV status. The provider also offers voluntary HTS to the partner.
- ◆ **Provider Referral-** With the consent of the HIV-positive index client, the **provider directly contacts (calls or sends text message) to the client's partner(s)** and offers them voluntary HTS while maintaining the confidentiality of the index client.

Based on index client preference, document the chosen referral method for each listed partner on the Clients file, ICT register.

**Step 7: Contact all named partners in addition biological children < 19 years old using the preferred notification approach and provide conventional HIV testing at the health facility and community level.**

- ◆ The healthcare provider will contact the listed or named contacts for facility- or community-based testing, as per the index client's preferred approach for each contact.
- ◆ The healthcare provider will contact or trace all named contacts as per the tracing policy and will record the outcomes.
- ◆ The facility should liaise with the community testing teams to reach all named contacts identified.

**If the index client chooses client referral:**

- ◆ Help the client to plan (where, when, using what words) and provide conversation starter. Index can use partner invitation card to invite partner(s).
- ◆ Invitation card explains how the facility/community wants to discuss on the disease prevention and control service it provides for the community and get feedback from him/her to further make the service improved.
- ◆ Brainstorm some questions/ reactions that partners might have and help the client determine some possible answers/ responses. Allow the index client to practice with you until he/she feels confident that they can say the words.
- ◆ Set an appointment with the index client to follow up and confirm that the partner has got tested.

**If the client chooses contract referral:**

- ◆ Following the above steps, an agreed date is identified 14 days after initial interview, that the client already notifies and refer his/her partner(s) for HIV testing.
- ◆ If the index fails to do that or the partner(s) do not come for HTS by 14 days, the provider can directly call/ contact the partner(s) with permission from the index client.
- ◆ If the client does not provide permission to contact his/her partner(s), record the outcome on the ICT register.

### **If the client chooses provider referral,**

- ◆ Contact and invite named partner for health services to the facility using telephone from ART or PMTCT clinics. For community testing service delivery points will be applied from the collected line list from the health facilities.
- ◆ Give the necessary information (when, where, and who to contact) when he/ she arrives at the facility. While contacting partner(s) via telephone, using the following “Script for Partner contact: Phone Call”.

### **Tips:**

- ◆ Secure a private place and plan for what you will say.
- ◆ Gratitude and ask the partner the convenience to talk.
- ◆ Confirm the partner’s identity by asking him/her father and grandfather name and home address.
- ◆ Do not give any information to anyone other than the partner.
- ◆ Respond to questions from the partner about how you obtained his/her information.

### **Telephone, text message (SMS) and face to face may be used to contact a partner.**

**Telephone:** Index case testing services provider may use telephone to contact named partner and plan to meet in person. It is recommended to call early morning or evening to reach partner when not on work.

### **Telephone call Procedure:**

- ◆ Greet mentioning his/her name,
- ◆ Introduce yourself by work address & responsibility, give your name
- ◆ Systematically confirm the person answering the phone is the partner you are looking for – like asking full name and residence, if unable to confirm, set up a face-to-face meeting Inform partner that you need to meet with him/her and plan meeting as soon as possible in your health facility or the community testing service delivery points.

### **Responding to incoming calls:**

Partners may call back for missed call(s) you made. So, you need to be prepared to respond to incoming calls appropriately.

- ◆ Ask caller's name.
- ◆ Introduce yourself by work address and responsibility, and
- ◆ Ask the caller to hold and check your records to confirm the caller is a partner.
- ◆ After confirming the caller's identity, provide information and plan time to come to health facility for counseling if partner agrees.

### **Example Script:**

Hello. My name is \_\_\_\_\_ and I am a health care provider at [Facility/community service deliver point Name] \_\_\_\_\_. Am I speaking with [partner's name] \_\_\_\_\_? [IF NO]: Is [partner's name] \_\_\_\_\_ available?

[If partner is not available], Thanks. I'll try back later. [If YES], I have some important information for you that I need to share with you in person. What time today or any other day can we meet? [Plan time, confirm meeting location and end call by thanking the partner.]

**Text messaging /SMS/:** It is a useful way of communication when a named partner is not responding to phone call.

### **Example Script:**

"I need to speak with you as soon as possible". Please call me at #.

Hi [partner's name], "I am XX I need to talk to you about". Please call me at #.

### **Responding to partners when they text you back:**

"This is important matter. I can tell you more when you call. Please call me at #. Thank you". During the partner contact attempt, there has to be at least three attempts at varying times of the day and using different methods. If the contact attempts were successful, schedule for face-to-face notification and assist partner to get the service.

The goal of sending a text message is to motivate the individual to call the health care provider so important and sensitive information can be exchanged. This should be considered when patients or their partners are not responding to phone call or client referral.

Text messaging partner notification should NOT BE conducted using personal phones, should be sent from work phone.

- ◆ Work cellphone/ wireless phone should be secured and turned off when not in use,
- ◆ Once you no longer need to continue communicating with the individual, all messages should be deleted.

**If the client chooses Dual referral:**

- ◆ Together with the index client, arrange an appointment to bring their sexual partners to health facility. The partner may come knowing HIV exposure (notified) or not knowing HIV exposure.
- ◆ The couple may get HIV testing together if the partner is not notified. If the partner is notified of the exposure, reaction management is critical, and voluntary HTS will be provided when the partner agrees.
- ◆ The testing will be done at ART and PMTCT room and or in a community testing service deliver point.

**Notification of index case partners about their potential exposure to HIV.**

- ◆ Notification to partner under ICT service means letting a partner to be aware that he/she has close risk and benefit from HTS and knowing his/ her own status.
- ◆ It does not have anything with disclosure of index status. Notifications should always be conducted in accordance with local procedures especially with respect to contacting people outside the provider's jurisdiction.
- ◆ Notification of disease or exposure to disease supports epidemiological efforts and serves as both a surveillance and control tool.

**Principles of Notification:**

- ◆ The principles of notification addresses confidentiality, Organization, promptness, thoroughness, communication, and creativity/ flexibility.
- ◆ Efforts to contact and communicate with infected patient, partners, and those at risk must be done in a manner that preserves the privacy of all involved.
- ◆ No information should be shared with unauthorized persons that could lead back to the identity of the original patient (Confidentiality).
- ◆ Being prompt with taking action that led people found at risk of or having HIV are protected or treated as well as followed-up timely.

- ◆ Explore all realistic possibilities to find and notify partners and others at risk for infection (Thoroughness).
- ◆ Organize room and medical record activities appropriate. Use effective communication and be clear on what they wish to communicate while speaking at the person's level of understanding (Listening).
- ◆ Creativity is essential so that individuals exposed to HIV are found and tested in a timely manner. Be creative and follow all notification leads and determine additional ways to locate using specific investigative practices.
- ◆ Being flexible requires the ability and willingness to change the course of investigation at any time. It is up to you to utilize baseline information and initial clues to expand the amount and quality of locating information in an unwavering attempt to locate, identify, and inform someone who may have been exposed to HIV.

**Face to Face Notification** is a discussion with partner to inform him/her of exposure and provide counseling service that will help him/her to agree accessing HIV testing.

While conducting face to face notification, you should review the record and memorize all pertinent data, identify private convenient place for partners and confirm identity then proceed with the notification procedures.

**Introduce yourself:**

“My name is [name] \_\_\_. I work at this clinic [name of health clinic/the community testing service delivery point] \_\_\_ as disease prevention and control focal. As part of this I work on HIV program to help people who could benefit from HIV prevention service that includes HIV testing STI screening and treatment”

**Notify of exposure, process reaction, answer questions:**

- ◆ Explain confidentiality and assure a private setting
  - “This is a place where we can speak privately without others hearing or interruption.”
  - “Our conversation is private, meaning I need to speak with you only and will never share with to others your personal information that you will share with me.”

Provide the notification and process reaction: “Recently our facility is planned to provide integrative service to the community to prevent and control communicable diseases one of it is HIV. So, it's important you get tested for HIV.”

Plan for immediate HTS “If you agree, we will provide you the HIV testing service today. This will take about 30 minutes.”

If the partner declines the test or test result is negative, Counsel on behavior change & risk reduction prevention packages.

If test result is positive, re-emphasize on ART, Link HIV+ partners to ART service and continue another cycle with the client as a new index client.

### **Notification Problems/ Challenges:**

The following are Typical Notification Problems and Suggested Responses.

**Partner may ask:** *“How did you get my name?”*

**Response:** *“From someone who benefits HTS and treatment and who cares enough about you and wants you to get a better health service.” “The health facility cares about the health of individuals in the catchment and want to notify their exposure.”*

**Partner may ask:** *“Who gave you, my name?”*

**Response:** Same reply as above, or if pressed further for an identity,

*“Ethically the procedure does not allow to give the name. The good thing is, your information is confidential too; just like I can’t share this information—I also can’t share yours.”*

**Partner may ask:** *“Do I have the disease?”*

**Response:** *“We won’t know until you get tested. We will arrange this as quickly as possible. How about going in right now?”*

**Partner may ask:** *“I haven’t had sex with anyone in over a month.”*

**Response:** *“This exposure may not be recent, may be you could have sexual contact more than months ago.”*

**Partner may ask:** *“I haven’t had sex with anyone but my husband/wife.”*

**Response:** *“Someone close to you had this disease and is concerned about your health. Your health and getting tested is the most important thing right now.”*



**Partner may ask:** *“But I feel fine. I haven’t had any sign and symptom.”*

**Response:** *“That’s a good sign, and I really hope it means everything is OK. But only testing can tell us for sure. Many people don’t have any signs or symptoms.” OR*

*“You’ve been exposed. If you get treated right away, you may be able to prevent problems! We can get you medication to prevent them.”*

**Partner may ask:** *“There isn’t anything wrong with me. I went to my doctor just last week.”*

**Response:** *“Doctors often don’t have enough information to give you holistic service preventive treatment.” Then ask the following questions, one question at a time,*

*“What’s your doctor’s name?” “What tests did you get?” “What treatment did you get?”*

*If the answers indicate the person might have gotten the appropriate diagnosis and treatment, consider contacting the physician immediately or consult the physician later on.*

*If it did not sound like the person was neither examined nor got treated for this infection, consider setting up an appointment as soon as possible to discuss afresh.*

*“Fine, I’ll take care of it with my doctor, and you don’t need to get involved. You just trust me that I will take care of it.”*

*“Thanks for wanting to take care of this all on you own. For you to get the best possible care at your doctors, I will need to give him or her some medical information. What is his/ her phone number?”*

*In this instance, try to arrange or confirm the appointment personally. Try to get a signed release of information form so that the test results and treatment can be easily confirmed.*

### **Step 8: Record outcomes of ICT (Partner Notification and Family testing results)**

Document the process and outcome of each partner and child elicited on the ICT register. Record the method(s) of contact used and the outcomes-notified, tested, result; and for HIV-positive partner/ child-record whether he/she has been started on ART. Follow to confirm whether:

- ◆ Elicited partners received HIV testing and know their HIV status (result documented),
- ◆ Partners tested HIV+ are linked to HIV treatment (UAN documented),

- ◆ Partners are examined and treated for STI, as applicable, and
- ◆ The above services are provided within “reasonable” amount of time (early testing-early prevention). When HIV-positive partner is enrolled to ART, reinstitute the same process of index case testing service to the client as index and elicited partner and children.

**Note: -**

- ◆ The facilities should have a secure environment to store patient/client information.
- ◆ All services providers must always uphold the rule of shared confidentiality.
- ◆ Document the outcome of all partner(s) and biological children testing attempts in the ICT Register.
- ◆ If the contacts have received an HIV test, document the HIV test result in the HTS and ICT registers.
- ◆ Capture data manually using the ICT register and electronically.

Continually update outcome and discuss with index client the presence of new partners every time the index client visits ART clinic with appointment.

At each ART refill visit, review client’s chart and update for ICT service. Check the intake form and ICT Service follow up form for documentation of HIV status of all the partner(s) and biological children and discuss on any gaps by asking the index client.

During the ART initiation encounter to new clients, provide ICT service as soon as possible to have maximum impact on controlling the transmission.

**Step 9: Provide appropriate services for children and partner(s) based on HIV status.**

- ◆ If the contact/s have tested HIV-positive, refer, or provide ART services. Same day ART initiation is important; the healthcare worker should facilitate this with the HIV-positive client.
- ◆ If the contact/s have tested positive, the healthcare provider should start the ICT process again and obtain consent to identify other index contacts.
- ◆ Offer the additional option of HIV self- test kits for the index client’s partner/s, if available, and determine measures for follow-up.
- ◆ If the contact/s tested HIV-negative, refer or provide HIV prevention services.

Below are list of service packages to be provided based on HIV test result.

Concordant Positive Couples	Sero-Discordant Couples
<ul style="list-style-type: none"> <li>• ART and adherence counseling</li> <li>• PMTCT (if female is HIV-positive)</li> <li>• Risk reduction counselling and condom promotion</li> <li>• STI screening and treatment</li> <li>• FP services, including pre-conception Counseling</li> </ul>	<ul style="list-style-type: none"> <li>• ART and adherence counseling for positive partner</li> <li>• PrEP for negative partner (until positive partner has achieved viral suppression)</li> <li>• Male circumcision (if male is HIV-negative)</li> <li>• PMTCT (if female is HIV-positive)</li> <li>• Repeat HIV testing of negative partner</li> <li>• Risk reduction counselling and condom promotion</li> <li>• STI screening and treatment</li> <li>• FP services, including pre-conception counseling</li> </ul>

**Step 10: Follow-up with client to assess for any adverse events associated with index testing**

**Adverse Event Monitoring and Reporting System**

Adverse Event is defined in the context of ICT, as an incident that results in harm to the client because of their participation in index testing services. Site level adverse event monitoring, response and reporting system forms need to be available at the facility or community testing sites for service providers to document and monitor consent, IPV, and frequency of adverse events. Actively monitor reasons for declining index testing services, prevalence of IPV and other adverse events (e.g., confidentiality breaches, stigmatization, coercive tactics, etc.) for improvement. Service providers should routinely ask index clients if they experienced any adverse events following participation in index testing services. NB: Unintended negative outcome as result of HIV status disclosure could still occur in the future and, as such, follow up should occur while all contacts are being traced. All reports of adverse events should be properly documented. They should also be informed of their ability to make a complaint if these rights are violated. This can be done through posters in waiting/examination rooms, patient handouts, and other educational materials. Index clients should be provided multiple pathways for issuing concerns or complaints regarding

index testing services. These include suggestion boxes within health facilities and community testing sites.

**Categories of adverse events include:**

**Severe**

- ◆ Threats of physical, sexual, or economic harm to the index client, their partner(s) or family members, or the index testing provider
- ◆ Occurrences of physical, sexual, or economic harm to the index client, their partner(s) or family members, or the index testing provider
- ◆ Withholding treatment or other services
- ◆ Forced or unauthorized disclosure of client or contact’s name or personal information
- ◆ Abandonment/forced removal from home for children < 19 years old

**Serious**

- ◆ Failure to obtain consent for participation in index testing and/or for notifying partners
- ◆ Health site-level stigma or criminalization (e.g. sharing personal information about PLHIV seeking care with the criminal justice system)

**Site Level Monitoring of Adverse Event**

- ◆ The facility should implement a robust mechanism for detecting, monitoring, reporting, and following up on any adverse events resulting from index testing. This includes gender-based violence/IPV.
- ◆ HCPs should routinely ask index clients if they experienced any adverse events following participation in index testing services

**Suggested question,**

*“Did you experience any harm from your partner, health care provider, or anyone else during or as a result of receiving index testing services at this [facility or site]? This includes physical, emotional, sexual, or economic harm?”*

This can be done at the client’s next visit to the facility or through a follow-up phone call 2-4 weeks after the client has received index testing services (optional phone call or appointment)

- ◆ All reports of adverse events should be documented and reported.
- ◆ Report adverse events associated with ICT within two to four days and respond appropriately.
- ◆ ICT offered by community organizations should also be monitored at the facility /site level.
- ◆ Conduct satisfaction surveys to identify obstacles/challenges encountered when conducting ICT.
- ◆ Track the reasons for clients opting out and declining the provision of ICT.
- ◆ Develop quality improvement plans to address obstacles/challenges with ICT.

Provide supportive supervision and monitoring. Index testing requires a lot of problem solving, coaching, and selfcare.

### **Potential Barriers to Index Testing**

There are possible feelings that the index client will face after diagnosis with HIV. So, the health care workers need to be aware and work with the client to alleviate the barriers.

#### **These barriers can be:**

- ◆ Fear reaction of partner(s)
- ◆ Guilt about having put partner or children at risk
- ◆ Doubts about confidentiality; think partner(s) will know that he/she gave the information
- ◆ Anger over probable source of infection
- ◆ Lack information about index testing services and ways to tell exposed individuals
- ◆ Ignorance of the benefits of index testing services
- ◆ Poor communication skills
- ◆ Unwillingness to spend time, money and energy to tell partner(s)
- ◆ Don't care about past partners (angry, depressed, unwilling to notify – infidelity)

## **Addressing barriers for index case testing**

You should not be surprised or discouraged when clients manifest resistance as you offer index testing services. Being infected with HIV is already scary to many clients. As a counselor/provider, you are a facilitator. You must make it easier for them to go through it all. Your approach, skill and commitment in doing your work will greatly affect your success rate with the index testing services.

### **Role play**

In this scenario two participants will play the role of HCP and index case client with one additional observer using standardized check list, HCP will be interviewing a woman who has recently tested positive. She indicates that she has had two partners during the interview period. She is willing to talk to the HCP about notifying one partner but does not want to discuss the other at all because he is married, and his wife is pregnant, how can the HCP support the IC client in notifying and testing both partners using the above ICT 10 steps covered

- ◆ Use the below questions to get reflection from the participants on the role play

Q1. What challenges did you encounter during the interview?

Q2. What are some strategies you might use to ensure that both partners get tested?

Q3. What messages would you give this client?

Q4. What type of partner notification method can we use in this scenario?

### **Index Case Testing (ICT) minimum standards**

Index testing should be client-centered and focused on the needs and safety of the index client and his / her partner(s) and child(ren). Further, sites offering index testing services must ensure appropriate systems are in place for testing service providers to identify and respond to clients who disclose their fear or experience with Intimate Partner Violence (IPV) from partner(s). The minimum standards for a site to provide safe and ethical ICT services are:

- ◆ Providers trained on HTS including index testing procedures, IPV screening, adverse event monitoring, 5Cs, and ethics.
- ◆ Adherence to 5C's (consent, confidentiality, counseling, correct test results, and connection to prevention/treatment)
- ◆ IPV risk assessment and provision of first line response, including safety check and referrals to clinical and non-clinical services (if not provided on site)
- ◆ Secure environment to store patient information.

- ◆ Site level adverse event monitoring reporting system

### **Phone Counseling for Index Case testing**

Index case testing is not a onetime activity. It requires follow up counseling, relationship and trust building between the client and the provider. To this effect, ongoing in person counseling has been the main stay used by ICT counselors. However, due to changes in service delivery following the COVID-19, providing in person counseling has been challenged and several clients are being put on multi month dispensing (MMD). Virtual Phone counseling is counseling strategy to use in the context of COVID-19 where clients prefer to stay away from sites. Phone counseling integrated to ICT helps to reach and counsel index cases who are on MMD but have contacts not yet tested/ not elicited, newly diagnosed but have not yet disclosed and required follow up counseling. It is a tool to support sites to provide phone-based counseling to elicit contacts of index clients ensuring communication privacy, support indexes virtually to select contact referral approaches, and provide exposure notification mechanisms for partners with testing options including the HIV self-test[refer virtual phone counseling SOP].

### **Follow up of index case testing**

- ◆ Record outcome of index case testing service
- ◆ Record the type of partner testing services, date and method of contact attempts, and whether the partner was successfully contacted.
- ◆ If partner was contacted, document who notified the partner and the outcome of the index case testing service (e.g., whether the partner tested for HIV).
- ◆ If the partner received an HIV test, document his or her HIV test result.
- ◆ If the partner tested HIV-positive, record whether he or she has been initiated on ART

## **CHAPTER 4: INDEX CASE HIV TESTING AND COUNSELING PROTOCOL FOR SEXUAL PARTNER OF INDEX**

### **Learning objectives:**

By the end of this session, the participants will be able to:

- ◆ Perform building rapport and pretest information
- ◆ Recommend and offer HIV testing
- ◆ Provide HIV negative test results and risk reduction counseling
- ◆ Provide HIV positive test results, linkage to care and treatment services

### **Contents**

- ◆ Conduct building rapport and pretest information
- ◆ Recommend and offer HIV testing
- ◆ Providing HIV Negative result
- ◆ Providing HIV Positive result

### **Component 1**

#### **Building rapport and pre-test information during provision of HIV testing for partners of index client**

Pre-test information should be provided by trained health care service providers. The relevant information that should be provided includes but not limited to:

- ◆ Building rapport with the partner of index client to establish a very good relationship.
- ◆ Exposure to HIV infection and implications of undiagnosed HIV infection.
- ◆ The clinical and prevention benefits of HIV testing individuals, sexual partners, and eligible biological children (less than 19 years).
- ◆ Benefits of early ART and the fact that people with HIV who achieve and maintain an undetectable viral load cannot transmit HIV sexually to their partners when the prerequisite for U=U are met (durable viral load suppression for the last 6 months).
- ◆ The meaning of an HIV-positive diagnosis and of an HIV-negative diagnosis.
- ◆ The importance of disclosing known HIV status to the provider to minimize repeat testing of a known case. There is a possibility for false negative result if a person who is already on ART is tested for HIV using an antibody test.



- ◆ The confidentiality of the test result and any information shared by the client.
- ◆ Discuss any concern through availing more time for the client. The need to acknowledge clients' fears and opportunity to ask the provider questions.
- ◆ The client's right to refuse testing and that declining testing will not affect the client's access to HIV-related services
- ◆ Verbal consent should be obtained before conducting HIV testing for the sexual partner:

## **Component 2**

### **Recommend and offer HIV Testing:**

- ◆ Inform sexual partner of index to be tested for HIV.  
*"HIV testing is among the services we provide, and I advise you to conduct HIV testing unless you refused".*  
*"You have a right to refuse to conduct HIV testing but you are exposed to HIV, and we advise you to know your status for your family health and future live".*
- ◆ If a client accepts HIV testing, proceed to HIV testing.
- ◆ If a client decline HIV testing, identify the problem and proceed to HIV testing if successful.
- ◆ If a client declines and our counseling is not successful, plan return for testing.

### **If partner accept HIV testing**

The health worker will perform the HIV testing per the national HIV testing Algorithm.

## **Component 3**

### **Posttest Counseling: HIV negative test result and risk reduction counseling**

Conduct posttest counseling services for individuals who tested HIV-negative using ICT cue card without compromising the steps.

- ◆ Clearly inform the meaning of HIV Negative test result.
- ◆ Result MUST be given in a private room or environment in person ONLY.
- ◆ Explaining window period in case of recent infection or ongoing risk.
- ◆ Recommendation on repeat test based on the client's level of recent exposure and/or ongoing risk of exposure.

- ◆ Emphasis on the importance of knowing the status of sexual partner(s) and information about the availability of partner testing services in case if he/she has another partner other than the index.
- ◆ If the client's another partner does not have HIV, both partners can protect each other from getting HIV by being faithful and not having sex with other partners.
- ◆ If possible, inform the client to abstain from sex or to have safe sex until the other partner gets tested.
- ◆ Clients who do have sex with HIV-infected partner(s) or with partner whose status is unknown can protect themselves by using condoms correctly & consistently every time they have sex.

#### **Component 4**

##### **Posttest counseling: HIV positive test result, linkage to care and treatment services**

Provide posttest counseling services using the ICT cue card for partner who tested HIV positive.

- ◆ Provide the HIV test result clearly and simply explain the meaning of test result.
- ◆ Result MUST be given in a private room or environment in person ONLY
- ◆ Give the client time to consider the meaning and implication of result and help the client

Cope with emotions arising from the diagnosis of HIV infection.

- ◆ Focus on the client level of understanding and the overall client situation, acknowledge that may be difficult to hear being HIV positive, however express the client confidence in her/his ability to adjust and cope through time.
- ◆ Discuss immediate concerns and help the client decide who in her/his social network may be available to provide immediate support as an individual or organizations in the community.
- ◆ Stress the importance of getting care and treatment for HIV including prophylaxis of OI.
- ◆ Provide clear information on ART and its benefits for maintaining health and reducing the risk of HIV transmission, as well as where and how to obtain ART, including information of the reduced transmission risk when virally suppressed on ART.

- ◆ Assess current health condition for prevention, support and other services as appropriate for example TB diagnosis and treatment, prophylaxis for opportunistic infections, STI screening and treatment.

Assess the risk of intimate partner violence and discuss possible steps to ensure the physical safety of clients, particularly women, who are diagnosed HIV-positive.

- ◆ Discuss positive living.
  - Retesting is required that all HIV positive clients linked to care and treatment services need to be retested before treatment is initiated using the existing testing algorithm **ONLY** by the health facility service providers where the ART services are provided.
  - Ensure confidentiality to client and advice to whom to disclose. Clients will be very concerned about others knowing their HIV status, and they will need time to figure out who to disclose to and how to manage their situation.
  - Inform clients about the importance of preventing transmission of HIV to the client's partner(s) and preventing the partner(s) from getting other STIs and/or re-infection with different strains of HIV by using condom regularly and consistently.
  - Explain about the importance of initiating partner notification services for the newly diagnosed client to inform to the other HIV exposed partner(s) to be tested for HIV. Because the client is infected with HIV, the other client's partner (s) must be tested, as soon as possible, to determine if he/she is infected.
  - Assist the client on disclosure and interview to elicit about her/his other partner(s) who can then be confidentially notified, referred, and provided ICT.
  - Inform the client that the partner notification and referral services are voluntary at the choice of the client and are provided confidentially at no cost in a person-centered framework.
  - The client may inform to you that his/her partner(s) has already been tested. Acknowledge this is a good thing but go on to discuss the need to prevent transmission of sexually transmitted infections and protection from other HIV strain, regardless of the testing status of the partner(s).
  - Be sure and emphasize the importance of protecting the negative partner.
  - Advise to using condom consistently and correctly all the time. Assess clients' knowledge on proper use of condoms and do a condom demonstration.

- Advise the client that if she is pregnant or planning to get pregnant that she should tell the health care provider at the HIV care clinic/ ANC to talk about how to protect the unborn child from HIV.
- If a newly diagnosed HIV positive client is female, assess for the importance of family planning service and arrange to meet with HF service providers.
- Make an active referral for a specific time and date. (Accompanies the client to ART room for enrolment into HIV clinical care.)
- Discuss barriers to linkage to care, same-day ART initiation. Arrange for follow-up of clients who are unable to be initiated on ART on the day of diagnosis.
- Give the client a referral to the HIV care clinic and arrange staff to escort for an HIV care clinic. Urge the client to go to the HIV care clinic with staff as soon as possible.
- Encourage and provide time for the client to ask additional questions.

Collect the referral feedback paper & Unique ART number (UAN) to ensure the effectiveness of linkage, tracking of clients and documentation on appropriate registers

### **Recency Testing**

Probable recent infection case is a confirmed newly diagnosed HIV positive individual who tested positive for recent infection. A detailed information is available in the main HIV CBS (Case based surveillance) response guideline.

Confirmed recent infection is a confirmed newly diagnosed HIV positive individual who tested positive for recent infection and has high viral load.

### **Purposes of Recency Testing**

The identification of newly infected individuals and the presence of recent infection will support the national HIV program to rapidly respond to sub-populations and sites where high levels of HIV transmissions are detected. Following identification of cases, responding to individuals with probable recent infection or groups of HIV-infected persons with sexual partners and social networks is a critical step toward bringing the nation closer to the goal of no new infections. Case reporting and HIV recency data should be used to guide an enhanced response at the health facility/site level and at the cluster/above site level. As country's getting closer to epidemic control it is recommend conducting recency testing for all newly diagnosed HIV cases above 15 years. For Ethiopia recency testing is currently endorsed and being done for 15+ years old newly identified HIV positive persons.

## **A. Site Level Response**

Healthcare providers are required to document all probable recent infections and risk factor information about the newly identified HIV positive cases to provide enhanced response and timely monitoring. Site level response includes:

- All newly diagnosed HIV positive individuals should be linked and start ART within the same day.
- ICT services should be provided for sexual partners and <19 biological children.

## **B. Above-Site level/Cluster response**

Above site response is primarily based on the identification and analysis of clusters based on the CBS data. The type and level of public health response needed for each identified cluster is guided by the magnitude and propagation of transmission. Some clusters may require routine public health actions such as ICT and linkage to care and treatment services, while other clusters may require enhanced response activities (e.g., targeted demand creation and testing as well as strengthen partnership of relevant stakeholders).

Role Play Aster is a 32-year-old secretary working in one of the shoe factories in Addis, who was enrolled and initiated on ART 2 weeks back. The HCP offered her ICT service, and she elicited two sexual partners. Aster preferred client referral method to bring both her partners to the health facility for HIV testing. The HCP offered HTS for Aster's partners but one of them refused while the other accepted. Hence the HCP needed to provide in depth counseling on the importance of ICT service finally the contact accepted and HIV test result for one partner was negative while for the other partner was positive. Now four participants will play the role of Aster's partners, HCP with one additional observer using a standard checklist

- ◆ Observe the HCP while building rapport and providing pretest information
- ◆ Observe the HCP while offering HIV testing
- ◆ Observe how the HCP Provide HIV negative test results and risk reduction issues
- ◆ Observe how the HCP Provide HIV positive test results, linkage to care and treatment services

## CHAPTER 5: INDEX CASE HIV TESTING AND COUNSELING OF < 19 YEARS OLD BIOLOGICAL CHILDREN OF INDEX CLIENTS

### Learning objectives:

By the end of this session, the participants will be able to:

- ◆ Describe the different approaches needed for testing of biological children of index client
- ◆ Use recommended scripts to children
- ◆ Describe the significance of HIV antibody and DNA-PCR test under 18 months of age born from HIV positive parents
- ◆ Conduct counseling for biological children of index using ICT cue card
- ◆ Address disclosure issues related to the HIV status of biological children of index

### Contents

- ◆ Rationale for testing infants, children and adolescents
- ◆ Testing of adolescents
- ◆ Testing infants and children
- ◆ Different approaches needed for testing infants, children and adolescents
- ◆ Use recommended scripts to children
- ◆ Description on the significance of HIV antibody and DNA-PCR test in infants under 18 months of age
- ◆ Counseling for biological children of index using ICT cue card
- ◆ Address disclosure issues related to the HIV status of biological children of index.

ICT service providers need to ensure all biological children <19y/o of PLHIV and biological siblings <19y/o of C/ALHIV have a known HIV status or are offered HIV testing.

### Rationale of HIV testing for an infant, child or adolescent clients

- ◆ There are broadly two types of HIV testing that can be performed on infant, **these are:**
  - Serological/antibody tests
  - virological/DNA PCR tests.

- ◆ For babies under the age of 18 months, antibody testing can be used as a screening tool to determine if a child has been exposed to HIV. However, they cannot be used to confirm if an infant has become infected. Therefore, all infants born to HIV- infected women should be tested using DNA PCR test at the age of 4-6 weeks.
- ◆ Infants born to women of unknown HIV status should get an antibody test and, if found positive, should get a DNA PCR test to confirm HIV status of the infant. If young children test HIV-positive, it is very likely that their mothers are also infected.

All HIV testing services, including index testing, must meet WHO's 5C standards

### **What is pediatric index testing?**

Pediatric index testing is part of family-based index testing with the aim of reaching biological children of PLHIV and biological siblings of C/ALHIV.

### **Why is it important to test biological children of PLHIV?**

Because of Perinatal HIV infection and HIV Infection during breast feeding. Thus, it is critically important to identify children who were exposed to HIV during pregnancy, delivery, or breastfeeding and ensure these children are offered HIV testing.

### **Why is it important to test biological siblings of C/ALHIV?**

Because if there is one HIV positive sibling in the family, there is a high probability of the rest of biological siblings being HIV positive.

### **Who should be offered index testing?**

Parents living with HIV (male and females) who are newly diagnosed, newly initiated on ART, currently on ART and C/ALHIV newly diagnosed, and initiated on ART , currently on ART who have biological family members with an unknown HIV status..

### **How should pediatric index testing be done?**

Through safe and ethical index testing, without coercion, and only where consent is provided by the caregiver or adolescent (based on national age of consent for testing policies).

### **Who are the possible index clients in index testing?**

- ◆ All HIV-positive women with biological children <19 y/o (e.g., PMTCT/ANC, ART entry points). Index testing programs should coordinate with early infant diagnosis (EID). programs to ensure HIV-exposed infants are tested at 2, 12, and 18 months.
- ◆ HIV-positive men who report that the child's biological mother is HIV-positive, deceased, or her HIV status is unknown.
- ◆ HIV-positive infants and children with biological siblings <19 y/o PLHIV should include KP living with HIV who can also be parents or caregivers.

## STEPS FOR PEDIATRIC INDEX TESTING SERVICES

The steps for providing ICT to children <19 years old are outlined below:

- ◆ Ensuring PLHIV, including C/ALHIV, who are newly diagnosed, initiated or already on ART **are asked to list their biological children or siblings** in need of testing
- ◆ Reviewing patient files before every visit to ensure PLHIV have a documented HIV status for all of their biological children, and **flag charts with incomplete index case testing service follow up form** to offer the client index testing services during their upcoming visits.
- ◆ Ensuring at-risk children and adolescents identified during the elicitation process **are offered testing within two weeks of their identification** either through community or facility-based testing platforms.

### Step 1: Identify Biological Children and Siblings <19 years in Need of HIV Testing

All children and adolescents less than 19 years of age who meet the criteria should be offered HIV testing services:

Index testing services should be offered at all entry points where PLHIV receive ART including at ART/PMTCT, KP clinic including drop-in centers.

The major entry for testing children of PLHIV are identifying PLHIV/Index patients who did not elicit/tested their children.

Based on category of index patients, service providers need to approach them to elicit and test their children/siblings.

For newly diagnosed PLHIV HCWs will encourage the client to list all of their biological children <19 years at their initial ART visit and will be documented on ICT service follow up tool and ICT register.

For PLHIV Enrolled in ART Services the HCWs need to: -

Use the active appointment tracking system currently in place to identify clients with upcoming appointments.

Prior to appointment, pull the chart and review the ICT service follow up tool of each incoming ART client to identify their biological children/siblings <19 years (names and testing history).

If the ICT Service follow up tool is not complete, flag this chart to be reviewed with the client.

If the index already elicited and test children <15 years, you will need to ask the client if there are any additional children 15-19 years who were not previously identified.



Community partners can help to track and contact HIV-Exposed Children Identified During Index Testing.

Once clinical staff have identified families with children or adolescents in need of HIV testing but unable to bring their children, these indexes should be made available to the community partner staff working with the clinic for further support, as needed.

Community Partners can also help track the children out in the community and offer them a referral for HIV testing with information about where they can access HIV testing. They can also help families address any barriers to HIV testing (e.g., lack of transport, disclosure, etc.)

*Remember: clients' personally identifiable information and their family's information must always be kept confidential. To support this, there has to be signed MoU between the health facility and community partner.*

Once the community partner has contacted the child, they should provide feedback to the health facility where the child's name was elicited so the parent's ICT service follow up tool can be updated.

## **Step 2: Introduce Index Testing to the Index Client**

During pre-test information OR PMTCT/ART visits, providers should inform the index client that:

The testing site (e.g., health facility or community testing site) is offering index testing services to assist the client to test their biological children (<19 years of age) for HIV.

The service is offered because we know disclosure of HIV status to children can be difficult.

Ensure the client knows that all information will be kept confidential. This means:

It's the client's choice whether to tell their child(ren) about their HIV status.

Their HIV status will be kept confidential and will not be disclosed to their child(ren).

Their child(ren) can be tested for HIV even if they do not feel comfortable sharing their HIV status with their children.

Ensure that the client knows that index testing services are voluntary.

Clients should be informed of their right to decline participation in index testing services

They will continue to receive the same level of care at this health facility or community site regardless of whether they choose to participate in index testing services.

Obtain verbal consent to continue with the elicitation interview.

If consent is given, the provider will ask for the names of all their biological child(ren) <19 years old.

If consent is not given, further conversation and follow-up is desired.

### **Step 3: Discuss Importance of Testing Biological Children with Index Client**

It is important to know your child(ren)'s HIV status due to many reasons:

Children living with HIV can start HIV treatment soon diagnosed. They will benefit from starting HIV treatment in a timely manner to ensure the child remains healthy (e.g., fewer illnesses, decreased viral load) and grows normally

Treatment also helps children and adolescents living with HIV grow and develop normally.

HIV-negative children and adolescents can know their status and take steps to remain HIV-free.

If the child is living with HIV, HCWs can help can decide when it is the right time to tell your child about his/her HIV status.

After discussing the importance of testing for their children, proceed to elicit the names of biological children and adolescents <19 Years.

During the elicitation, service providers will ask women to name all the children less than 19 years to whom she has physically given birth (so that she does not name non-biologic children who may be under her care).

If the index client is a child, ask the caregiver or parent to name the child's siblings and biological parents and record the name, age, contact information, and HIV status (positive, negative, or unknown) for all the children and adolescents identified on ICT register.

### **Step 4: Work with the Index Client to Develop a Testing Plan for Each Named Child and Adolescent**

A variety of different interventions can be employed to increase access to index testing for biological children and siblings of PLHIV and C/ALHIV on ART. Once biological children and siblings of PLHIV are identified, systems should be in place to facilitate access to testing, including involvement of community partner Programs, where applicable.

Index testing should follow national testing recommendations and be conducted in a safe and private environment.

HCWs need to discuss with index patients on the different testing options and support to choose the one appropriate for them.

Several options are available to assist clients with getting their children tested for HIV:

Home-Based HIV Testing

Provider-Facilitated Home Testing

## Facility-Based HIV Testing Options

Contract Referral

Facility-Based Testing

Community based HIV testing Options.

Testing Campaign

Community-Based Testing

Home-Based HIV Testing

This is the option where community testing providers come to the family's home to offer HIV testing to all HIV-exposed children (with consent from the index client). All HIV-positive children and adolescents are escorted to a facility for ART initiation and registered on facility ICT register.

### **Facility-Based HIV Testing Options**

Contract Referral:

In this option, the parent/caregiver will have 14 days to bring child(ren) to the facility for testing. After which, the counsellor will call the index client to obtain permission to send a counsellor to test the child(ren) in the home or refer for facility testing.

Community Partners can also help facilitate access to a facility or community testing point.

Service providers will identify a date 14 days from the date and agree with the client that they will bring their child (ren) for HIV testing by this date.

In follow up, client has to be reminded if their child (ren) do not come for an HIV test by that date, you will call to get his or her permission to give the list of the children to community level testing organization to visit his/her home, bring his/her child where appropriate for testing.

If the client does not provide permission to come to their home, record this outcome on the ICT Register.

### **Facility-Based Testing:**

This is an option where PLHIV bring their children to the facility for HIV testing. Once the child is tested, results are documented in the index testing register by the testing provider. HIV-positive children are linked to treatment.

**Community HIV Testing Options:** Under community HIV testing options, there are 2 options.

### **Testing Campaign:**

This option will be given for the index usually on the weekend to increase access and reduce time away from school. If the index preferred this option, service provider will further discuss the to identify appropriate areas as well time and let them bring their child(ren) where agreed.

### **Community-based testing:**

This option is another type of testing options where indexes are advised to bring their children in the community where they preferred and nearby them.

If the client chooses community-based:

Schedule a date when a health care worker will visit the client and his/her child(ren) in their home or another place appropriate for the index client.

Document the date of the requested home visit, or a day of the week and time of day that works well for the client to bring his/her child (ren) where selected by index client.

Confirm mobile phone numbers and home address (include landmarks) and place where the index client prefers for testing his/her child (ren).

**HCWs will develop a testing plan with the Index Client through** Determining the preferred testing approach for each named child and adolescent: During the testing plan support, service providers will:

Walk through each of the available testing options with the index client ensuring they understand the steps and process for each option

Schedule an appointment for the client to bring in their child(ren) or arrange for day/time for home or community-based testing.

Confirm mobile phone numbers and home addresses for all biologic contacts (including landmarks).

For those index clients who decline to have their biologic children and adolescents tested for HIV service provider will ensure proper follow up with counseling and referral to community partners, where applicable.

### **Step 5: Conduct Testing and Counseling for All Children Using the Preferred Approach**

Provide HIV testing and counseling services to all biologic children and adolescents based on the testing plan.

If the child/adolescent tests HIV-positive, link them to ART services

If the child/adolescent tests HIV-negative, provide referrals to prevention services as applicable.

Refer all children/adolescents of PLHIV to OVC programs.

All the outcome of the index case testing service will be documented on ICT service follow up tool and ICT register.

NB: Child(ren) testing HIV-negative, do not need additional testing unless they have a new exposure.

### **Step 6: Conduct an Ongoing Review of PLHIV and C/ALHIV for Additional Index Testing Opportunities**

For Individuals Newly Diagnosed as HIV-Positive/Newly Initiated on AT, Service providers will ensure a pool of elicited contacts is created at their initial ART visit and offer them index testing services.

For all PLHIV Enrolled in ART/PMTCT Service, service providers will conduct ongoing discussions with PLHIV on ART at every clinical visit to review ICT Service follow up tool completion and ensure there are no additional biological children in need of HIV testing/linkage to ART.

If there are newly elicited children, repeat steps 2-5 for all children and adolescents who are newly elicited.

#### **Testing of biological children born to HIV positive parents**

According to the newly approved national comprehensive HIV prevention, care and treatment guideline all biological children of index age less than 19 are eligible for HIV testing.

However, you may need to speak with the child parents or guardians about HIV testing recommendations or guidelines because it may be the parents' or guardians' responsibility to make decisions regarding testing,

#### **At what Age are adolescents legally responsible for their own health care decisions?**

In Ethiopia, the legal age at which an adolescent may be considered an adult is 18. However, adolescents 15 years and older are allowed to make their own decisions with regarding to HIV testing as mature enough.

Adolescents aged 13–15, who are married, pregnant, commercial sex workers, street children, heads of households or sexually active are referred to as mature minors and eligible to conduct testing without bringing their guardians.

#### **Testing of biological Adolescent born to HIV positive parents**

Adolescent to be able to participate fully, he/she must be educated along with the parent about the need for HIV testing as part of their diagnostic work-up, the benefits and so on.

Participation of adolescents in this process may have benefits for their clinical care. Being active participants in their own care may support the adolescents' for better decision making in the future.

In addition, open communication may build trust between the adolescent and the health care provider, which may lead to the adolescent tested for a better adherence for future treatment.

For these reasons, it is better to involve both the parent and adolescent in the testing process. The script advises that you speak primarily to the adolescent while acknowledging the role of the parent.

It is best if the adolescent and parent can sit next to each other while you are talking.

You may want to explain to the parent first that you will be talking to the adolescent so that you do not seem disrespectful.

**Handling the reactions of parents and adolescents that includes but not limited:**

Reassuring adolescents and parents that this does not mean that their life is over. With the ART, HIV-positive persons can live long and productive lives.

Parents may be visibly upset and worried about their children. Acknowledge their feelings and inform parents they will cope up through time as hearing for the first time creates such difficulties.

Reassuring the parents that the HIV test does not indicate how a person got HIV only that they have the virus. Remind the parent that their current support of their adolescent is critically important to cope up.

Reminding adolescents and parents that there are community resources that can help the family deal with the situation.

Referring the adolescent and parent(s) to local support groups or youth friendly services that may be available in your community.

In rare cases, parents may abandon their adolescent or even throw him or her out of the home to live on the street. This happens especially when the parent is not around, and the adolescent is accompanied by guardians.

It will be important to make sure that the adolescent knows that they can come to the clinic at any time to address concerns or questions.

## **INITIAL DISCUSSION WITH PARENTS AND CHILDREN USING THE ICT PROTOCOL**

### **Component 1 INTRODUCE THE RISK OF EXPOSURE OF HIV AND INFORM THE PARENTS/GARDIAN ON THE NEED TO TEST CHILD/REN FOR HIV**

#### **Importance of testing of biological children born to HIV positive parents**

The most common way that children get HIV is from their HIV positive mothers during pregnancy, labor and delivery, or through breastfeeding. Thus, the mothers of children who have HIV are very likely to have HIV as well.

If the mother is HIV-negative, the child most likely contracted HIV from a blood transfusion, breastfeeding from another HIV-positive woman (wet nursing), medical injection, harmful traditional practices, or (rarely) sexual abuse.

ARV treatment helps children infected with HIV feel better and stay healthy for these reasons; HIV testing is highly recommended for all HIV exposed children with a simple blood test, in addition better health care can be provided for him/her in case of HIV positive test result.

Parents make the decisions about testing for their children, you will be discussing the testing of the child with the parent/guardian.

You will also need to talk to the child, who is being tested, but this must be done in a **developmentally appropriate manner**; this means that what we say and how we say it when talking to a three-year-old will be quite different from when we are talking to a 10-year-old.

#### **What is the children level of understanding during testing and counseling?**

Adolescents and some older children may be able to understand what you are saying to their parents about HIV testing and the results of their tests.

Children around four to five years of age are likely to be able to understand most of the words that you are saying.

Although children may understand the words that they may not grasp the meaning. However, younger children, might not understand all your words, they can be very good at reading your tone and feelings on a subject.

Children older than five years may understand more of the meaning of the words but lack the maturity to understand the significance of HIV testing and HIV test results.

Most adults will keep the HIV status of the child private to protect the child's confidentiality and minimize discrimination.

Children may not understand the concepts of confidentiality or discrimination and may freely share their HIV-positive status which can harm the family.

Regardless of the child's age, most children are clearly aware of the emotions and actions of the adults around them, particularly the parent. This is true even if for very young children; children will sense the parent's emotional stress upon learning of his or her child's HIV infection.

All these issues need to be kept in mind when considering what information to share with children.

### **Why parents refuse testing their children for HIV?**

Parents may refuse because they think their child is not at risk or is too young.

Acknowledge this but remind the parents that it is recommended to test all tested clients with their son or daughter's condition, even if they are at low risk for HIV.

Some parents may want to consult the other parent; acknowledge that this is not mandatory.

If the parent insists on getting permission, encourage the parent to bring the other parent in as soon as possible if your clinical judgment suggests that the adolescent needs a test immediately.

If the adolescent's medical condition is not life-threatening, encourage the parent to bring the other parent along when the adolescent returns to the clinic.

The other important reason why parents refuse HIV testing for children is a fear that it will indicate their HIV status as well (inadvertent disclosure). Parental fear of facility and community level stigma and discrimination.

### **Why biological Adolescents born to HIV positive parents refuse for HIV testing include:**

Ashamed

Feeling guilty about sexual activity

Fear of needles while collecting blood sample

Mistrust of the test

Feeling unable to cope with the result

Worried about stigma/discrimination from peers and others in the community

### **Service providers can encourage adolescent born to HIV positive parents for HIV test:**

Reassuring adolescents about the confidentiality of the result

Asking parents' permission to speak to the adolescent alone



Reassuring adolescent that the pain is minimal

Ensuring availability of treatment for the disease and for preventing other infections

Explain all the possible source of HIV infection to the client (Vertical transmission, unprotected sexual intercourse, blood transfusion, wet-nursing, traditional surgical intervention (tonsillectomy, FGM...)).

Counsel the client to focus on the future- solution instead of thinking on the “Why” and “How”.

Discuss with the parent on the need and possibility of bringing the child/ren for testing another time (specify time limit) if parent/guardian refuse HIV test this time round

### **What is the process for providing ICT service to the biological children of index?**

To facilitate the discussion with both the parent and the child, ideally you should first talk with the parent about the need for HIV testing without the child being present.

Children older than five years of age should be able to wait for us in a separate area where the testing is conducted.

Children greater than five years of age should not attend the counseling session.

Young children will likely be reactive to the emotions of the adults in the testing place, particularly the parent.

### **COMPONENT 2: PREPARE CHILD FOR HIV TESTING WHEN PARENT/GARDIAN AGREES TO TEST**

If the parent agrees to conduct HIV for his/her child, you may then bring the child into the testing room/area to discuss the need for drawing blood.

Most children are afraid of pricks and needles, so you need to reassure the child by telling him/her that his/her parent will be following the procedure and the pain from needle is minimal.

### **Meaning of the HIV test results in infants**

The most used HIV tests are those that detect HIV antibodies, not the actual virus. All HIV-infected mothers will pass their antibodies to their babies while they are in the womb. Thus, all babies born to HIV-infected mothers will have antibodies and will test positive using the antibody test for several months.

Remember that not all babies born to an HIV-infected mother will become infected; this is true even if the mothers do not receive ARV treatment during pregnancy, labor or delivery.

If the infant is sick or appears ill, and the antibody test is positive, it will be important for the service provider to refer the infant for DNA PCR to define the status of HIV in the infant as soon as possible.

In giving the baby's result to the mother, you will need to be able to explain the meaning of a positive result to the mother.

### **COMPONENT 3: POSTTEST COUNSELING FOR HIV NEGATIVE RESULT**

#### **Informing the parent of the child's results**

Children 18 months to 5 years of age may remain in room with parent or guardian for this discussion. For children between 6–12 years of age, the child should not be present for this discussion

Conduct posttest counseling services for parent/guardian whose child/ren tested HIV-negative using ICT cue card without compromising the steps.

Clearly inform the meaning of HIV Negative test result.

Result **MUST** be given in a private room or environment in person **ONLY**.

If the child asks specifically about his/her HIV status or other test results, reassure him/her that the blood tests were "normal." The parent may never have a reason to tell the child that he/she was tested for HIV. There is no reason to encourage this disclosure.

### **COMPONENT 4: POSTTEST COUNSELING FOR HIV POSITIVE RESULT AND HELP PARENTS TO COPE**

Provide posttest counseling services using the ICT cue card for parents/guardian whose child/ren tested HIV positive.

Provide the HIV test result clearly and simply explain the meaning of test result.

Result **MUST** be given in a private room or environment in person **ONLY**

Give the parent/guardian time to consider the meaning and implication of result and help them to cope with emotions arising from the diagnosis of HIV infection.

Give the parent some time to adjust before bringing the child back into the testing room.

The parent may be upset when informed the HIV test result that his/her child has been exposed to HIV or is HIV-positive.

Thus, the provider may need to reassure the frightened child until the parent can gain emotional control.

It will be the parent's responsibility to decide when to tell the child about his/her result.

Health care worker should not tell children less than 12 years of age their HIV diagnosis unless specifically requested by the family.

## **COMPONENT 5: HIV CARE AND TREATMENT FOR HIV-INFECTED CHILDREN.**

HIV Infected Children should be initiated on ART same day to improve and sustain the health status of the child(ren).

Reassure the parent/guardian that his/her child(ren) will be productive and live longer if only received ART.

Discuss barriers to linkage to care, same-day ART initiation. Arrange for follow-up of clients who are unable to be initiated on ART on the day of diagnosis

Stress the importance of getting care and treatment for HIV including prophylaxis of OI.

Discuss with the parent/guardian to identify any concern/challenges related adherence and discuss on possible steps that need to be taken.

Assess current health condition for prevention, support and other services as appropriate for example TB diagnosis and treatment, prophylaxis for opportunistic infections.

Retesting is required that all HIV positive child/ren linked to care and treatment services. need to be retested before treatment is initiated using the existing testing algorithm **ONLY** by the health facility service providers where the ART services are provided.

Explain about the importance of initiating ICT services for the sibling of newly diagnosed HIV positive child/ren if any.

Encourage and provide time for the client to ask additional questions.

Collect the referral feedback paper & Unique ART number (UAN) to ensure the effectiveness of linkage, tracking of clients and documentation on appropriate registers

## **COMPONENT 6: INFORMING THE CHILD HIS/HER POSITIVE HIV TEST RESULT (for children 6–12 years of age)**

### **Inform the HIV-positive test result to the child**

Telling a child about his or her HIV status is likely to be very difficult for parents, assistance from trained counselors in the HIV testing place can be very helpful.

Counselor should conduct appropriate coaching, provide in advance mental pictures to problem solving with role play skills and addressing the four “W” and the one “H” how part is the key basic disclosure steps to have effective disclosure.

Information should be given in a way a child can understand at a pace she/he can cope with according to their cognitive and emotional maturity.

If the child asks questions about their illness, the responses should always be truthful and age-appropriate.

### **How should a child be informed of their HIV status?**

In addition to using language and words that children of different ages will understand, we must also consider what information children need to know and the appropriate times and settings to share that information with the child.

It is important to note that telling a child about their HIV status is a process that does not need to be done immediately after testing but can be done over time.

In general, an initial understanding between the health care worker and the parents about how and when to disclose a child's HIV status can be defined.

Usually, disclosure of a child's HIV status to the child will be done over time in the health facility where they receive their HIV care and treatment.

A good general rule is to respond truthfully to the questions a child may ask about their illness in an age-appropriate manner.

Children should be given information about issues that will affect their lives and should be able to voice their opinions.

Children need information and support to understand the things that are happening to them; this approach is important to minimize fear. Children need to be told their status, but it is important to share information with them:

In an age-appropriate manner

At the appropriate time

In a supportive environment or setting where they can be emotionally reassured

Parents have responsibility to provide information and support to their child, they may need assistance from professionals to know what to say and when to say it.

Providers working in busy health facility and community set up may have limited time to provide counseling to parents.

It is important to keep this in mind as we consider how best to provide counseling services to tested children.

Within the context of ICT, the information that is shared with children during the initial discussion is best limited to informing them that they need a blood test because you are trying to find out why they are sick.

For detail knowledge on pediatric HIV positive result disclosure, please refer to National Comprehensive HIV prevention, care and treatment training manual.

### **What information should children be provided about their HIV status?**

It is suggested that health workers have to limit the information given to young children about testing because they can easily misunderstand what you are saying about HIV. Many children will not be HIV-infected, so providers do not want to cause unnecessary emotional distress.

The situation of a child who tests positive is more difficult. In a busy health facility and community testing site, where the parent is first learning the child's HIV diagnosis, is not the appropriate time or setting to properly inform a child about his/her HIV status.

The parent needs time to adjust to this information before he/she is able to properly inform the child who tests HIV-positive can be informed that the blood test showed they have a germ in the body and will receive special care and treatment.

When the parents and the HIV-infected child are followed in the ART, at the health facility the issue of disclosure can be discussed. Some parents may want to inform their children within the setting of the home and others may need assistance from the counselors.

ART service providers are responsible to provide in-depth family counseling. Therefore, parents will be able to access supportive counseling for themselves and their children in the ART clinic at the health facility.

### **Benefit of telling children their HIV status include:**

To help children cope with their illness, addressing their fears, concerns and questions in an honest and supportive manner, and allowing them to participate in support groups or other coping activities.

To facilitate involvement of children in their care (preventive therapy and ARVs), especially the issue of adherence.

### **Issues to know when telling children their HIV status include:**

Children may not fully understand the situation and become emotionally distressed.

Children may reveal their status without realizing the possible negative consequences.

Think about what might happen if children are not told about their HIV-positive status.

Pretend you are a 10-year-old with HIV infection. You are frequently tired and often too sick to play with other children in your village/neighborhood. Your mother says you must take pills every day that make you sick to your stomach. You must go to the clinic every month, and the clinicians frequently stick you with needles for drawing blood.

The needles hurt and you feel faint at the sight of blood. Although your mother says you are sick, you don't know why or what's wrong with you. And the clinicians are vague when you ask questions.

If children are not told about their HIV status, they may be more anxious and depressed about their illness. And if children are not told the truth, they may become angry and disappointed.

They may be relieved to find out the cause of their illness, even if it is HIV. Children also need to know their HIV status as they may become sexually active adolescents. Therefore, it is very much important to timely disclose their HIV status to prevent spreading of HIV to others, have improved treatment adherence, reduce psychological distress and etc.

### **RECORD THE ICT OUTCOMES**

Recording the outcome of ICT is very much important

Partner(s) uptake of HIV testing and result, and linkage to care and treatment

Document change of preferred notification strategies if the initial plan does not work.

If the partner refused for testing

If IPV screening positive.

Document adverse event monitoring outcome

Record if it is unsuccessful. Why?

### **Role Play**

Abebech has a 14-month-old baby that has had a fever and cough for four days. She took leave from her workplace and took her child to a private clinic. The doctor in the clinic has managed all the acute problems and wants to test the baby for HIV. But the mother was not well convinced with the need of testing her baby. – Assume that the mother refused HIV testing for her baby

Assume that mother agreed to get her baby tested for HIV, and the result was negative

Assume that mother agreed to get her baby tested for HIV, and the result was positive

PROVIDER- INDEX CLIENTS OBSERVATION CHECKLIST DURING INDEX CASE TESTING SERVICE PROVISION AT HEALTH FACILITIES.

**Provider- Index clients Observation checklist during index case testing service provision at health facilities.**

**Purpose:** To observe index client –partner and ICT service providers during interview session at health facilities and build the interviewing capacity of the service provider to meet its objective.

**Instruction:**

**Who will use the checklist?** Observation checklist is designed to use by index case testing trained mentor/ supervisor.

**Where do we put the observation checklist?** After observation of the interview sessions, the preceptor checklist needs to be given to index case testing service provider to build his/herself to improve areas commented for improvement.

**How many provider- patients interview session is adequate?** At least 3 interview session per service providers need to be conducted before providing session feedback.

Date of observation: \_\_/\_\_/\_\_ Name of index case testing service provider:  
\_\_\_\_\_ Name of Mentor/Observer/Supervisor: \_\_\_\_\_

Write N/O (not observed) if the interview did not present an opportunity to observe the skill.

	Not observed/ Not Applicable	Needs Improvement	Satisfactory	Excellent	Comments
<b>Preparation</b>					
Review Medical Record (confirm diagnosis, quick review of intake forms and FU Card for address documentation, contacts documentation and other pertinent info)					
<b>Introduction of self &amp; purpose of interview</b>					
Demonstration of Professionalism					
Welcome clients and introduce self					
Clearly explain the purpose of the interview					
<b>Communication</b>					
SOLER position					
Established Rapport					
Used Open-Ended Questions					
Communicated at Patient's Level					
Solicited Patient's Feedback					
Listened Effectively					
Paid Attention to Non-Verbal Cues					
Presented Factual Information					
Used Affirming Statements to Normalize Client					



Challenges					
Reinforced the Client's Commitment to Notify Their Partner					
Summarized Client's Plan					
Emphasizes Confidentiality					
Information about the index will not be shared with the partner					
Information about the partner HIV status will not be shared to the index clients					
Anything they talked about during their interview and/or clinical review will not be shared to any.					
Index clients documents archival in locked cabinet, secured soft copy in computer with password.					
Index clients and their contacts information sharing with other HFs & community partner importance (Shared confidentiality) discussed					
Privacy					
Only Provider-clients sitting together during interview					
Provider clients are sitting where no interrupting events and patients can talk more without fear of hearing their voice by others.					

Contacts Elicitation					
Review importance of partner and children testing					
Identify Partner(s) and children (Probing as necessary)					
Conducts IPV screening for each named partner					
Provides Appropriate Response to Disclosure of IPV (e.g. LIVES and referrals for GBV)					
Provide four referral/ notification methods and assist the index clients to choose the appropriate one					
Couch index clients who preferred client referral & contractual on how to disclose their status, where, when and how to bring the issue on the table.					
Document all the necessary information of index clients contacts on appropriate forms and registers (CIF, ICT register)					
Identified Client's Concerns					
Assisted Clients to Address These Concerns					
Summarizes Session					
Summarize major points of the interview including agreed up on notification/referral methods with specific days.					



## Module Five Summary

Goal of index case testing and partner notification services are to break the chain of HIV transmission by offering HTS to persons who have been exposed to HIV and linking them to prevention if they are HIV negative and to care and treatment if they are HIV positive.

Sexual partner(s) and biological children <19 years old of HIV positive clients are at higher risk of HIV infection or already being infected with HIV.

Index case testing services will enable identify HIV infected partners and children and to start ART.

ICT is a proven high yield and targeted case finding strategy to reduce future transmission

Clients will undergo testing unless they refuse.

It is recommended that all traced and contacted clients be tested for HIV.

Giving HIV-negative test result is simple, but it is necessary to raise issues of retesting if the client has an ongoing risk and to consistently follow prevention practices, importance of partner notification, test and future prevention.

All positive individuals need to be linked to ART clinic and initiated on ART in same day.

Partner testing, being faithful, abstinence and using condoms are important preventions messages in HIV for both HIV negative and positive clients.

Posttest counseling should be done using the newly approved ICT protocol cue card

All eligible children will undergo HIV testing unless the children or their parents/guardian refuse.

HIV testing services should be provided using the national ICT cue card, protocols and job aids

Sexually active adolescents should follow the Absence, Be faithful, use Condom, Dialogue (ABCD) preventions messages for both HIV negative and positive clients.

Health workers must be aware of the legal age and criteria that allow adolescents to make their own health care decisions

All HIV-infected children will need to be told about their HIV status before adolescence and readiness ongoing counseling is needed, as disclosure of HIV is a process.

## **ANNEX: COMMUNICATION WITH CHILDREN: GUIDE FOR HCPS**

### **1) APPROXIMATE AGES: 6 - 11 YEARS: MIDDLE CHILDHOOD/SCHOOL AGE**

Middle childhood (6-11 yr. of age) is the period in which children increasingly separate from parents and seek acceptance from teachers, other adults, and peers. Children begin to feel under pressure to conform to the style and ideals of the peer group. Self-esteem becomes a central issue, as children develop the cognitive ability to consider their own self-evaluations and their perception of how others see them. Concrete operations allow children to understand simple explanations for illnesses and necessary treatments, although they may revert to prelogical thinking when under stress. A child with pneumonia may be able to explain about white cells fighting the “germs” in the lungs but may still secretly harbor the belief that the sickness is a punishment for disobedience.

### **2) APPROXIMATE AGES 12-15: EARLY ADOLESCENTS**

As children progress through adolescence, they develop and refine their ability to use formal operational thought processes. Abstract, symbolic, and hypothetical thinking replaces the need to manipulate concrete objects. The capacity for verbal expression is enhanced. At this age they start to think abstractly; goes by simple solutions and considers many options. They can make independent decisions, can consider consequences, chooses own values, is idealistic and thinks about the future. This is the stage at which they develop own identity, builds close relationships, tries to balance desire to be part of peer group with family interests, concerned about appearances, challenges authority, may set career goals and lifestyle, likes to feel in control.

**Communication:** Need for privacy, respect, and acceptance. Be open and communicate as it is practiced for adults.

#### **Parents/guardians can use the following steps to communicate with their child(ren).**

If the child was apparently healthy, refer the time he/she was having common childhood illness (Simple headache, URTI, Acute OM, Diarrhea or even fever....) and if the child had history of medical illness (necessitating medication or in-patient care) use that time as a reference for raising the following question. Ask, “What do you think make you sick at that time?” If the child says, “I have no idea.” ..... Proceed with stating that, “It is a GERM that made you sick.

Do you know what GERM is?” If the child says “Yes”, let him/her explain what it is and explain that “I am going to check whether the GERM is still inside your body so that we can prevent it from making you sick again.

ASK: “What GERMs you know or heard that make you sick?” If the child mention HIV, proceed to discussion saying that “Let us talk about HIV. What do you know about HIV?”

If the child says “No” to the question “What GERM is?”, explain to the child that GERM is a living thing that cause disease in a person. It is what made you sick last time and I want to check whether the GERM is still inside your body so that we can prevent it from making you sick again.

**Tips for parents/caregivers:** Respect their opinions, avoid authoritarian approach. Show respect and patience. Be considerate of how needing medical care is affecting them. Friendships and friends’ opinions are important to them. Provide guidance in making positively healthy choices, correct misinformation. Encourage communication between health care team and adolescent. Encourage them to ask questions regarding any fears they may have. Involve them in decision making.





# INDEX CASE TESTING REGISTER

Outcome of Contact Trial					Previous HIV Test Status		HTS Provided				RTRI for newly diagnosed HIV positive contacts			Linkage to care & treatment			PrEP services cascade for HIV Negative Sero Discordant Couples			Adverse Events monitoring			Remark												
1 <sup>st</sup> Trial		2 <sup>nd</sup> Trial		3 <sup>rd</sup> Trial	Notified face to face (Y/N)	Tested Before (Y/N)	Prior HIV test result (P/N/I)	Duration since last test (in month)	HIV Self-test		National Algorithm	Is s/he Eligible for Recency testing? (E, NE)	Is s/he Tested for recency? (Y/N)	Recency testing result: Probable Recent (R), Long-term (LT), inconclusive (W)	Date Linked to ART	Date ART started	UAN of newly identified HIV positive	Date new HIV Positive Contact linked to ICT service	If not linked to ICT (Code 1-3)	Assessed for PrEP (Y, N)	PrEP eligibility (E, NE)	Started Oral PrEP (Y, N)		Date started PrEP	Adverse Events for IPV (Y, N)	If Y, AE type (1-13)	Linked to appropriate service (Y, N)	Case closure status (code 1 to 4)							
Date (D/M/Y)	Outcome (1 - 4)	Date (D/M/Y)	Outcome (1 - 4)	Date (D/M/Y)					Outcome (1 - 4)	Date HIV Self-test kit distributed (D/M/Y)	Date contact reported self test result (D/M/Y)																		Contact HIV Self-testing result (R/NR)	Date contact tested for HIV (D/M/Y)	Contact HIV test result (P/N/I)				
20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51				



## ANNEX 2: ICT SERVICE PROVISION FOLLOW UP TOOL

### INSTRUCTION

#### Purpose of the tool.

This ICT \_ PrEP service provision tool is designed to be used at ART & PMTCT providing health facilities to be filled at every client visit for continuous patient follow up until cases are closed. This tool is believed to optimize individual level index follow up support and basic service to be provided for the index clients and their contacts. It will also be used as data source for automated ICT data as one features of EMR ART which will help facilities to know their ICT contacts pool/universe (to identify index contacts with unknown HIV status) which helps providers to discuss with the index client and plan about the untested contacts. This tool will also be used to support individual level response for newly diagnosed adults with recent HIV infection. Identifying IPV, linking those with IPV risk to post GBV care and monitoring of adverse events is the additional importance of this tool.

#### Instruction

SN	Data elements	Descriptions
1	Category of index clients to be identified for further follow up to elicit and test their contacts	
1.1	Follow up Date (D/M/Y)	Write the date patient came for follow up and completed the tool (DD/MM/YY).
1.1	Already offered and tested all contacts (Y, N)	Identify and write those indexes already offered and tested their contacts and list their and document their tested contacts.
1.3	HVL adult(Y/N)	Assess and write the Category of index as Y/N if he/she is with HVL during the specific visit.
1.4	Known positive not started ART(Y/N)	Assess and write the Category of index as Y/N if he/she is with known positive but not started ART during the specific visit.
1.5	Already enrolled and on ART not offered ICT.	Assess and write the Category of index as Y/N if he/she is known positive who started ART but missed to offer ICT during the specific visit.
1.6	Known positives on ART lost and returned to care(Y/N)	Assess and write the Category of index as Y/N if he/she is with known positive on ART but lost and returned during the specific visit.
1.7	STI(Y/N)	Assess and write the Category of index as Y/N if he/she is

		with STI during the specific visit.
1.8	FSW(Y/N)	Assess and write the Category of index as Y/N if she is FSW during the specific visit.
1.9	Index with untested contacts(Y/N)	Assess and write the Category of index as Y/N if he/she is index with untested contacts documented during the specific visit.
1.10	Newly tested positives and enrolled(Y/N)	Assess and write the Category of index as Y/N if he/she is newly diagnosed HIV positive and enrolled to care during the specific visit.
1.11	CRF Completed(Y/N/NA)	Assess and write Y if the index is new positive and completed CRF, N if new positive and not completed CRF and intervene, NA if the index is not newly diagnosed HIV positives in that specific health facility.
1.12	RTRI Result (R/LT/I/NA)	Assess and write R if the index recency test result is recent, LT if index recency test result long term, I if index recency test result inconclusive.
1.13	Offered (Y/N)	Write Y if ICT service is offered for those list of indexes [1.2-1.9] with Yes response, N if ICT is not offered,
1.14	Accepted (Y/N)	Write Y if the index accepted ICT service and N if the index not accepted ICT service.
2	IPV monitoring service for adult Index	
2.1	IPV Screened (Y/N/NA)	Assess and write Y if the index is adult and selected for further follow up for elicitation and tested and screened for IPV per elicited sex partners, N if IPV is not screened per elicited partners, NA if the index is child and already have partner with known HIV status during the follow up date.
2.2	IPV Risk identified (Y/N)	Write Y is IPV risk is identified which can be either emotional, physical, Sexual and N if IPV risk is not identified during specific follow up visit.
2.3	Linked to PGBV service (Y/N/NA)	Write Y is index with IPV risk identified is linked to post GBV care, N if not linked to PGBV care and NA is IPV risk is not identified during the specific follow up visit.
2.4	Adverse events assessed (Y/N/NA)	Write Y is adverse events are screened, N if AE is not screened and NA if the index is child/ already have known status sexual partners during follow up visit.

3	Elicited Contacts HIV test result and linkage information	
3.1	Contacts Name Initials	Write 1st letter from each contact name and father name
3.2	Age	Write age in years
3.3	Sex	Write contact sex as M- Male and F- for female
3.4	Elicited Contact category (1-5)	Write contact category (1. Sex Partner 2. Child (<19) 3. Parent 4. Sibling (<19)5. Others (Specify))
3.5	Elicited date	Write date the contact is elicited (DD/MM/YY)
3.6	Tested before (Y/N)	Assess the previous HIV testing status of the contacts and write Y= if tested before, N= if not tested before.
3.7	Prior HIV test Result (P/N/I)	Write previous HIV test result of those with already known status as P-Positive, N- Negative & I-Invalid during follow up visit.
3.8	Duration since last test (in months)	Write contact test duration in months.
3.9	Notification method used (1-4)	Write notification methods used (1. Client 2. Contractual 3. Dual 4. Provider ) to notify exposure and test the partner
3.10	Date Self-test distributed/NA	Write date HIV self-test distributed for those index partners HIV self-test collected or NA if the contact is known HIV status.
3.11	HIVST Result(R/NR/I/NA)	Write HIV self-test result if the result is tracked and documented as R-Reactive, NR-Nonreactive, I-Invalid, NA-Not applicable.
3.12	Date appointed for testing	Write the exact date the contact appointed for testing ether through index or providers in DD/MM/YY.
3.13	Date tested by conventional testing	Write date the contacts tested by conventional testing under use in the country during the follow up visit.
3.14	HIV test result (N/P/I)	Write HIV test result of those with already known status as P-Positive, N-Negative & I- Invalid during follow up visit.
3.15	Linked to care(Y/N)	Write Y if the contact is HIV positive and linked to care and N if not linked to care and treatment.
3.15	Started ART(Y/N)	Write Y if the contact is HIV positive and started ART and N if not started ART.

4	PrEP for HIV Negative Partner	
4.1	Screened (Y/N/NA)	Write Y if the HIV negative sero discordant partner is screened for PrEP and N- if not screened.
4.2	Eligible(Y/N)	Write Y if screened HIV negative sero discordant partner is eligible for PrEP and N- if not eligible based on eligibility criteria.
4.3	Started (Y/N)	Write Y if Eligible HIV negative sero discordant partner started on PrEP and N- if not started PrEP.

**ICT and PrEP service provision Follow up tool**

**Index Name:** \_\_\_\_\_ **Age:** \_\_\_ **Sex:** \_\_\_ **Date tested positive:** \_\_\_\_\_ **ART started / Enrollment date:** \_\_\_\_\_ **S.No on ICT Register:**\_\_\_\_\_

**Address: Region:** \_\_\_\_\_ **Zone/Town/Woreda:** \_\_\_\_\_ **HF:** \_\_\_\_\_ **Kebele:** \_\_\_\_\_ **House No:** \_\_\_ **Phone number:** \_\_\_\_\_

**Marital status:** 1. Single                      2. Married                      3. Divorced                      4. Separated                      5. Widowed                      6. Cohabiting

**Target Population:** A-FSW B-Long distance truck drivers C-Prisoners. D-Mobile Worker/Daily laborer E -Other MARPS (Widowed, Divorced, Separated, Re-Married) F- General Population

Check the status at every client visit \_ **Y** (Yes), **N** (No), **NA** (Not Applicable)

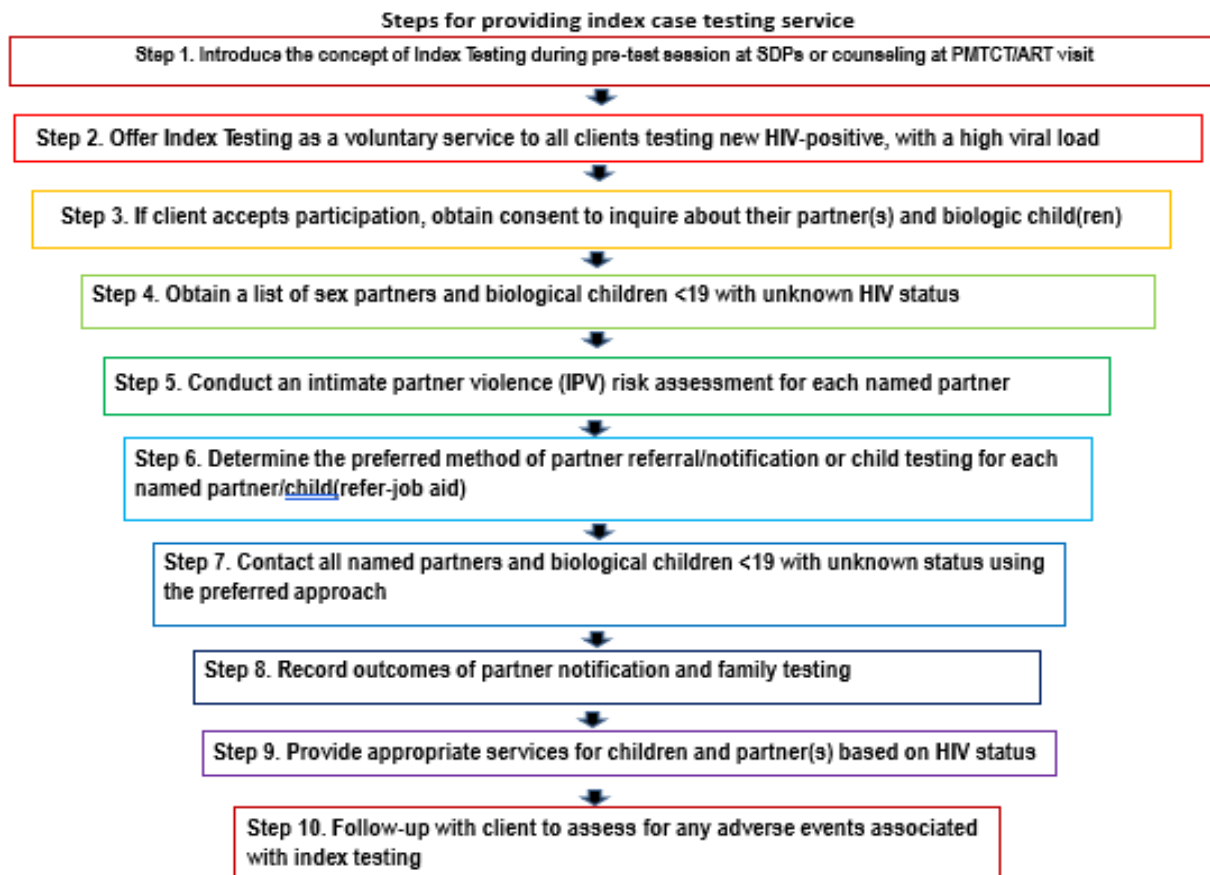
Follow up Date (DD/MM/YY)	Already offered and tested all contacts (Y, N)	Category of index clients to be identified for further follow up to elicit and test their contacts											IPV monitoring service for adult index				
		HVL adult (Y/N)	Known positive not started ART (Y/N)	Already enrolled and not offered ICT(Y/N)	Known positive on ART lost and returned to care(Y/N)	STI (Y/N)	FS Ws (Y/N)	Index with untested contacts (Y/N)	Newly enrolled (Y/N)	CRF completed (Y/N/NA)	RTRI Result (R/L/T/I/NA)	Offered (Y/N)	Accepted (Y/N)	IPV Screened (Y/N/NA)	IPV risk identified (Y/N)	Linked to PGBV service (Y/N/NA)	Adverse Event assessed (Y/N/NA)

Elicited contacts HIV test result and linkage information															PrEP for HIV Negative Partner			
Contacts Name initials	Age	Sex	Elicited Contact Category (1-5)	Elicited date	Tested Before (Y,N)	Prior HIV test result (P/N/I)	Duration since last test (in month)	Notification method used (1-4)	HTS Service							Screened (Y/N/NA)	Eligible (Y/N)	Started (Y/N)
									Date Self-test distributed/NA	HIVS T Result (R/NR/I/NA)	Date appointed for testing	Date tested by conventional testing	HIV test result (N/P/I)	Linked to care (Y/N)	Started ART (Y/N)			

**Notification Method Used:** 1. Client 2. Contractual 3. Dual 4. Provider  
 2. Child (<19) 3. Parent 4. Sibling (<19) 5. Other (Specify)

**Contact category** 1. Sex Partner

### ANNEX 3: STEPS FOR PROVIDING INDEX CASE TESTING SERVICE



## ANNEX 4: OPTIONS FOR HIV TESTING FOR BIOLOGICAL CHILDREN OF INDEX CLIENTS

### Options for HIV Testing for Biological Children of Index clients



**Facility-Based Testing** = You bring your child to the facility for HIV testing.



**Provider-Facilitated Home Testing** = A counselor or other health care provider will come to your home and test your children.



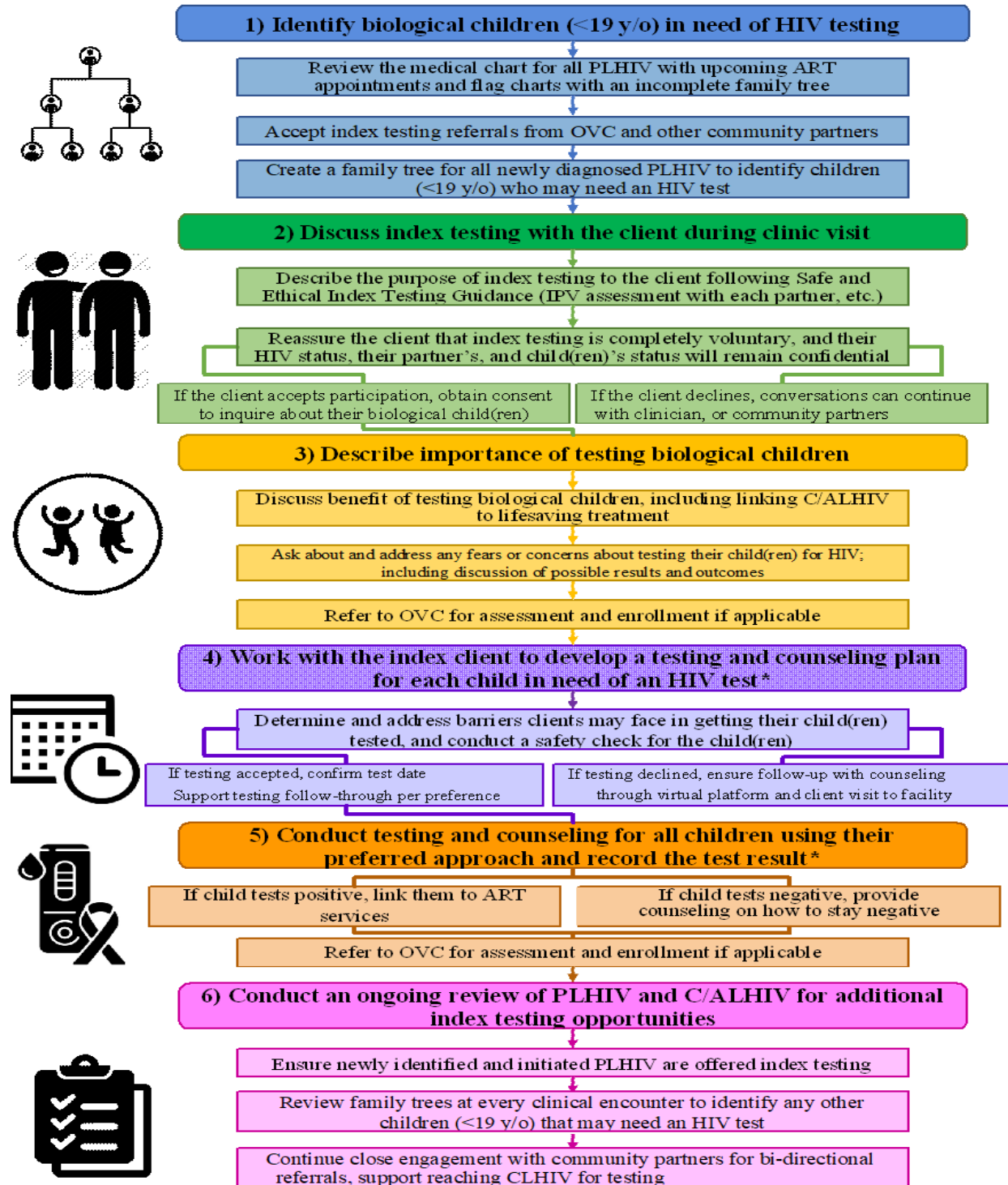
**Contract Referral** = You and the counsellor will work together to test your child. You will have 14 days to bring your child to the facility for a test. After 14 days, the counsellor call to you and identify the reason for not bringing the child and offer test to your child based on your preference.



**Community-Based Testing** = I will give you a date and time for where you can take your child to a place in the community for testing.



ANNEX 5: STEPS FOR PROVIDING INDEX TESTING TO CHILDREN <19 YEARS OLD



# **MODULE 6**

## **HIV RAPID TESTING**

## CHAPTER 1: OVERVIEW OF HIV TESTING TECHNOLOGIES

**Learning objectives:** By the end of this session the participants will be able to:

- ◆ Discuss settings where HIV testing will be part of service delivery points
- ◆ Understand the spectrum of testing technologies for HIV diagnosis
- ◆ Explain the advantages and drawbacks of HIV rapid tests
- ◆ Accurately interpret individual test and final status of the clients

### Contents

- ◆ HIV Rapid Testing at all Service delivery points
- ◆ Spectrum of HIV Diagnostic Tests
- ◆ Challenges with HIV Testing
- ◆ Advantages and Drawbacks of HIV Rapid Testing
- ◆ Three Formats of Rapid Tests
- ◆ Reading Individual Test Results

### HIV Rapid Testing and service integration

HIV testing occurs in a variety of settings outside of the laboratory. Self-testing is likely, as are testing and counselling centers (T&C), antenatal care (ANC) clinics, blood banks, surveillance programs, tuberculosis (TB) clinics, and sexually transmitted infections (STIs) clinics.

While all settings where testing occurs can triage persons to treatment and care, for providing antiretroviral treatment to HIV-infected persons, and for providing care to HIV-affected persons. T&C, ANC, blood banks and surveillance are the primary venues for providing prevention programs.

Testing will need to be integrated at all levels of services delivery points. To facilitate innovative case detection and effectively identifying HIV infection among the key and priority population groups, non-traditional test approaches will need to be incorporated with the national testing strategy. These non-traditional sites must be supervised by the laboratory experts to ensure the qualities of HIV testing services.

## **Use of HIV Testing Technologies in the Continuum of Care:**

A variety of tests are performed at different stages. HIV rapid tests play an important role in initially identifying those who are infected with the HIV virus.

Other tests, e.g, viral load, play an important role to monitor the therapy whether the drugs are working or not.

The list below reflects commonly performed test associated with HIV. Some tests are for diagnostic purposes, e.g., EIAs, rapid tests, Western blot and p24. Other tests are supplemental in monitoring disease progression, such as CD4 and viral load.

- ◆ HIV diagnosis (antibody/antigen testing)
  - Enzyme immunoassays (EIAs)
  - Rapid tests
  - Western blot (WB)
- ◆ Early diagnosis in infants
  - p24
  - DNA/RNA PCR
- ◆ Initiation and monitoring of ART
  - CD4
  - Viral load
  - Clinical chemistry and hematological tests

**Enzyme Immunoassays (EIAs):** EIA is a quantitative assay that measure HIV antibodies.

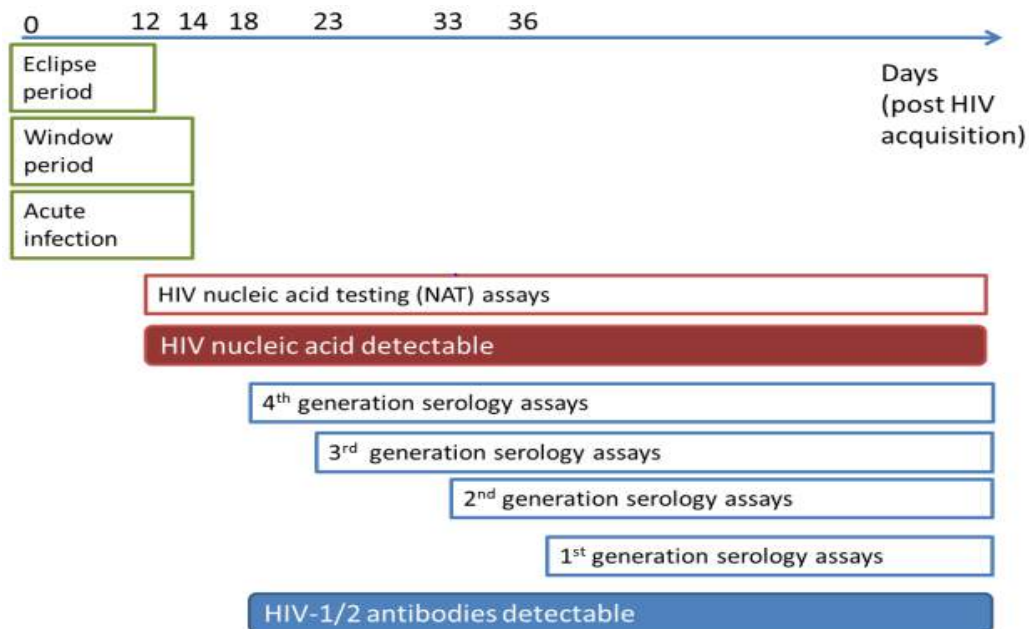
- ◆ Most EIAs can detect antibodies to HIV-1 and HIV-2. Here is how EIA works:
- ◆ Sample is added to micro well plate that has been coated with HIV antigen(s).
- ◆ After a series of reagent additions, incubations and washings, the plate is placed in reading device.
- ◆ The reading device measures the optical density of color that develops if HIV antibody is present in the client's sample.

Multiple factors can affect testing such as a skilled lab technician, large-volume testing and properly maintained equipment. A certain level of technical skill and functioning equipment is a must.

**HIV Rapid Test:** HIV rapid tests are qualitative assays that detect HIV antibodies. Most of them can detect HIV-1 and HIV-2. These tests are as reliable as EIAs.

### Detecting HIV- infection with various formats and generations

The picture below illustrates the types of assays that can be used at different points in the natural history of HIV infection.



Source: *Web Annex I. In vitro diagnostics for HIV diagnosis. In: Consolidated guidelines on HIV testing services, 2019.*

### Challenges of HIV Testing:

There are several challenges associated with HIV testing:

- ◆ The ability of some tests to detect early infections is sub-optimal.
- ◆ Specialized testing is required to diagnose HIV infection in infants younger than 18 months.
- ◆ Some tests may not be able to detect antibodies produced against specific HIV subtypes. For example, early generation of HIV test kits could not detect antibodies produced against strains of sub type O.
- ◆ Cross-reactivity with other health conditions or infections decreases performance of the assay, e.g., cytomegalovirus and Epstein-Barr virus.
- ◆ Personnel need a certain level of skill to accurately perform and interpret tests; this level of skills varies from minimal to high level.

### **Complexity of HIV Tests Varies:**

Four levels of complexity for HIV tests have been described in a number of WHO reports. The complexity of tests varies, from minimal (level 1) to complex (level 4), in terms of equipment and technical skill.

- ◆ Level 1: No additional equipment and little or no laboratory experience needed
- ◆ Level 2: Reagent preparation or a multi-step process is required; centrifugation or optimal equipment
- ◆ Level 3: Specific skills such as diluting are required
- ◆ Level 4: Equipment and trained laboratory technician are required

### **HIV Rapid Tests: Advantages:**

HIV rapid testing provides an excellent tool for expansion of services. The remaining portion of this unit will focus on HIV rapid tests.

HIV rapid tests have the following advantages:

- ◆ Increase access to prevention (self-testing, VTC) and interventions (PMTCT)
- ◆ Support increased number of testing sites (PITC)
- ◆ Encourage self-testing
- ◆ Same-day diagnosis and counseling
- ◆ Robust and easy to use
- ◆ Test time under 30 minutes
- ◆ Most require no refrigeration
- ◆ None or one reagent (a substance used in a chemical reaction to detect or produce other substances)
- ◆ Minimal or no equipment required
- ◆ Minimum technical skill

### **Drawbacks of HIV rapid testing**

One advantage of an HIV rapid test is its ability to use whole blood. While HIV rapid tests in general are considered to be low in complexity, all tests must be appropriately evaluated prior to use and personnel be properly trained. It is equally important that the test be validated for use in the environment where testing will occur.

- ◆ Monitoring testing practices
- ◆ Subjective interpretations
- ◆ Adherence manufacturer instructions

### Body Fluids Used for HIV Rapid Testing

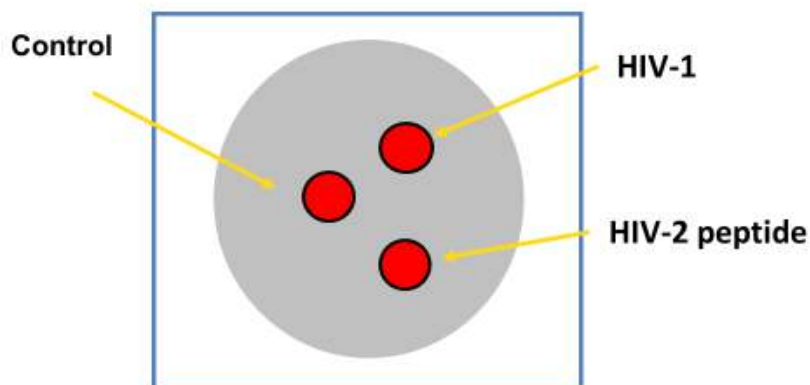
HIV tests could be performed on a wide range of body fluids. Serum, plasma, whole blood and oral fluids are used the most. The samples used for HIV rapid testing will most likely be whole blood collected from clients' fingertips

**Three Formats of HIV Rapid Tests:** There are three main formats or types of rapid HIV tests:

- ◆ Immuno-concentration (flow-through device)
- ◆ Immuno-chromatography (lateral flow)
- ◆ Particle agglutination

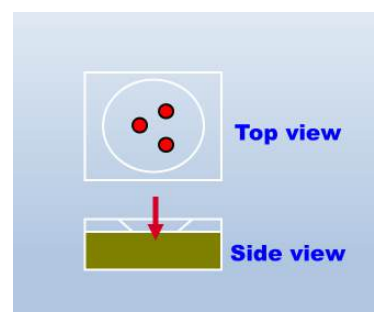
**How Immuno- concentration Works:** Read on to find out more about each format.

HIV antibody links to bound HIV peptide antigens forming the color spot.

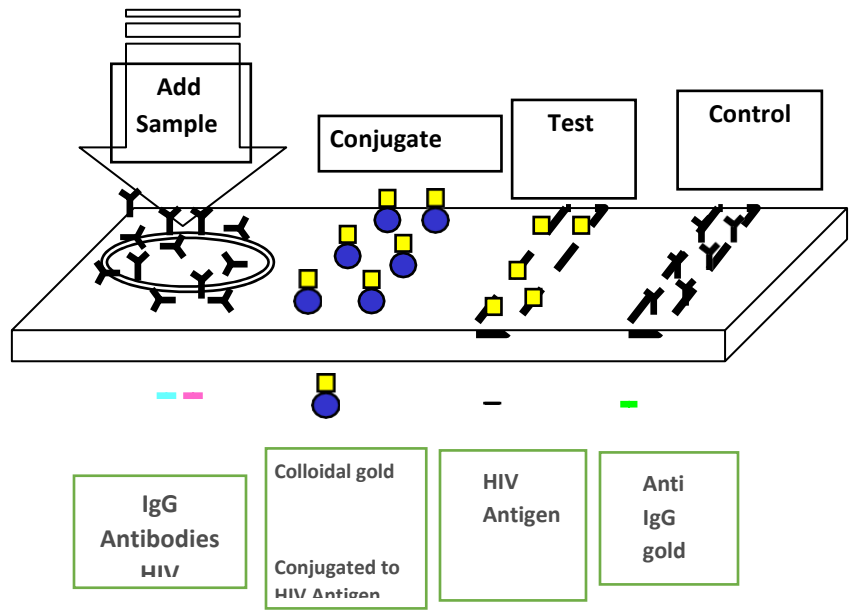


Flow-through (or immuno-concentration) devices are usually cartridges with HIV antigen attached to a membrane. The specimen and individual reagents are each added to the cartridge in a series of steps. Presence of HIV antibodies is indicated by the development of a colored spot or line

**Tests Based on Immuno- concentration:** Some examples of flow-through devices are the Multi-Spot and Genie II.



## How immune-chromatography works:



## Tests Based on Immuno- chromatography:

Specimen is applied to a pad (filter) where it mixes with gold or selenium colloid- antigen conjugate. This mix migrates through the nitrocellulose strip to immobilized recombinant antigens and synthetic peptides at the patient window. If HIV antibodies are present then a red line will form in the test area of the strip.

Some examples of lateral flow devices include:

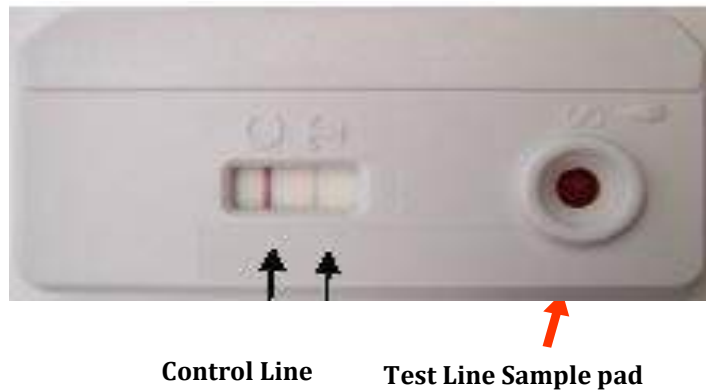
- ◆ ONE STEP Anti-HIV (1&2)
- ◆ First Response HIV 1-2.0
- ◆ Uni-Gold HIV
- ◆ SD Bioline ½ 3.0
- ◆ Stat- Pak

Capillary flow (lateral flow) devices resembles dipsticks. All of the necessary reagents are usually incorporated with the test strip embedded in the device. Specimen (and sometimes a buffer or a reagent) added to the strip flows across the reagents, and a coloured line develops in the presence of antibodies. Most lateral flow devices also have an internal control that detects human IgG. This internal control indicates that specimen was added to the test strip. If no human IgG is detected, an internal control line does not develop

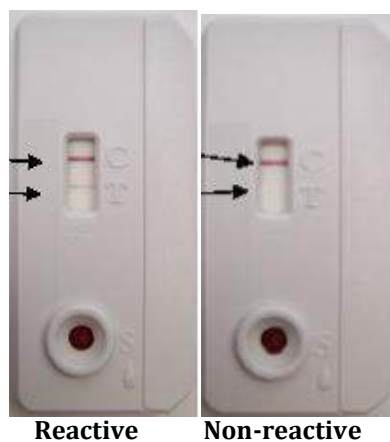


indicating an invalid test.

### Reading Results: Reactive



The reactive result shows two or more lines: one for the control band and the other for the test. A band in the test area means a reactive result. You will see either one or two visible lines. One line for HIV-1, and the other for HIV-2. A non-reactive reaction will show a control band only. The control band (line) must always be present for the test results to be valid. If the result is non-reactive, you will only see one visible line in the control region. At the control line, human IgG links to membrane-bound anti-human IgG. (refer the manufacturer instruction).



Besides reactive and non-reactive, there is a third possible result—the control line is not present. When the control line fails to show, it indicates that the test has failed. The result is therefore called “invalid.”

In summary, the three possible outcomes for a single HIV antibody test are:

- ◆ Reactive when both test band and control band are present.
- ◆ Non-reactive when only the control band is present.
- ◆ Invalid: when no control band is present.

The final client status is going to be reports as Positive or Negative.

If a test yields an invalid result, the test has failed. The test **MUST** be repeated using a new test device.

### **Exercise: Interpreting Individual HIV Rapid Test Results**

At the end of this unit, you will find an exercise handout. Study the examples and write your interpretation of the test results in the space provided.

#### **EXERCISE #1: INTERPRETING INDIVIDUAL HIV RAPID TESTS**

Instructions: Interpret the test results in the following examples. Write your interpretation of the test result on the line provided below each example.



## CHAPTER 2: HIV TESTING STRATEGIES AND ALGORITHMS

**Learning objectives:** By the end of this session the participants will be able to:

- ◆ Explain the national testing strategy and algorithm
- ◆ State the development of national testing algorithms
- ◆ Describe sensitivity, specificity, and positive/negative predictive value

### Content

- ◆ Testing Strategies and Algorithms
- ◆ Process for the development of the National testing algorithm
- ◆ Measuring Performance of HIV Rapid Tests
- ◆ Chapter Summary

### Strategies and Algorithms

**Testing strategies** are defined as the testing approach used to meet a specific need, such as for blood safety, surveillance and diagnosis. For a given strategy, multiple algorithms may be used depending on the needs of testing settings.

**Algorithms** are defined as the combination and sequence of specific tests used in a given strategy. The number of algorithms used should be limited. Testing algorithms describe the sequence of tests to be performed. An HIV- positive status should be based upon the outcome of two or more tests.

Parallel and serial testing can be part of any testing strategy. Parallel testing means that samples are tested simultaneously by different tests. Serial testing means that samples are tested by a first test; and the results of the first test determine whether additional testing is required.

Ethiopia is currently using serial algorithm (three test algorithms instead of tie- breaker). In a serial testing algorithm, the samples are tested by a first test. The results of the first test determine whether additional testing is required.

- ◆ When the first test is non-reactive, then the final HIV result is negative.
- ◆ When the first test (T1) is reactive, the result will be tested by a second test (T2); and if the result of the second test is reactive, then the third test (T3) will be done and if the result is again reactive, the final HIV status will be positive. This test will be repeated at ART clinic for confirmation prior to treatment initiation. When the first

test is reactive, the result will be tested by a second test; and if the result of the second test is non-reactive, then repeat test one (T1) only. After repeating the tests T1, if T1 is non-reactive (T1-NR, T2-NR), report HIV negative. If repeated T1 is reactive and T2 is non-reactive, then report HIV inconclusive and retest in 14 days. After repeating the tests if both T1 and T2 are reactive, then conduct test three (T3). If T3 is reactive, report HIV positive. If T3 is non-reactive, report HIV inconclusive.

Before any test is adopted in-country for use, a series of key steps must be taken. These steps include:

- ◆ Identifying appropriate tests
- ◆ Developing an algorithm
- ◆ Building consensus
- ◆ Developing policy
- ◆ Bringing into national scale
- ◆ Reviewing testing algorithms in 2-3 years interval

Because multiple tests are marketed and available in-country, each country must identify the appropriate tests for use within given environment. A standardized approach to developing an algorithm must be taken. This involved building consensus and developing a policy before a test is brought to national scale.

### **Advantages of National Testing Strategies and Algorithms:**

After testing algorithms are adopted and implemented nationally, they must be reviewed every three to five years, will ensure that the products chosen continue to work well together, and to determine if any changes need to be made to the algorithms.

Nationally adopted testing strategies and algorithms facilitates:

- ◆ Country-level standardization of tests used in-country—supporting a limited number of tests is more feasible and practical than many different tests.
- ◆ Procurement and supply management—using standardized tests allows for bulk procurement that facilitates controlling costs.
- ◆ Training—implementation of a national training program is eased when test sites follow the same testing algorithm. This facilitates pre-planning of workshops, as

well as assuring that staff who move from one test site to another will not require total re-training.

- ◆ Quality Assurance—national oversight of quality of testing operations is easier when test sites use the same tests and have similar operations.

### **Evaluating Test Performance: Basic Terms**

- ◆ **Sensitivity** (Se) and **Specificity** (Sp) relate to the performance of the test capacity. Sensitivity of a test is its capacity to correctly identify people who are infected with HIV.
- ◆ **Specificity** (Sp) of a test is its capacity to correctly identify peoples who are not infected with HIV.

## National HIV Testing Strategy

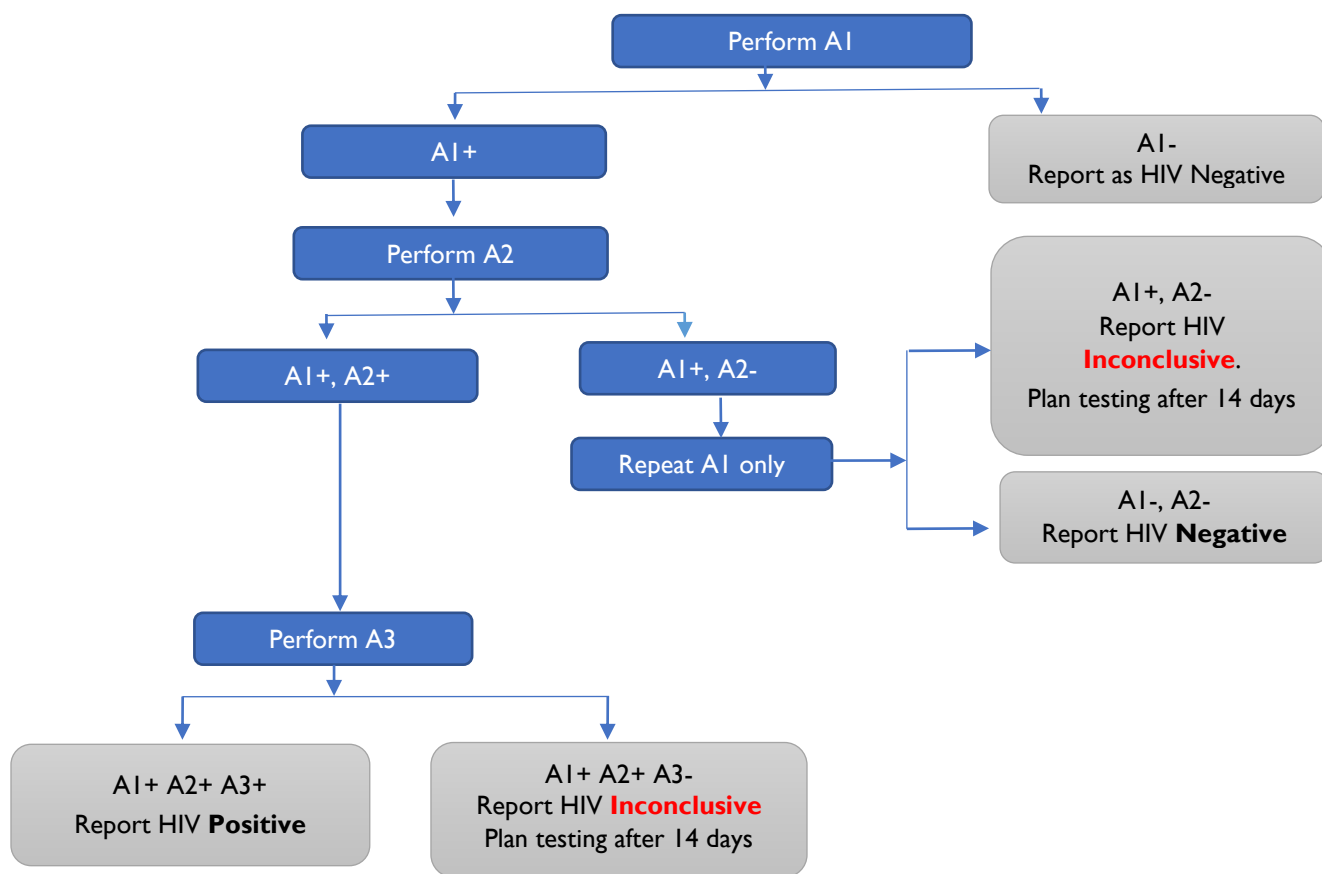


Figure 2.2. Recommended HIV testing strategy for Ethiopia, 2023

### Note.

- ◆ All individuals are tested on Assay 1 (A1). Anyone with a non-reactive test result (A1-) is reported HIV negative.
- ◆ Individuals who are reactive on Assay 1 (A1+) should then be tested on a separate and distinct Assay 2 (A2).
- ◆ Individuals who are reactive on both Assay 1 and Assay 2 (A1+; A2+) should then be tested on a separate and distinct Assay 3 (A3).
  - Report HIV-positive if Assay 3 is reactive (A1+; A2+; A3+)
  - Report HIV-inconclusive if Assay 3 is non-reactive (A1+; A2+; A3-). The individual should be asked to return in 14 days for additional testing.
- ◆ Individuals who are reactive on Assay 1 but non-reactive on Assay 2 (A1+; A2-) should be repeated on Assay 1
  - If repeat Assay 1 is non-reactive (A1+; A2-; repeat A1-), the status should be reported as HIV negative;
  - If repeat Assay 1 is reactive (A1+; A2-; repeat A1+), the status should be reported as HIV-inconclusive, and the individual asked to return in 14 days for additional testing.

## CHAPTER 3: SAFETY AT THE HIV RAPID TESTING SITE

**Learning objectives:** By the end of this session the participants will be able to:

- ◆ Describe the importance of biosafety practice.
- ◆ Practice the biosafety requirements while blood specimens collecting and HIV rapid testing.
- ◆ Use disinfection and waste disposal method
- ◆ Apply appropriate actions following accidental exposure to infectious materials

**CONTENTS** General safety practices on:

- ◆ Work habits (personal, work space, material)
- ◆ Proper disposal of sharps and waste
- ◆ Disinfection of work areas
- ◆ Appropriate measures for accidental exposure to potentially infectious specimen
- ◆ Safety documentation

**Why Is Safety Important?** Performing HIV tests poses a potential health hazard to the tester. Coming in contact with human blood or blood products is potentially hazardous. Safety involves taking precautions to protect the tester, other staff, clients and environment, and the community against infection.

Besides the tester and client, we need to protect other people from infection:

- ◆ Never leave blood spills that could infect others.
- ◆ Never leave used lancets lying around for anyone else to pick up—they could prick themselves with HIV contaminated lancets.
- ◆ Always seal contaminated waste—you don't want to risk infecting the person who removes contaminated waste from the rapid testing site.
- ◆ In addition, it is important to protect the integrity of test products. Shield unused tests from any contamination. If a new or unused kit is contaminated by a drop of blood from a previous client, the test may not yield accurate result when used on the next client.
- ◆ It is also important to protect the environment from hazardous material. Avoid transferring contaminated materials into areas outside of the testing area.

## Universal or Standard Precautions

Every specimen should be treated as though it is infectious. Why? Because harmful agents/organisms may be present in a client's blood. If a person comes into direct contact with the blood, that person could be infected. We must follow safety practices in every step of the testing process.

During testing, follow the safety rules when performing finger-prick and actual testing of the client's blood. After testing, remember to clean up working area and properly dispose of contaminated waste.

## Develop Personal Safe Work Habits:

It is important that you:

- ◆ **Wash hands between testing each client**—to wash away any germs that might be present on the tester's hands; this will ensure that no infections are passed from the tester or previous client onto the next, new client.
- ◆ **Wear fresh gloves for each new client**—to protect the client and tester from cross-infection (that is, the transfer of infection from one person to another).
- ◆ **Wear lab coat or apron** —to protect the tester from reagent spills and client's blood.
- ◆ **Get rid of used sharp objects** such as needles or lancets—Sharp objects can cut human skin. Any germs or pathogens present on the lancet can be passed from the lancet into that person's blood through the cut.
- ◆ **Never eat, drink or smoke in the test area**—Harmful germs or pathogens can be an entry point to the mouth from touching contaminated objects followed by contact with your mouth.
- ◆ **Keep food away from the testing area or a refrigerator that *contains blood samples***—Infectious agents/pathogens can be carried in food and transmitted to people.
- ◆ **Never go to the restroom wearing gowns/aprons.**
- ◆ **Remember to never let your mouth or face touch anything from work, such as pens, pencils, etc.**

## Maintain Clean and Orderly:



It is important to:

- ◆ **Keeping work areas uncluttered** – So there is less chance for accidents.
- ◆ **Disinfecting daily**

**Workspace:**

- ◆ **Keeping supplies locked** – To prevent unauthorized persons having access to potentially dangerous objects such as lancets.
- ◆ **Collocate all necessary supplies in orderly manner in working station**
- ◆ **Keep emergency eye wash units in working order and within expiry date**
- ◆ **Allocate specific site and chair/table for testing**
- ◆ **Always** perform testing at designated work station

The eye wash unit is used to clean one's eyes when they are accidentally splashed with any type of specimen). If an eye wash unit is not available, please consult your local infection control personnel for alternate procedures to follow in the event of an accidental splash.

- ◆ The left container is a plastic bag for contaminated waste. It should not be used for sharp objects as they can pierce the bag and injure someone.
- ◆ The red plastic container on the right is suitable for sharp objects as the plastic is thick enough so that sharp objects cannot puncture the container. It also has a lid.
- ◆ Just because a work area was disinfected yesterday, it does not mean it is still free of germs today



**Answers:**

What is wrong with the Picture on the left?

- ◆ It is an open container with a mixture of blood, sharps and other contaminated waste.
- ◆ It has no lid.
- ◆ It has no label to warn people of biohazardous waste.
- ◆ It is placed on the floor and prone to spill.



What is right with the Picture on the right?

- ◆ The container is made of thick plastic. This is appropriate for disposing of sharps.
- ◆ The bottle has a lid and sealed.

**Remember:** waste should be segregated based on the nature of the wastes in to infectious, non-infectious and sharp.

**Never Place Needles or Sharps in Office Waste Containers:** Plastic bags must be securely tied once filled. This is appropriate for disposing of contaminated waste such as used gauze. This type of container is NOT appropriate for disposal of sharps.

Contaminated waste should be kept separate from office waste. It is the tester's responsibility not to put any other persons at risk of infection.

Below, the image of the right illustrates improper disposal of objects. And on the left, sharps are mixed with non-sharp items and the opening is exposed, posing a potential hazard.

Sharps containers must be:

- ◆ Placed near workspace



- ◆ Closed when not in use
- ◆ Sealed when  $\frac{3}{4}$  full

### **Policy for Handling Sharps:**

Important rules about handling sharps:

- ◆ User responsible for disposal of sharps
- ◆ Must dispose of sharps after each test
- ◆ Must place sharps in sharps boxes
- ◆ Do not drop sharps on the floor or in the office waste bin
- ◆ Place sharps container near your workspace
- ◆ Seal and remove when box is  $\frac{3}{4}$  full
- ◆ Incinerate all waste

### **Burial of Waste**

For burial waste disposal:

- ◆ Access to the disposal site should be restricted
- ◆ Burial site must be lined with material of low permeability
- ◆ Selected site should be 50 meters away from any water source

**Incineration of Waste:** Incineration is the burning of contaminated waste to destroy and kill micro-organisms. Contaminated waste should be burned to completion (that is, beyond re-use). It protects the environment and must be supervised. Care should be taken in transporting waste from one site to another for incineration.

**Disinfect Work Areas with Bleach:** To keep a clean and orderly work area, disinfect your work surface on a daily basis. It is part of the general safe practice that you need to follow.

Remember, disinfection:

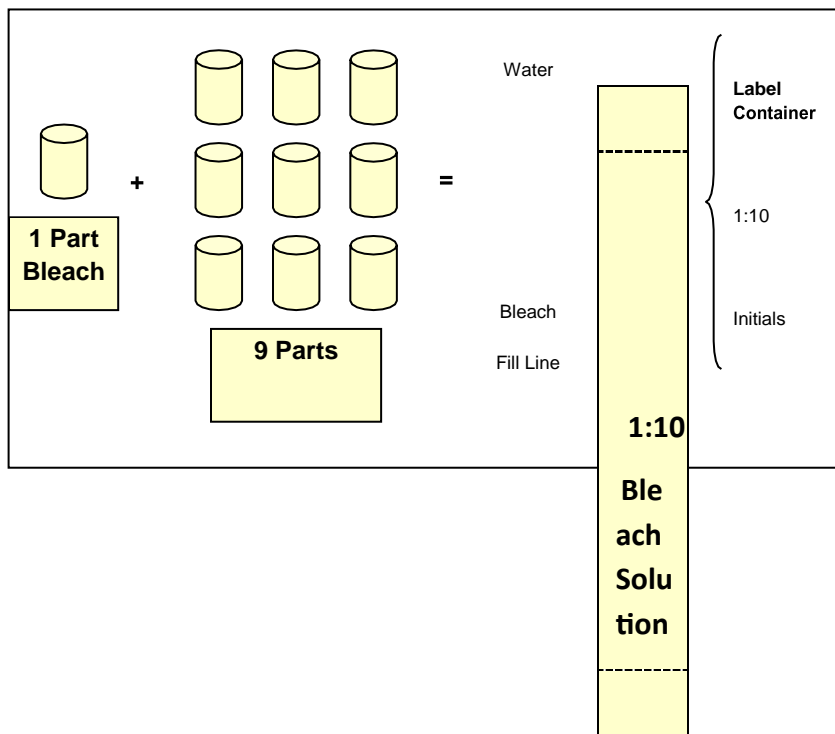
- ◆ Kills germs and pathogens
- ◆ Keeps work surface clean

- ◆ Prevents cross-contamination
- ◆ Reduces risks of infection

**Different Cleaning Jobs Requires Different Bleach Solutions:** The WHO Laboratory Bio safety Manual recommends that:

- ◆ For spills, you should use a 10% bleach solution (1-part bleach + 9 parts water). The larger the spill, the longer the contact time with the 10% bleach solution.
- ◆ For general disinfection purposes such as wiping down all surfaces at the end of the day, use a 1% solution (1-part bleach + 99 parts water).

You should have 10% bleach readily available at your test site. Make bleach solutions at the beginning of each week. Disinfect work surfaces, at a minimum, at the end of each day.



**In Case of a Spill or Splash:** Follow these steps in case of a spill or splash:

- ◆ Wear clean disposable gloves.
- ◆ Immediately and thoroughly wash any skin splashed with blood.
- ◆ Large spills: Cover with paper towels and soak with 10% household bleach and allow to stand for at least fifteen minutes.
- ◆ Small spills: Wipe with paper towel soaked in 10% bleach.
- ◆ Discard contaminated towels in infectious waste containers.

- ◆ You should never leave any spill unattended.

### **In Case of an Accident:**

There are three types of accidents that may happen:

- ◆ Potential Injury, i.e., needle-pricks, falls
- ◆ Environmental, i.e., splashes or spills
- ◆ Equipment damage

In case of an accident, you should report to your supervisor immediately. Assess the situation and act accordingly. Record the accident using appropriate forms, and continue to monitor the situation.

It is important to follow Standard Operating Procedures (SOP). If an SOP is available, get a copy and review the sections related to the safety procedures in a test site. Does it cover the following safety procedures?

- ◆ Housekeeping
- ◆ Personal protection
- ◆ Personnel responsibilities
- ◆ Decontamination and waste disposal
- ◆ Emergency procedures
  - In-lab first aid
  - Accidental injury
  - Post-exposure prophylaxis (PEP)
  - Contacts

## **CHAPTER 4: PREPARATION FOR TESTING SUPPLIES, KITS AND WORKING SPACE**








**Learning objectives:** By the end of this session the participants will be able to:





- ◆ Describe all the supplies required for HIV rapid testing

- ◆ List and identify all the components of HIV rapid testing
- ◆ Describe the appropriate workstation set-up for HIV rapid testing

## CONTENTS

- ◆ Supplies for HIV Rapid Testing
- ◆ Components of Test Kits
- ◆ Organizing Working Area

Name of supplies	Description	Picture
GLOVES	Gloves come in latex or polypropylene. Gloves are used for safety reasons—to protect both you and the client or client. Dispose of in a container labelled as biohazardous waste.	
Alcohol Swabs	Alcohol is used to cleanse the client's finger before performing a finger-prick. Alternatively, use a bottle of rubbing alcohol and cotton wool.	
Cotton Gauze or Cotton Balls	Cotton balls are used to: wipe away the first drop of blood and to stop bleeding after specimen is collected. They are for single-use only. Contaminated cotton gauze or cotton balls should be disposed of with other hazardous waste.	
Aprons or laboratory coats	Are designed to be worn to provide extra protection during sample collection and testing	
Sterile Lancets	A variety of lancets available in different depth for figure puncture. Some are easier to use than others. Should be used for each individual	
Timer	Are used to measure specific time intervals when performing HIV RTKs. You may also use a watch or clock.	
Standard Operating Procedures and Forms	Each site will also need to follow standard operating procedures (SOPs) and use standard forms for recording test results.	

Job aides	Enable the professionals to complete their activity effectively by using this job aids.	
Labeling and Writing Pens	A permanent marker as is best used for labeling test devices. Pens are used to fill in forms. Never use pencils, especially for recording client results, as results can be erased and changed.	
Safety materials	Different safety materials available and designed to protect workers and clients against health or safety risks on the jobsite. It includes; Infectious and non-infectious waste container, Biohazard bag, Sharp container, Household bleach.	
Test Kits	Three test kits of the algorithm should be available for testing. <ul style="list-style-type: none"> <li>◆ One step Anti-HIV (1&amp;2) Tests</li> <li>◆ First Response HIV 1-2.0 CARD test (Version 2)</li> <li>◆ Uni-Gold</li> </ul> Pay attention to the components of each test kit.	

**Check Test Kits:** Examine the test kits that are approved in your country. Pay attention to the components of each test kit. In addition, notice the following two components:

- ◆ Desiccant packet—this is not used when performing the test. It only serves to keep the packet contents dry before use. It should be discarded when the test kit packet is opened.
- ◆ Buffer solution—Required by some kits following the manufacturer instructions

**Organize Your Work Area:** Having an organized workspace is key to produce quality results. It is important to keep working area neat, clean and organized.

- ◆ Each site or set-up where HIV rapid testing is performed must have an appropriate physical space for testing. Appropriateness of the physical space includes that for the storage of test kits and QC samples and other supplies used for testing. Facility appropriateness should include:
  - Adequate and labelled bench surface to perform testing
  - Test kits and consumables storage cabinet

- Adequate lighting for interpreting results

**Environmental control:** adequate temperature-controlled storage space and room

- ◆ Hand washing facility
- ◆ Proper waste disposal facility (infectious and non-infectious), chemical and paper waste and sharps.

**Supplies and Materials Checklist:** Refer to the checklist at the end of this unit for a list of materials and supplies required for HIV rapid testing in **annex A**.

## **CHAPTER 5: WORKSTATION SET UP AND BLOOD COLLECTION - FINGER PRICK**

**Learning objectives:** By the end of this session the participants will be able to:

- ◆ Describe all the supplies required for HIV rapid testing
- ◆ List and identify all the components of HIV rapid testing



- ◆ Describe the appropriate workstation set-up for HIV rapid testing

## CONTENTS

- ◆ Workstation set up
- ◆ Preparation for Testing
- ◆ Introducing Your Client
- ◆ Performing a Finger Prick
- ◆ Demonstration and hands-on practice.

**Work station set up:** Having an organized workspace is a key step to produce quality results. It is important to keep working area neat, clean and organized.

Each site or set-up where HIV rapid testing is performed must have an appropriate physical space for testing. Appropriateness of the physical space includes that for the storage of test kits and QC samples and other supplies used for testing.

### Facility appropriateness should include;

- ◆ The laboratory must be designed to ensure proper ventilation throughout, with an active ventilation system.
- ◆ Laboratory design should ensure that patients and patient samples do not have common pathways.
- ◆ Each site or set-up where HIV rapid testing is performed must have an appropriate physical space for testing.
- ◆ Adequate and labeled bench surface to perform testing
- ◆ Test kits and consumables storage cabinet
- ◆ Adequate lighting for interpreting results
- ◆ Environmental control: temperature should be controlled
- ◆ Hand washing facility
- ◆ Proper waste disposal facility (Infectious and non-infectious), chemical and paper waste and sharps



## Performing a capillary blood collection

### Initial Steps of Finger Prick Procedure

#### Introduce the client and reassure for blood collection

- ◆ Introduce the client that you are going to collect a blood sample from his/her ring finger (preferably) and reassure that the volume of the sample is small and the procedure is not painful.



- ◆ Position hand palm-side up. Choose whichever finger is least calloused.

- ◆ Apply intermittent pressure to the finger to help the blood to flow



- ◆ Clean the fingertip with alcohol. Allow the area to dry. Never touch cleaned area of the finger.



- ◆ Hold the finger and firmly place a new sterile lancet off-center on the fingertip.
- ◆ Firmly press the lancet to puncture the fingertip.



- ◆ Wipe away the first drop of blood with a sterile gauze pad or cotton ball. Put intermittent pressure on the base of the punctured finger several times.



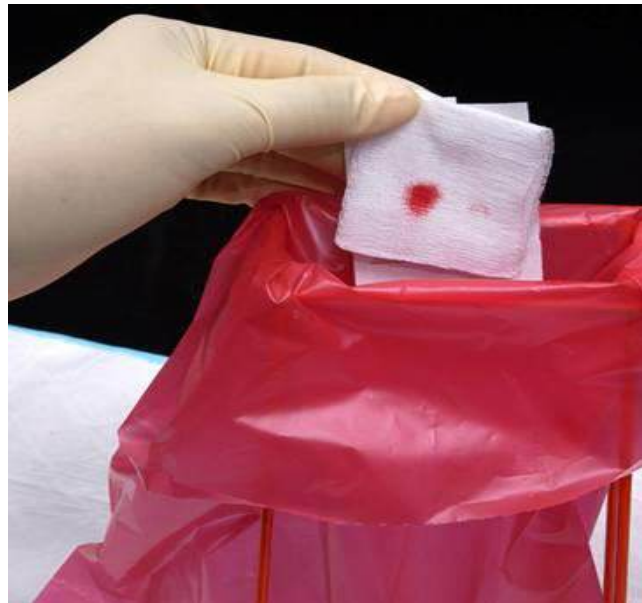
- ◆ Touch the tip of the EDTA Capillary Tube to the drop of blood. Blood may flow best if the finger is held lower than the elbow.



- ◆ Avoid air bubbles, fill the tube with blood between the two marked lines. After you've collected all the blood that's needed for the test, give the client a gauze pad or cotton ball to place on his/her finger until the bleeding stops. And finally, properly dispose of the gauze before the client leaves the testing area.



**Properly dispose of all contaminated supplies**



## **Demonstrations and Questions:**

The above finger prick procedure explains the important steps for taking blood samples from a client's fingertip.

You are expected to be able to answer these questions after you have demonstrated:

- ◆ How do you ...
  - Position the hand?
  - Decide which finger to use?
  - Clean the fingertip?
  - Use a lancet?
  - Ensure blood flow from your client's fingertip?
  
- ◆ Do you ...
  - Use a previously used lancet on a client?
  - Collect the first drop of blood?

Space is provided below for you to take notes during or after the demonstration.

**How do you position the hand?**

---

**How do you decide which finger to use?**

---

**How do you clean the fingertip?**

---

**How do you use a lancet?**

---

**How do you ensure blood flow from your client's fingertip?**

---

**Do you use a previously used lancet on a client?**

---

**Do you collect the first drop of blood?**

---

## CHAPTER 6: PERFORMING HIV RAPID TESTS

**Learning objectives:** By the end of this session the participants will be able to:

- ◆ Perform three types of HIV rapid tests according to standard operating procedure (SOP)
- ◆ Perform multiple tests simultaneously
- ◆ Accurately interpret individual test results
- ◆ Accurately determine the final HIV status

**Outline:**

1. Introduction
2. Types rapid HIV testing kits and their procedures
3. Interpretation of test results
4. Demonstration and
5. Hands-on practice on HIV rapid tests.
6. Chapter summary

### 1. Introduction

Performing HIV rapid testing and interpretation of test result should follow the SOPs and manufacturer's step-by-step instructions. Interpreting rapid HIV tests requires good eyesight and adequate lighting. The test should be read from a comfortable distance without manipulating the test device. Test result of each device could be reactive, non-reactive or Invalid.

### 2. Types of rapid HIV testing kits in Ethiopia and their procedures

Based on the current HIV test kits evaluation for the development of the national testing algorithm, One step anti-HIV (1&2), First response HIV 1-2 card test (Ver.2.0) and Uni Gold HIV 1.2.0 were selected chronologically based on their performance characteristics.

#### 2.1. ONE STEP Anti-HIV (1&2) Test

##### Test principle

The test band region on the nitrocellulose membrane is pre-coated with recombinant HIV antigen (containing predominant epitope of gp41, gp120 of HIV-1 and predominant epitope of gp36 of HIV-2), and the control band region on the nitrocellulose membrane is pre-coated with sheep anti-rabbit IgG. The fibreglass is pre-coated with recombinant HIV antigen (containing predominant

epitope of gp41, gp120 of HIV-1 and predominant epitope of gp36 of HIV-2) conjugated with colloidal gold and rabbit IgG conjugated with colloidal gold.

For reactive specimens, HIV antigen conjugated with colloidal gold reacts with HIV antibody in whole blood, serum or plasma, forming a colloidal gold conjugate/HIV antibody complex. The complex migrates through the test strip and is captured by the recombinant HIV antigen immobilized in the test band region, forming a test band.

A non-reactive specimen will not produce a test band due to the absence of colloidal gold conjugate/HIV antibody complex. To ensure assay validity, a purplish red control band in the control region will appear regardless of the test result.

**Note: The assay is only valid when the control band appears.**

### **Test Procedure**

1. Do not open the pouch until ready to perform a test. Use the test immediately after opening the pouch.
2. Equilibrate all reagents and specimens to room temperature (10-30°C) before use;
3. Unseal the foil pouch and put the cassette on a clean, dry and level surface;
4. Mark the specimen ID number on test cassette;
5. Add 1 drop of the specimen using the provided dropper (or 30µl by transfer pipette) into port "S" of the cassette;
6. Then add 1 drop of sample diluent into port "S" immediately;
7. Wait and interpret the result between 15-20 minutes.

### **Caution:**

- ◆ Always apply specimen with a new and clean dropper or pipette tip to avoid cross contamination.
- ◆ Non-reactive results cannot rule out the possibility of exposure to or infection with HIV-1 or HIV-2 viruses.

**Name of KIT: ONE STEP Anti-HIV (1&2) Test- InTech HIV 1/2 (40 Testes)**  
**Test Procedure: For Testers**

<p>1. Collect test items and other necessary supplies</p>	<p>2. Remove device from package &amp; label with panel ID</p>	<p>3. Collect specimen using a new disposable pipette provided with the kit</p>
<p>4. Hold vertically and add 1 drop of specimen to the sample port</p>	<p>5. Hold vertically and add 1 drop of buffer to sample port</p>	<p>6. Wait for 15 minutes but no longer than 20 minutes</p>

**Interpretations: For both Testers and Readers**

<p>Non-Reactive</p>	<p>Reactive</p>	<p>Invalid</p>
<p>o Bring kit and stored specimen to room temperature prior to use</p>		

Record result including invalid; check the job aid and repeat invalid and document in following row

Figure 1. Job aid for HIV rapid testing using One Step Anti-HIV (1&2) test kit

**Test Result Interpretation**

**Reactive result**

- ◆ Purplish red bands appear at both the test band area (even though very weak) and the control band area.

**Non-Reactive result**

- ◆ Purplish red band only appears on control band area.



### **Invalid result**

- ◆ A purplish red band appears only at the test band area of the cassette. Repeat the test. Contact the supplier if the control band remains invisible. OR
- ◆ Purplish red band appears at neither the control band area nor the test band area of the cassette.

**Note: The Invalid test results should be retested with new test device.**

## **2.2. First Response HIV 1-2.0 Card test (Ver.2.0)**

### **Test Principle:**

First Response HIV 1-2.0 Card Test (Ver.2.0) is based on the principle of immunochromatography for the qualitative detection of antibodies specific for HIV-1 and HIV-2. The nitrocellulose membrane is coated with recombinant HIV-1 capture antigens (gp41 including Group O) on test line "1" region and with recombinant HIV-2 capture antigen (gp36) on test line "2" region and control reagent coated at control line "C". When serum or plasma or whole blood specimen is applied followed by assay buffer addition to the specimen well of the test device, the recombinant HIV-1 and 2 antigens (gp41 and gp36) conjugated with colloidal gold particles (CGC) bind to HIV-1 and 2 antibodies present in the test specimen.

This conjugated antigen-antibody complex moves through the nitrocellulose membrane and bind to the corresponding immobilized HIV-1 antigen and HIV-2 antigen (Test Lines) leading to the formation of purple colored visible line as the capture antigen-antibody-conjugated antigen complex, indicating reactive results. Purple colored control line will appear irrespective of the reactive or non-reactive specimen. The control line is a procedural control, serves to demonstrate functional reagents and correct migration of fluid.

### **Test Procedure:**

1. Ensure that the test device & other components are at room temperature (15°C to 30°C) before starting the procedure.
2. Open the device pouch, take out the test device from aluminum pouch. Do not use the test device if the desiccant color has changed from orange to green.
3. Label the test device with the patient identification number. Place the test device on a flat, clean and dry surface. Take out the specimen transfer device from the plastic bag provided inside the kit.
4. Gently squeeze the bulb of specimen transfer device and immerse the open end in the specimen and release the bulb slowly to draw up the serum/plasma up to 10 µl marking

line and for the capillary or venous whole blood up to 20 µl marking line on the specimen transfer device.

5. Gently wipe away the excess specimen from the outer surface of the specimen transfer device with tissue paper before dispensing the specimen into the specimen well.
6. Gently squeeze the bulb of specimen transfer device to add 20 µl of whole blood or 10 µl of serum/ plasma to the specimen well by gently touching the tips of the specimen transfer device to the sample pad.

Caution: Dispose of used specimen transfer device and tissue paper as biohazard waste immediately after use.

7. Hold the assay buffer bottle vertically and add one drop of assay buffer to the specimen well.
8. Observe for development of purple colored lines in the results window. Interpret test results at 15 minutes after adding assay buffer to the specimen well.
9. Do not interpret the test result after 25 minutes.

---

**Caution**

- Add exactly 1 drop of assay buffer. Adding more than 1 drop of assay buffer may cause over flooding or reverse migration phenomenon, which may lead to inaccurate results of the test.
  - Do not read the test results after 25 minutes. Reading the results after 25 minutes window may give inaccurate results. After recording the results, dispose of used test device as a biohazard waste.
-



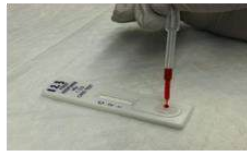
1. Collect test items and other necessary testing supplies.



2. Remove device from package and label device with client identification number



3. Collect specimen (whole blood, serum or plasma) using the disposable pipette.



4. Add 2 drops (~20µL) of whole blood to the sample well; for serum or plasma add 1 drop (~10µL) to the sample well



5. Add 1 drop (~35µL) of the appropriate wash reagent to sample port.



6. Wait for 15 - 25 minutes before reading results. (DO NOT read results after 25 minutes).



7. Read and record the results and other pertinent info on the worksheet

Observe for development of coloured bands on the result window and interpret test result at 15-25 minutes.

**Non-Reactive Result**  
Purple coloured line appears in the control area and no line in the test area.

**Reactive Results**  
Lines of any intensity in the result window with below result

Presence of 2 lines on "C" & "1" areas

or Presence of 2 lines on "C" & "2" areas

or Presence of 3 lines on "C", "1" & "2" areas

**Invalid Results**  
No line appears in the control area

Whenever a band appears without being accompanied by a control line

**Non- Reactive**



**HIV-1 Reactive**



**HIV-2 Reactive**



**HIV-1&2 Reactive**



**Invalid**



**Invalid**

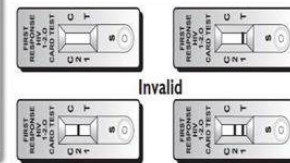


Figure 2. Job aid for HIV rapid testing using First response testing kit

## Test Result Interpretation

### Reactive result

- ◆ If two purple colored lines appear, one at the control line 'C' and other at the test line HIV-1 '1' as in the figure, then the specimen is reactive for antibodies to HIV-1. Interpret purple colored faint line as a reactive line.
- ◆ If two purple colored lines appear, one at the control line 'C' and other at the test line HIV-2 '2' as in the figure, then the specimen is reactive for antibodies to HIV-2. Interpret purple colored faint line as a reactive line.

- ◆ If all three purple colored lines appear, one at the control line 'C' and other two at the test lines HIV-1 '1' and HIV-2 '2' as in the figure, then the specimen is reactive for antibodies to HIV-1 and 2. Interpret purple colored faint line as a reactive line.

#### **Non-Reactive result**

- ◆ If only a single purple colored line appears, at the control line 'C' as in the figure, then the specimen is non-reactive for antibodies to HIV-1 and 2.

#### **Invalid result**

- ◆ No presence of purple colored control line 'C' in the results window (irrespective of presence of test lines) indicates an invalid result.

**Note: The Invalid test results should be retested with new test device.**

### **2.3. Uni Gold HIV 1.2.0 test**

#### **Test Principle:**








Uni-Gold™ HIV is a rapid immunoassay based on the immunochromatographic sandwich principle. Recombinant proteins representing the immunodominant regions of the envelope proteins of HIV-1 and HIV-2, glycoprotein gp41, gp120 (HIV-1) and glycoprotein gp36 (HIV-2) respectively, are immobilized at the test region of the nitrocellulose strip. These proteins are also linked to colloidal gold and impregnated below the test region of the device. A narrow band of the nitrocellulose membrane is also sensitized as a control region.

During testing, two drops of serum, plasma or whole blood is applied to the sample port, followed by two drops of Wash Solution and allowed to react. Antibodies of any immunoglobulin class, specific to the recombinant HIV-1 or HIV-2 proteins will react with the colloidal gold linked antigens. The antibody protein colloidal gold complex moves chromatographically along the membrane to the test and control regions of the test device.

Excess conjugate forms a second pink/red band in the control region of the device. The appearance of this band indicates proper performance of the reagents in the kit.

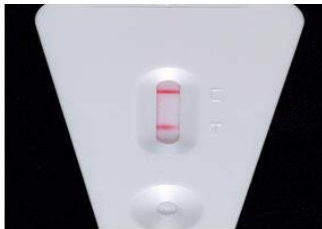
## Test Procedures:

- ◆ Wear gloves and massage the fingertip gently. It will help to obtain a round drop of blood.
- ◆ Wipe the complete fingertip with the alcohol swab provided and wait until the fingertip is dried completely.
- ◆ Do not use the auto safety lancet if the auto safety lancet found uncapped. Detach the protective cap of the auto safety lancet provided. Squeeze the fingertip then push gently at the lateral side (avoid callus) of the fingertip as shown in above figure. Safely dispose of the used auto safety lancet in sharps container immediately after use.
- ◆ Wipe the first drop of the blood using sterile gauze. Without pressing too hard, gently squeeze fingertip once again to obtain second drop of blood (~60 µl).
- ◆ To collect the blood into the fingerstick disposable pipette, gently press the pipette bulb, hold the pipette horizontal to the sample. This is important, as the specimen may not be adequate if the pipette is held in a vertical position. Slowly release pressure on the bulb to draw up the sample.
- ◆ Hold the pipette vertically above the sample port, squeeze the bulb and discharge two (2) drops of whole blood onto the sample pad. Allow the sample to fully absorb. Ensure there are no air bubbles in the sample port. Failure to hold the pipette in a vertical position may lead to erroneous test results. Do not touch the sample pad with the disposable pipette. Dispose of the pipette into biohazard waste.
- ◆ Hold the Wash Solution dropper bottle vertically over the sample port; add two (2) drops of Wash Solution to the sample port. Time the assay from this point. Ensure no air bubbles are introduced into the sample port. Failure to hold the bottle in a vertical position may lead to erroneous test results. Do not touch the sample pad with the dropper bottle tip.
- ◆ Read test results after 10 minutes but no later than 12 minutes incubation time.

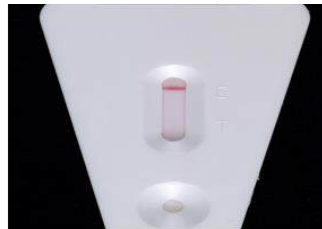
1.  Collect test items and other necessary lab supplies.
2.  Remove device from package and label device with client identification number.
3.  Collect specimen using the disposable pipette.
4.  Add 2 drops of specimen (whole blood, serum or plasma) to the sample port in the device.
5.  Add 2 drops of the appropriate wash reagent to sample port.
6.  Wait for 10 minutes (no longer than 12 min.) before reading the result
7.  Read and record the results and other pertinent info on the worksheet.

### Uni-Gold HIV Rapid Test Results

**Reactive**  
2 lines of any intensity appear in both the control and test areas.



**Non-reactive**  
1 line appears in the control area and no line in the test area.



**Invalid**  
No line appears in the control area. Do not report invalid results. Repeat test with a new test device even if a line appears in the test area.



Figure 7.3. Job aid for HIV Rapid testing using Uni Gold kit

### Test Result Interpretation

#### Reactive result

- ◆ Two pink/red lines of any intensity in the device window, the first adjacent to letter “T” (test) and the second adjacent to “C” (control).

#### Non-Reactive result

- ◆ A pink/red line of any intensity adjacent to the letter “C” (control), but no pink/red line adjacent to “T” (test).

## **Invalid result**

- ◆ No pink/red line appears in the device window adjacent to the letter “C” control) irrespective of whether or not a pink/red line appears in the device window adjacent to “T” (test).

### **Note: The Invalid test results should be retested with new test device**

Proper interpretation of each test results according to the validated testing algorithm is important to accurately diagnose and know the final status of the clients.

## CHAPTER 7: ASSURING THE QUALITY OF HIV RAPID TESTING

**Learning objectives:** By the end of this session the participants will be able to:

- ◆ Explain principle of Quality assurance.
- ◆ Recognize errors that may compromise the quality of HIV rapid testing
- ◆ Apply internal and external source of quality controls at HIV rapid testing sites
- ◆ Analyze common problems associated with invalid test results
- ◆ Practice external quality assessment (EQA) at HIV rapid testing sites

### Contents

- ◆ The Approach We Take to Achieve Quality
- ◆ Quality Assurance Procedures at the HIV Rapid Testing Site
- ◆ How You Can Contribute to Quality Before, During and After Testing
- ◆ What Is Quality Control (QC)?
- ◆ Benefits of QC in Rapid Testing
- ◆ Internal Versus External Quality Control
- ◆ Troubleshooting Invalid Results
- ◆ Quality Control Records

What is “Quality”?

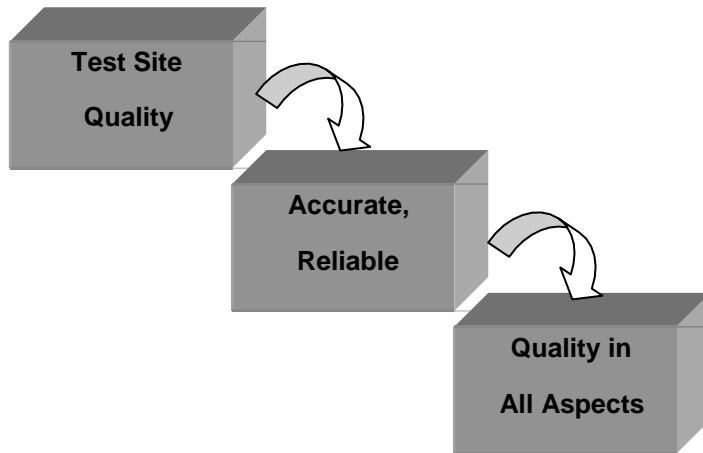
Quality is the ability of a product or service to satisfy the needs of a specific customer. You may achieve it by conforming to established requirements and standards.

Quality is about: Knowing what you want to do and how you want to do it.

### Why Quality?

- ◆ Learning from what you do
- ◆ Using what you learn to develop your organization and its services
- ◆ Seeking to achieve continuous improvement
- ◆ Satisfying your customer





Quality at a testing site will result in accurate and reliable test results, which are essential to all aspects of client health, including prevention, care and treatment.

**Who Is Responsible for Quality?**

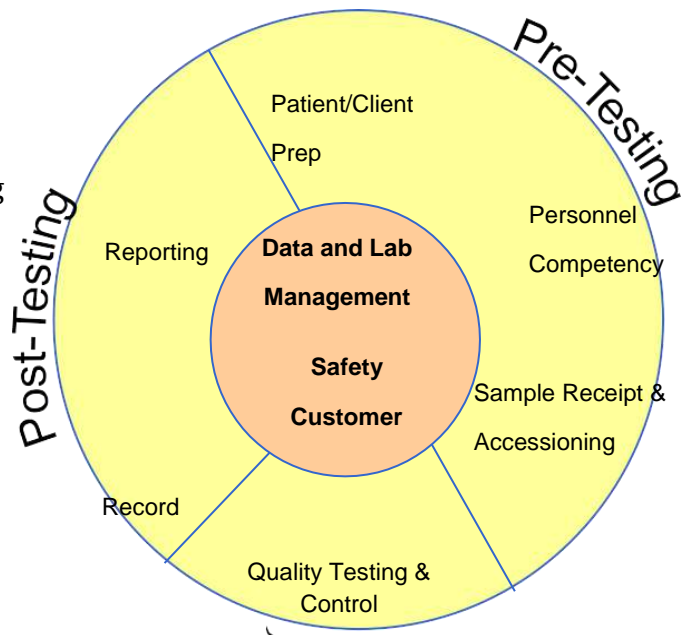
Quality is everyone’s responsibility. For example, laboratory management and program staff establish quality assurance procedures, and test site personnel implement the quality assurance procedures.

**Quality Assurance vs. Quality Control**

Quality assurance (QA) is the activity that ensure process are adequate for a system to achieve its objectives. Quality control (QC), on the other hand, is the activities that evaluate a product or work result.

**The Quality Assurance Cycle:**

QA is applied throughout the testing process at all testing sites. It is not a one-time event. As you can see in the graphic above, this is a continual process comprising three phases, and there are multiple activities associated with each phase of testing.



**Why Do Errors Occur?** Errors can occur throughout the **Testing** testing

**process. Some causes include:**

- ◆ Individual responsibilities unclear
- ◆ No written procedures
- ◆ Written procedures not followed
- ◆ Training is not done or not completed
- ◆ Checks not done for transcription errors
- ◆ Test kits not stored properly
- ◆ QC, external quality assessment (EQA) not performed

The table below provides the examples of errors that may occur during the three phases of the Quality Assurance Cycle, and what you can do to prevent them.

	<b>BEFORE TESTING</b>	<b>DURING TESTING</b>	<b>AFTER TESTING</b>
<b>Common Errors</b>	<ul style="list-style-type: none"> <li>• Testing device mislabeled or unlabeled</li> <li>• Specimen stored/ kept inappropriately before testing</li> <li>• Test kits stored and transported inappropriately</li> </ul>	<ul style="list-style-type: none"> <li>• Country algorithm not followed</li> <li>• Incorrect timing of test</li> <li>• Results reported when control results invalid</li> <li>• Improper measurements of specimen or reagents</li> <li>• Reagents stored inappropriately or used after expiration date</li> <li>• Incorrect reagents used (i.e., using buffers from a different kit)</li> </ul>	<ul style="list-style-type: none"> <li>• Transcription error in reporting</li> <li>• Report illegible</li> <li>• Report sent to the wrong location</li> <li>• Information system not maintained</li> </ul>
<b>How to Prevent/ Detect Errors</b>	<ul style="list-style-type: none"> <li>• Check storage and room temperature</li> <li>• Select an appropriate testing workspace</li> <li>• Check inventory and expiration dates</li> <li>• Review testing procedures</li> <li>• Record pertinent information, and label test device</li> <li>• Collect appropriate specimen</li> </ul>	<ul style="list-style-type: none"> <li>• Perform and review Quality Control (QC)</li> <li>• Follow safety precautions</li> <li>• Conduct test according to written procedures</li> <li>• Correctly interpret test results</li> </ul>	<ul style="list-style-type: none"> <li>• Re-check client/client identifier</li> <li>• Write legibly</li> <li>• Clean up and dispose of contaminated waste</li> <li>• Package EQA specimens for re- testing, if needed</li> </ul>

**REMEMBER, EVERY TESTER IS RESPONSIBLE FOR PREVENTING AND DETECTING ERRORS BEFORE, DURING AND AFTER TESTING.**

**What Is Quality Control?**

**Sources of Controls**

**Internal and External Quality Control**

**QUALITY CONTROL**

Quality control (QC) seeks to monitor the quality of the test itself. QC ensures that the test is working correctly and the tester can report accurate test results with confidence.

There are two types of quality control for HIV rapid testing: internal and external to the test kit.

**Internal quality control:**

- ◆ Control samples with known reactivity may be included with the test kit that you would test as you would client/client specimens.
- ◆ Another type of internal control is an area or region within the individual testing device. This area or region is also termed the procedural or in-built control. This type of control verifies the flow of either specimen and/or buffer through the test device resulting in an appearance of a line or dot in the control region. In other words, in some test devices, a line in the control area may appear even if a specimen is not added, unlike other test devices with an anti-IgG control. In this instance, a control line will not appear if IgG is not detected.
- ◆ Since it is not always known if the test device includes a true IgG control, it is important to test an external control sample.



**Control**

### **External quality control:**

- ◆ Control samples that do not come with the test kit. They are provided by an external source such as your regional reference laboratory or a facility laboratory.
- ◆ This type of control should also be tested in the same manner as you would test a client or client specimen.

Control samples are often received in tubes called cryovials. This photo illustrates control samples neatly stored in a Styrofoam container.



### **Sources of External Quality Control Samples**

It is important to store controls appropriately. For in-house prepared controls, these should be refrigerated upon receipt.

For both internal and external control samples, you already know whether the control is positive or negative. Once tested, you should receive the expected results. If not, this is one sign that there is a problem with your testing operation.

For all controls, you must:

- ◆ Label vial with date when first used
- ◆ Test before expiration date
- ◆ Take care as to not contaminate the control materials

At a minimum, test your external control samples:

- ◆ Once a week
- ◆ When a new shipment of test kits are received at the testing site
- ◆ In the beginning of a new lot number

### **Frequency of Use: When Should You Test External Control Samples?**

## Invalid Results

### - What Do You Do?

If you get an invalid result, you must repeat the test. In addition, you should identify the cause of the problem, inform your supervisor and take corrective actions.

It is important to always follow the standard operating procedure (SOP) for each type of test used, as the following may differ from kit to kit:

- ◆ Sample volume – This may differ from kit to kit, and might differ depending on the sample type (e.g., whole blood vs. serum).
- ◆ Buffer volume – Some kits require different volumes of buffer.
- ◆ Incubation time – This time may also differ from kit to kit. Always follow the time required by the manufacturer.

Use the following table to help you troubleshoot invalid results.

### Troubleshooting Invalid Results

PROBLEM	POTENTIAL CAUSE	ACTION
No control line or band present	Damaged test device or controls	◆ Repeat the test using new device and blood sample
	Proper procedure not followed	◆ Follow each step of testing according to SOP ◆ Re-check buffer and/or specimen volumes ◆ Wait for the specified time before reading the test
	Expired or improperly stored test kits or controls	◆ Check expiration date of kits or controls. Do not use beyond stated expiration date ◆ Check temperature records for storage and testing area
Positive reaction with negative external control, i.e., false positive	Incubation time exceeded	◆ Re-test negative control using a new device and read results within specified time limit
Extremely faint control line	The control line can vary in intensity	◆ No action required. Any visible line validates the results

## **Maintaining Quality Control Records**

Why are these records important? Because they help with troubleshooting and provide proof of reliable test results.

How are the records maintained? By using standard worksheets.

## **Periodic Review of Records**

When should you maintain QC records? Every time when you test QC materials. You should also record all invalid results and inform supervisor.

During a review of QC results, it is easier to have one log of all QC results rather than going from page to page in a logbook. A format such as this also provides an easy glance at consistent frequency in testing QC samples, and readily identification of problems.

You should review QC results periodically to detect any problems early. This review involves:

- ◆ Daily review of internal control results before accepting test results
- ◆ Review of external control results by test performer
- ◆ Weekly or monthly review of external quality control results by testing site supervisor
- ◆ Periodic audits or assessments

Keep in mind that if problems are detected, you must take corrective actions immediately.

## **External Quality Assessment: Definition**

### **EXTERNAL QUALITY ASSESSMENT**

External Quality Assessment (EQA) is the objective assessment of a test site's operations and performance by external agency or personnel.

## **Why EQA?**

EQA allows comparison of performance and results among different test sites offering not only an opportunity for performances checks, but an opportunity to systematically identify problems with kits or operations.

Additionally, EQA also provides objective evidence of testing quality, indicates areas that need improvement and identifies training needs.

## Testing Personnel's Responsibilities

Test providers' EQA responsibilities include:

- ◆ Participating in the EQA program
- ◆ Taking corrective actions
- ◆ Maintaining EQA records
- ◆ Communicating outcomes to supervisors

## EQA Methods

There are three main EQA methods:

- ◆ Proficiency testing (PT) – Proficiency panel may be used during on-site visits.
- ◆ On-site evaluation, which is sometimes referred to as onsite monitoring visits or audits.
- ◆ Re-checking or re-testing of specimens. Now a day, this method is not relevant for HIV rapid testing.



Proficiency Testing

On-site Evaluation

Re-checking/ Re-testing

## What Is Proficiency Testing?

In proficiency testing (PT), a reference laboratory or EQA centers sends out panels of specimens to multiple test sites, which in turn perform tests on these panels and report results. Dry tube specimen (DTS) is used in HIV PT program in Ethiopia for all testing points. The reported results indicate quality of personnel performance and test site operations. Results are often compared across several testing sites.

## What is Onsite Evaluation?

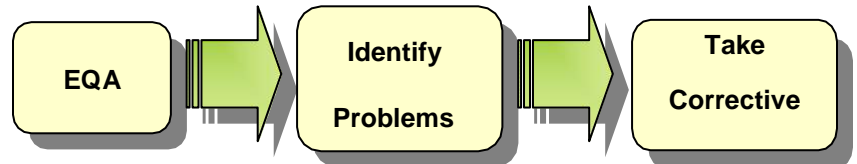
Once evaluation is periodic site visits to systematic assessment of laboratory practices. These visits focus on how the lab monitors its operations and ensures testing quality. They also provide information for internal process improvement. Onsite evaluation is also referred to as audits, assessments and supervisory visits.

These site visits enable us to learn “where we are” so we may measure gaps or deficiency. From the visits we can collect information for planning and implementation, monitoring

## **EQA should Lead to Corrective Actions**

and continuous improvement. They are part of every laboratory quality system.

These visits should be instructional rather than punitive. The main purpose of onsite visits is to observe the testing site under routine conditions to check that it is meeting quality requirements.



A corrective action is an action taken to correct a problem or non-conformance/ deficiency within the quality management system. Examples of a non-conformance include:

- ◆ Production of an incorrect result
- ◆ Test performed by untrained personnel
- ◆ Not following SOPs
- ◆ When the quality system does not meet the requirements of quality standards or requirements

## **Problems May Occur Throughout the Testing Process**

Problems may lie anywhere in the testing process: pre-testing, testing and post-testing. Most problems occur in the pre- and post-analytic phases of testing. The integrity of the specimen may have been compromised during preparation, shipping or after receipt by improper storage or handling.

Problems such as with reagents, test methods, quality control or competency of staff may occur during testing. Due to the large number of specimens collected and transported by numerous test sites, care must be taken to ensure proper transcription of data throughout the testing process.

## **Take Corrective Actions**

Whenever problems are detected, corrective actions must be taken:

- ◆ Use problem-solving team
- ◆ Investigate root causes and develop appropriate corrective actions
- ◆ Implement corrective actions
- ◆ Examine effectiveness
- ◆ Record all actions and findings



- ◆ Check the sample corrective action logbook/form

## Chapter 8: Documents and Records

**Learning objectives:** By the end of this session the participants will be able to:

- ◆ Explain the difference between a document and a record
- ◆ Explain the rationale for following documents and keeping records
- ◆ Provide examples of documents and records kept at a test site
- ◆ Identify SOPs at HIV rapid testing sites
- ◆ Describe how to properly keep and maintain test site documents and records

### Contents

- ◆ Definition of documents and records?
- ◆ Why are they important?
- ◆ What documents and records should you keep?
- ◆ Why is it important to follow SOPs?
- ◆ What is the proper way to keep and maintain documents and records?

## **Definition of documents and records?**

Documents are written policies, process descriptions and procedures used to communicate information. They provide written instructions for HOW TO do a specific task.

Records are generated when written instructions are followed. In other words, after data, information or results are recorded onto a form, label, etc., then it becomes a record.

Documents and records may be paper or electronic.

## **Examples of Documents and Records**

Examples of documents include: country testing algorithm, safety manual, SOPs for an approved HIV rapid test, manufacturer test kit inserts, and quality control record (blank form).

Examples of records include: client test results, summary of findings form onsite evaluation visit, report of corrective actions, stock cards and stock book (completed), and EQA result submission form (completed).

## **Documents Are the Backbone of the Quality System**

Verbal instructions often are not heard, misunderstood, quickly forgotten and ignored. Policies, standards, processes and procedures must be written down, approved and communicated to all concerned.

## **SOPs are Documents**

SOPs are documents that describe how to perform various operations in a testing site. They provide step-by-step instructions and assure consistency, accuracy and quality. SOPs are one type of document. Using SOPs results in reliable and consistent results.

## **SOPs Are Controlled Documents**

“Controlled” documents means that documents must be approved for use in- country, have document control features and be kept up-to-date. Key features of SOPs include:

- ◆ Cover page
- ◆ Descriptive title
- ◆ SOP number
- ◆ Version number
- ◆ Date when SOP become effective
- ◆ Signature of person responsible for writing the SOP
  - ◆ Signature of person authorizing the SOP

## **What SOPs Should You Keep at a Test Site?**

Each test site should have on hand current/approved SOPs. Typical SOPs kept at a test site include:

- ◆ Daily routine schedule
- ◆ National HTC guideline and algorithm
- ◆ Safety manuals (for example, safety precautions, preparation of 10% (vol/vol) bleach solution and post-HIV exposure prophylaxis management and treatment guidelines)
- ◆ Blood collection (for example, finger prick, venipuncture and DBS)
- ◆ Test procedures
- ◆ Reordering of supplies and kits

## **SOPs Must Be Followed**

SOPs must be followed. Not following safety precautions poses unnecessary risk to you, the client and the environment.

## **Do Not Rely Solely on Manufacturer Product Inserts**

Manufacturer product inserts do not provide specific information for test sites. Examples include:

- ◆ Materials required, but not in kit
- ◆ Specific safety requirements
- ◆ Sequence of tests in country algorithm
- ◆ External quality control requirements

## **Proper Record- Keeping Makes Quality Management Possible**

Recordkeeping allows a test site to:

- ◆ Communicate accurately and effectively—Recordkeeping enables sites to be timely in reporting to program managers and site supervisors.
- ◆ Minimize error—All records must be written.
- ◆ Monitor quality system—Records allow for periodic review of testing operations. Only through the review of records can improvements be identified.
- ◆ Assist management in developing policy and plans and M&E programs.

## **What Records Should You Keep at a Test Site?**

## Tips for Good Recordkeeping

- ◆ HIV positive referral feedbacks
- ◆ HIV test request/client test result
- ◆ IQC records
- ◆ PT feedbacks
- ◆ HTS register
- ◆ Inventory records/ IFRR forms(completed)

Here are some tips for good recordkeeping:

- ◆ Understand the information to be collected. Before you record any information, make sure that you understand what is to be collected
- ◆ Record the information every time. Record on the appropriate form each time you perform a procedure.
- ◆ Record all the information. Make sure that you have provided all the information requested on a form.
- ◆ Record the information the same way every time. Be consistent in how you record information.

## Client Test Records

Types of information captured on test records when testing is requested by different units includes:

- ◆ Client/Client ID number
- ◆ Date of test
- ◆ Results from Test 1, Test 2 and Test 3
- ◆ Repeat results
- ◆ HIV status
- ◆ Kit name and lot number
- ◆ Person performing test

(Refer to standard HIV test recording form in **Annex C**)

Records must be maintained secure storage. The length of time you will need to store test site records will depend on national policies and the availability of secure storage space at your test site.

## How Long Should You Retain Client Records?

It is recommended that you keep these records at your test site:

## Logbooks Are Cumulative Records of Test Site Operations

**Records Should be Permanent, Secure, Traceable**

**Information Recorded will Feed into M&E System**

Storage of logbooks and records should be kept in a manner that will minimize deterioration. Although

many sites use paper-based logbooks and records, they should be indexed so that they will be accessible while they are needed.

Facilities where records are kept should be secure to maintain client confidentiality. Procedures and mechanisms should prevent unauthorized access.

Records should be permanent, secure and traceable. Examples of keeping records permanent include: keep books bound, number pages, use permanent ink and control storage. To keep records secure, you need to maintain confidentiality, limit access and protect them from environmental hazards. To keep records traceable, make sure every record is signed and dated.

Records must be kept permanent, secure, and traceable because they will be used for reporting and monitoring purposes. Monitoring is the routine tracking of program information. Accurate facility records provide essential information for providing high-quality health care and monitoring HTS programs. It is recommended that you analyze on a monthly basis the number of clients served and summarize the test results.

**Module Summary**

- ◆ HIV rapid tests can be as reliable as EIAs.
- ◆ All tests require attention to training, supervision and monitoring at points of service.
- ◆ As testing is expanded and decentralized, training, supervision and monitoring must follow accordingly and become all the more important.
- ◆ Before any test is adopted in-country for use, a series of key steps must be taken to evaluate the tests before they are fully adopted for use countrywide.
- ◆ The ideal algorithm used is one in which tests are highly sensitive and highly specific.
- ◆ No test is 100% sensitive or 100 % specific when compared to the “gold standard.” Always follow the sequence of the tests in the algorithm
- ◆ Report any accidents immediately and take appropriate actions
- ◆ Always apply safety work practices throughout the testing process.
- ◆ Do not break, bend, re-sheath or reuse lancets, syringes or needles.
- ◆ Dispose of contaminated waste in the appropriate container.
- ◆ Disinfect your work surface on a daily basis.
- ◆ Having an organized workspace is key to producing high-quality results.
- ◆ Be sure to have all the supplies you need in reach before beginning a test.

- ◆ You must prepare your workstation and client prior to performing a finger prick.
- ◆ Always follow universal safety precautions to protect your client and yourself when performing finger prick.
- ◆ Follow standard operating procedures when performing a finger prick.
- ◆ An accurate HIV rapid test result is dependent in part on the quality of the sample collected.
- ◆ Always follow universal safety precautions when performing any laboratory procedure.
- ◆ Always follow your country's testing algorithm.
- ◆ EQA provides early warning for systematic problems associated with kits or operations.
- ◆ Onsite visits are designed to be instructive, not punitive.
- ◆ Corrective actions should be implemented and recorded for any problems identified.
- ◆ A test result is only as good as the specimen received for testing.
- ◆ Always follow standard operating procedures (SOPs) for each test performed.
- ◆ If problems or errors occur, you must immediately take corrective actions before you give results to clients.
- ◆ If an invalid result is obtained at any point, corrective actions should be taken prior to reporting test results.
- ◆ QC results must be documented and reviewed periodically for early detection of problems.
- ◆ Quality is the foundation of everything we do.
- ◆ The simplest rapid test is not fool-proof.
- ◆ Errors can occur throughout the testing process.
- ◆ Quality is everyone's responsibility.
- ◆ Written policies and procedures are the backbone of the quality system.
- ◆ Complete quality assurance records make high-quality management possible.
- ◆ Keeping records facilitates meeting program reporting requirements.

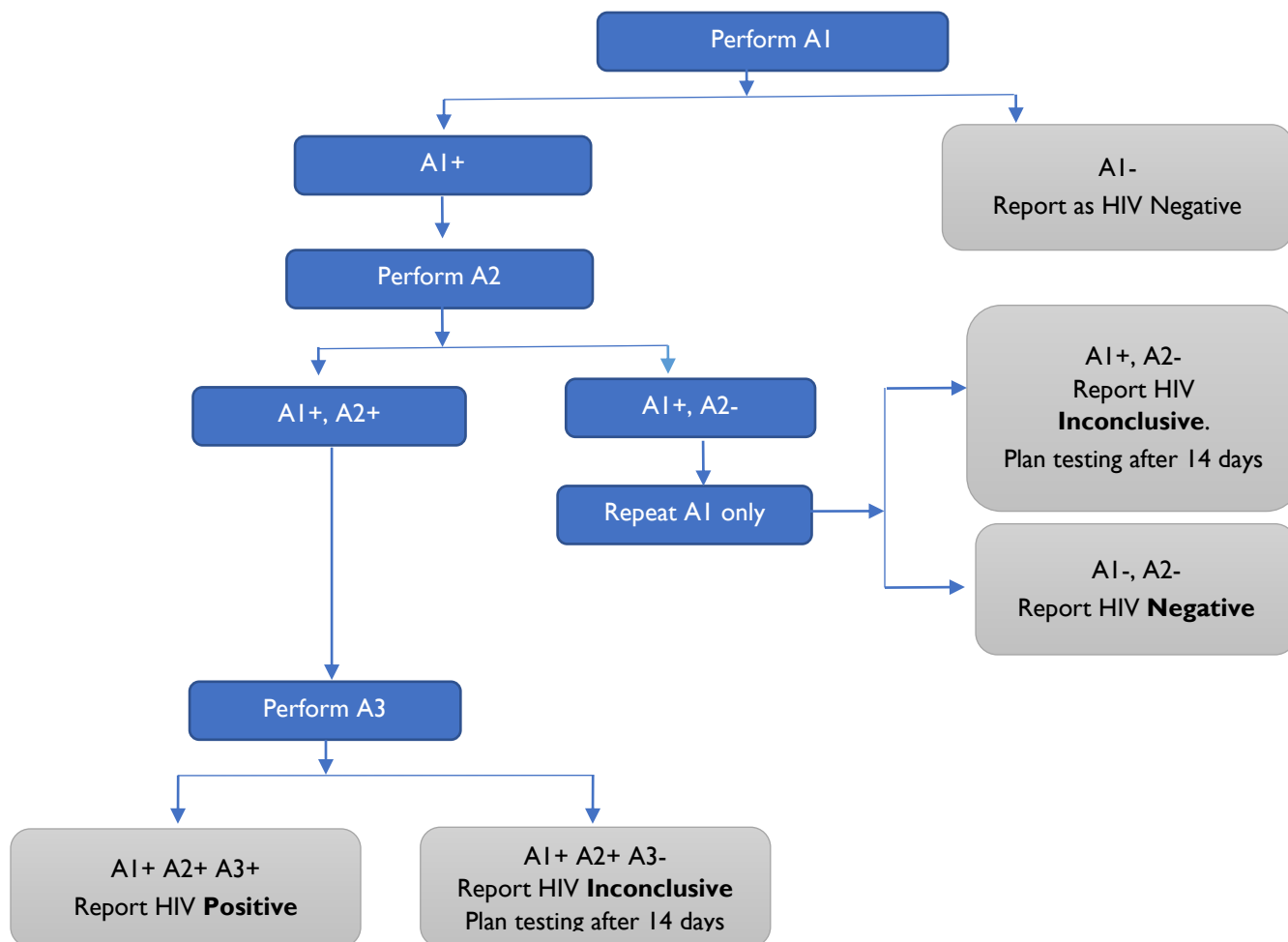
## Annexure

### Annex A: Checklist for HIV Rapid Testing Supplies and Materials

- |                                      |  |
|--------------------------------------|--|
| _____ HIV rapid test kit(s)          | _____ Disposable gloves                |
| _____ Alcohol or alcohol prep pads   | _____ Cotton gauze/wool                |
| _____ Laboratory coats or aprons     | _____ Timer, clock or watch            |
| _____ Sterile lancets                | _____ Lancet bin or disinfectant jar   |
| _____ Paper towels                   | _____ Pens for labeling                |
| _____ Leakproof bag                  | _____ Handwashing soap                 |
| _____ Band-Aids or plasters          | _____ Disinfectant                     |
| _____ Positive and negative controls | _____ Standardized Logbook or register |
| _____ Spray/wash bottle              | _____ Standard operating procedures    |
| _____ Capillary tubes                |  |



## Annex B: Job Aid for HIV Rapid Testing Algorithm



- ◆ All individuals are tested on Assay 1 (A1). Anyone with a non-reactive test result (A1-) is reported HIV negative.
- ◆ Individuals who are reactive on Assay 1 (A1+) should then be tested on a separate and distinct Assay 2 (A2).
- ◆ Individuals who are reactive on both Assay 1 and Assay 2 (A1+; A2+) should then be tested on a separate and distinct Assay 3 (A3).
  - Report HIV-positive if Assay 3 is reactive (A1+; A2+; A3+)
  - Report HIV-inconclusive if Assay 3 is non-reactive (A1+; A2+; A3-). The individual should be asked to return in 14 days for additional testing.
- ◆ Individuals who are reactive on Assay 1 but non-reactive on Assay 2 (A1+; A2-) should be repeated on Assay 1
  - If repeat Assay 1 is non-reactive (A1+; A2-; repeat A1-), the status should be reported as HIV negative;
  - If repeat Assay 1 is reactive (A1+; A2-; repeat A1+), the status should be reported as HIV-inconclusive, and the individual asked to return in 14 days for additional testing.

## Annex C: Practical Exercise Recording Worksheet

Sample ID	<b>HIV Test-1*</b> Kit Name _ _____ Lot No. _____ Expiration Date ____/____/____	<b>HIV Test-2*</b> Kit Name __ _____ Lot No. _____ Expiration Date ____/____/____	<b>Repeat Test-1</b> Kit Name _____ Lot No. _____ Expiration Date ____/____/____	<b>HIV Test-3*</b> Kit Name _____ Lot No. _____ Expiration Date ____/____/____	<b>Final Result**</b>
9	10	11	12	13	14
/ /	NR R INV	NR R INV	NR R INV	NR R INV	NEG POS INC
/ /	NR R INV	NR R INV	NR R INV	NR R INV	NEG POS INC
/ /	NR R INV	NR R INV	NR R INV	NR R INV	NEG POS INC
/ /	NR R INV	NR R INV	NR R INV	NR R INV	NEG POS INC
/ /	NR R INV	NR R INV	NR R INV	NR R INV	NEG POS INC
/ /	NR R INV	NR R INV	NR R INV	NR R INV	NEG POS INC

Circle the results of the individual test results and final status, once the testing is completed for each sample  
 NR – Non-reactive    R – Reactive    INV – Invalid

NEG – Negative    POS – Positive    IND – Indeterminate

	Signature/Date	Additional comments
<b>Supervisor</b>		

## Annex D: Job Aid for ONE STEP Anti-HIV (1&2) card test

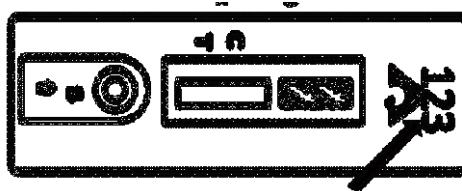


### ONE STEP Anti -HIV (1&2) Test

For use with whole blood, serum, or plasma  
Store Kits: 2 - 27 °C



- Check kit before use. Use only items that have not expired or been damaged.
- Bring kit and previously stored specimens to room temperature prior to use.
- Always use universal safety precautions when handling specimens. Keep work areas clean and organized.
- Do not read the test results after 15 minutes. Reading the results after 20 minutes window may give inaccurate results. After recording the results, dispose of used test device as a biohazard waste.



1. Collect test items and other necessary lab supplies.



4. Add 1 drop of specimen (whole blood, serum or plasma) to the sample port in the device.

2. Remove device from package and label device with client identification number.



5. Add 1 drop of the appropriate wash reagent to sample port.

3. Collect specimen using the disposable pipette.



6. Wait for 15 minutes (no longer than 20 min.) before reading the result

#### ONE STEP Anti

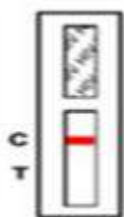
#### -HIV (1&2)

#### Rapid Test Result

#### interpretations

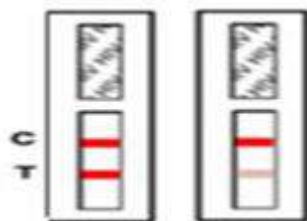
##### Non - Reactive

1 line appears in the control area and no line in the test area.



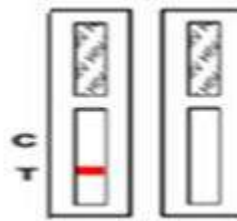
##### Reactive

2 lines of any intensity appear in both the control and test areas.



##### Invalid

No line appears in the control area. Do not report invalid results. Repeat test with a new test device even if a line appears in the test area.



Read and record the results and other pertinent information on the register

## **Annex E: Job Aid for First Response HIV 1-2 Card Testing**



## Job Aid for First Response HIV 1-2.0 card Test, For use with whole blood, plasma and serum

- Check kit before use. Use only items that have not expired or been damaged.
- Bring kit and previously stored specimens to room temperature prior to use.
- Always use universal safety precautions when handling specimens. Keep work areas clean and organized.
- Do not read the test results after 25 minutes. Reading the results after 25 minutes window may give inaccurate results. After recording the results, dispose of used test device as a biohazard waste.



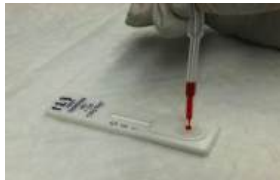
1. Collect test items and other necessary testing supplies.



2. Remove device from package and label device with client identification number



3. Collect specimen (whole blood, serum or plasma) using the disposable pipette.



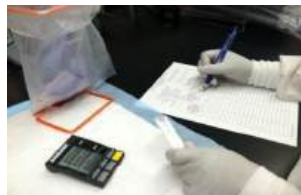
4. Add 2 drops (~20ul) of whole blood to the sample well; for serum or plasma add 1 drop (~10ul) to the sample well



5. Add 1 drop (~ 35ul) of the appropriate wash reagent to sample port.



6. Wait for 15 - 25 minutes before reading results. (DO NOT read results after 25 minutes).



7. Read and record the results and other pertinent info on the worksheet  
Observe for development of coloured bands on the result window and interpret test result at 15-25 minutes.

### Non-Reactive Result

Purple coloured line appears in the control area and no line in the test area.

### Reactive Results

Lines of any intensity in the result window with below result

Presence of 2 lines on "C" & "1" areas or Presence of 2 lines on "C" & "2" areas or Presence of 3 lines on "C", "1" & "2" areas

### Invalid Results

No line appears in the control area or Whenever a band appears without being accompanied by a control line

#### Non- Reactive



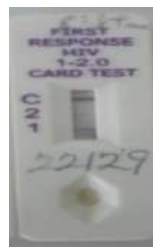
#### HIV-1 Reactive



#### HIV-2 Reactive



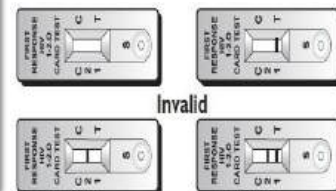
#### HIV-1&2 Reactive



#### Invalid



#### Invalid



## Annex F: Job Aid for Uni Gold HIV 1.2.0 HIV Rapid Testing



## Uni-Gold HIV

For use with whole blood, serum, or plasma  
Store Kits: 2 - 27°C



- Check kit before use. Use only items that have not expired or been damaged.
- Bring kit and previously stored specimens to room temperature prior to use.
- Always use universal safety precautions when handling specimens. Keep work areas clean and organized.
- Do not read the test results after 12 minutes. Reading the results after 12 minutes window may give inaccurate results. After recording the results, dispose of used test device as a biohazard waste.



1. Collect test items and other necessary lab supplies.



2. Remove device from package and label device with client identification number.



3. Collect specimen using the disposable pipette.



4. Add 2 drops of specimen (whole blood, serum or plasma) to the sample port in the device.



5. Add 2 drops of the appropriate wash reagent to sample port.



6. Wait for 10 minutes (no longer than 12 min.) before reading the result



7. Read and record the results and other pertinent info on the worksheet.

### Uni-Gold HIV Rapid Test Results

#### Reactive

**2 lines** of any intensity appear in **both** the **control** and **test** areas.



#### Non-reactive

**1 line** appears in the **control** area and no line in the test area.



#### Invalid

**No line** appears in the **control** area. Do not report invalid results. Repeat test with a new test device even if a line appears in the test area.



## Annex G: Standard Operating Procedure for ONE STEP Anti-HIV (1&2) Test

<b>Purpose</b>	To provide guidelines on procedures to perform rapid HIV screening test using ONE STEP Anti-HIV (1&2) Test
<b>Applicability</b>	For all HTC providers/testers/ including laboratory technicians, laboratory technologists, nurses, midwives and community counselors
<b>Principle</b>	<p>The test band region on the nitrocellulose membrane is pre-coated with recombinant HIV antigen (containing predominant epitope of gp41, gp120 of HIV-1 and predominant epitope of gp36 of HIV-2), and the control band region on the nitrocellulose membrane is pre-coated with sheep anti-rabbit IgG. The fiberglass is pre-coated with recombinant HIV antigen (containing predominant epitope of gp41, gp120 of HIV-1 and predominant epitope of gp36 of HIV-2) conjugated with colloidal gold and rabbit IgG conjugated with colloidal gold.</p> <p>For positive specimens, HIV antigen conjugated with colloidal gold reacts with HIV antibody in whole blood, serum or plasma, forming a colloidal gold conjugate/HIV antibody complex. The complex migrates through the test strip and is captured by the recombinant HIV antigen immobilized in the test band region, forming a test band.</p> <p>A negative specimen will not produce a test band due to the absence of colloidal gold conjugate/HIV antibody complex. To ensure assay validity, a purplish red control band in the control region will appear regardless of the test result.</p> <p>The assay is only valid when the control band appears.</p>

<b>Abbreviations</b>	<p><b>HIV</b> .....human immunodeficiency virus</p> <p><b>AIDS</b> ..... Acquired immune deficiency syndrome</p> <p><b>ELISA</b> ..... Enzyme linked immunosorbent assay</p> <p><b>C</b>..... control</p> <p><b>T</b>..... Test</p> <p><b>Ags</b> ..... Antigens</p> <p><b>Abs</b> ..... Antibodies</p>
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<b>Materials</b>	<b>Material provided</b>
	<ul style="list-style-type: none"> <li>◆ Test Device with sample Pipette and desiccant (Test device enclosed nitrocellulose test strip on which test and control lines are coated)</li> <li>◆ Sample diluent</li> <li>◆ Alcohol swab</li> <li>◆ Sterile lancets</li> </ul> <p><b>Reagents, stability and storage:</b> should be stored at 2-30 °C.</p>
	<b>Supplies and Materials not provided</b>
	<ul style="list-style-type: none"> <li>◆ New pair of disposable gloves and face mask for each test conducted/specimen collected by fingerstick.</li> <li>◆ Sterile gauze pad and tissue paper.</li> <li>◆ Permanent marker pen and timer.</li> <li>◆ Extra sterile twist lancets, alcohol swabs and specimen transfer device, if needed.</li> <li>◆ Sharp disposable box and biohazardous waste container.</li> <li>◆ Venipuncture blood collection kit (if whole blood is collected by venipuncture).</li> </ul>

<b>Specimen Collection and Storage</b>	<p>1. <b>Fingerstick whole blood:</b></p> <p>Rub the target finger to stimulate blood flow. Clean the finger with an alcohol swab and leave it to dry. Stick the skin of target finger with a sterile safety lancet (for the provided sterile safety lancet: a) Twist clockwise the protective cap and remove it; b) Place the lancet firmly on side of finger (avoid callus) to trigger it, gently press around the site of puncture to obtain a drop of blood (avoid excessive bleeding). Wipe away the first drop of blood with a sterile gauze pad. Allow a new drop of blood to form.</p> <p>Collect the blood specimen with the dropper provided. Gently squeeze the bulb of the dropper and touch the tip of the blood. Gently release bulb to draw up blood past tip of dropper.</p>
	<p><b>Venous whole blood:</b> Collect whole blood specimen into a collection tube (with specified anticoagulant, namely EDTA, heparin sodium or sodium citrate) according to standard venous blood sampling process. Other</p>



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anticoagulants may lead to incorrect results.

Store whole blood specimen at 2-8°C for up to 3 days if it is not used immediately after being sampled. Do not freeze whole blood specimen. Before testing, gently shake the blood tube to obtain a homogeneous specimen.

**Serum:** Collect whole blood specimen into a collection tube contains no anticoagulant according to standard venous blood sampling process. Leave to settle for 30 minutes for blood coagulation, then centrifuge at 3000rpm for at least 5 minutes to obtain the serum supernatant.

**Plasma:** Collect whole blood specimen into a collection tube (with specified anticoagulant, namely EDTA, heparin sodium or sodium citrate) according to standard venous blood sampling process. Gently invert the collection tube for several times and leave to settle for 30 minutes for blood coagulation, then centrifuge at 3000rpm for at least 5 minutes to obtain the plasma supernatant.

**Notes:**

- Serum or plasma specimens shall be stored at 2-8°C for up to 7 days from time of draw. Store at -18°C or below for long time storage. Multiple freeze-thaw cycles should be avoided (3 times at most). Frozen specimens shall be equilibrated to room temperature (10-30°C) before testing.
- Serum or plasma specimen containing precipitate may lead to invalid results. Centrifuge the specimen and use the supernatant for the test.

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**Limitation**

- ◆ The kit is designed to detect antibodies against HIV-1 and HIV-2 in human serum, plasma, and whole blood. Specimens other than those specified may not supply accurate results and the device will not notify this kind of misuse to the user.
- ◆ The intensity of test band does not necessarily correlate to the titer of antibody in specimen.
- ◆ The presence of the control band only indicates the flow of the conjugate.
- ◆ When a specimen contains high concentration of antibody to HIV-1 or HIV-2 is tested on the device, the control band could be absent due to the test principle. In this case, please perform further analysis according to section of "Test result and

interpretation".

- ◆ As this product is intended to detect antibodies against HIV from individuals, clinical diagnosis of HIV infection or AIDS should not be made only based on the results of the product.
- ◆ A negative result should not exclude the possibility of infection caused by HIV-1 or HIV-2. A negative result can also occur in the following circumstances:
  - Recently acquired HIV infection.
  - Low levels of antibody (e.g., early seroconversion specimens) below the detection limit of the test.
  - HIV antibodies in the patient that do not react with specific antigens utilized in the assay configuration, in exceptional cases this may lead to observation of negative results.
  - Specimens are not properly stored.
  - High concentrations of a particular analyte.
  - Recently discovered type or subtype of HIV.
- ◆ For reasons above, care should be taken in interpreting negative results. Other clinical data (e.g., symptoms or risk factors) should be used in conjunction with the test results.
- ◆ Positive specimens should be retested using another method and the results should be evaluated considering the overall clinical evaluation before a diagnosis is made.
- ◆ The product is not validated on specimens from infants, children, or patients on antiviral treatment.
- ◆ Use of hemolytic specimens, rheumatoid factors-containing specimens, hyperlipemia specimens or icteric specimens may lead to impairment to the test result.
- ◆ Only specimens with good fluidity and without hemolysis can be used with this test.

**Safety Precautions** Using universal persecution (gloves, lab coat, washing hands) when handling infectious materials refer to the national health and safety guideline for standard safety procedure

Maintenance	Step	Action
		Daily Bench Cleaning

Quality Control	Control	Stability	Frequency	Preparation (y/n)

Internal kit control	Room temperature	Each run	N
In house control	-20 °C or colder	At least Weekly, New batch started, new manipulator and result suspicious.	Y

**Procedure**

8. Do not open the pouch until ready to perform a test. Use the test immediately after opening the pouch.
9. Equilibrate all reagents and specimens to room temperature (10-30°C) before use;
10. Unseal the foil pouch and put the cassette on a clean, dry and level surface;
11. Mark the specimen ID number on test cassette;
12. Add 1 drop of the specimen using the provided dropper (or 30µl by transfer pipette) into port "S" of the cassette;
13. Then add 1 drop of sample diluent into port "S" immediately;
14. Wait and interpret the result between 15-20 minutes.

**Caution:**

- Always apply specimen with a new and clean dropper or pipette tip to avoid cross contamination.
- Negative results cannot rule out the possibility of exposure to or infection with HIV-1 or HIV-2 viruses.

**Caution**

1. Do not use if the kit box safety seal is absent, damaged or broken.
2. Do not use any device if the pouches have been perforated.
3. Each device is for single use only.
4. Do not mix Wash Solution/test devices from different kit lots.
5. Do not use the kit past the expiration date (this date is printed on the kit box).
6. Adequate lighting is required to read the test results.
7. The result should be read immediately after the end of the 10-minute incubation time following the addition of Wash Solution. Do not read results beyond 12 minutes.
8. Lancets should be placed in a puncture resistant container prior to disposal.

**Result**

**Reactive result**

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**Interpretation**

- Purplish red bands appear at both the test band area (even though very weak) and the control band area.

**Non-Reactive result**

- Purplish red band only appears on control band area.

**Invalid result**

- A purplish red band appears only at the test band area of the cassette. Repeat the test. Contact the supplier if the control band remains invisible. OR
- Purplish red band appears at neither the control band area nor the test band area of the cassette.

**Note: The Invalid test results should be retested with new test device.**

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**Reference**

1. Blattner, W., Gallo, R.C. and Temin. H.M. HIV causes AIDS. Science. 241:515, 1998.
  2. InTec PRODUCTS, INC.,. *ONE STEP Anti-HIV (1&2) Test* Rapid Immunochromatographic Card Test for the detection of Antibodies to HIV 1 & 2 in Human Whole Blood/Serum/Plasma. February 2020.
  3. WHO. Consolidated guidelines on HIV testing services. December 2019.
-

## Annex H: Standard Operating Procedure for FIRST RESPONSE HIV 1-2 CARD TEST (Ver.2.0) for HIV screening testing

**Purpose** To provide guidelines on procedures to perform rapid HIV screening test using First Response HIV 1-2.0 (Ver.2.0) Card Test.

For all HTC providers/testers/ including laboratory technicians, laboratory technologists, nurses, midwives and community counselors

**Applicability** First Response HIV 1-2.0 Card Test (Ver.2.0) is based on the principle of immunochromatography for the qualitative detection of antibodies specific for HIV-1 and HIV-2. The nitrocellulose membrane is coated with recombinant HIV-1 capture antigens (gp41 including Group O) on test line “1” region and with recombinant HIV-2 capture antigen (gp36) on test line “2” region and control reagent coated at control line “C”. When serum or plasma or whole blood specimen is applied followed by assay buffer addition to the specimen well of the test device, the recombinant HIV-1 and 2 antigens (gp41 and gp36) conjugated with colloidal gold particles (CGC) bind to HIV-1 and 2 antibodies present in the test specimen.

**Principle** This conjugated antigen-antibody complex moves through the nitrocellulose membrane and bind to the corresponding immobilized HIV-1 antigen and HIV-2 antigen (Test Lines) leading to the formation of purple colored visible line as the capture antigen-antibody-conjugated antigen complex, indicating reactive results. Purple colored control line will appear irrespective of the reactive or non-reactive specimen. The control line is a procedural control, serves to demonstrate functional reagents and correct migration of fluid.

**Abbreviations**

- HIV**.....human immunodeficiency virus
- AIDS** ..... Acquired immune deficiency syndrome
- ELISA** ..... Enzyme linked immunosorbent assay
- C**..... control
- T**..... Test
- Ags** ..... Antigens
- Abs** ..... Antibodies

<b>Materials</b>	<b>Material provided</b>
	<ul style="list-style-type: none"> <li>◆ Test Device with sample Pipette and desiccant (Test device enclosed nitrocellulose test strip on which test and control lines are coated)</li> <li>◆ Assay buffer</li> <li>◆ Alcohol swab, sterile lancets and instruction for use</li> </ul> <p><b>Reagents, stability and storage:</b> should be stored at 4-30 °C.</p>
	<b>Supplies and Materials not provided</b>
	<ul style="list-style-type: none"> <li>◆ New pair of disposable gloves and face mask for each test conducted/specimen collected by fingerstick.</li> <li>◆ Sterile gauze pad and tissue paper.</li> <li>◆ Permanent marker pen and timer.</li> <li>◆ Extra sterile twist lancets, alcohol swabs and specimen transfer device, if needed.</li> <li>◆ Sharp disposable box and biohazardous waste container.</li> <li>◆ Venipuncture blood collection kit (if whole blood is collected by venipuncture).</li> </ul>

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### Specimen collection

#### Specimen Collection and Storage

2. **Venous blood collection:** Collect the Whole blood in the collection tubes containing anticoagulants like EDTA, Heparin, Sodium citrate or ACD by venipuncture.
  3. **Plasma collection:** Collect the Whole blood in the collection tubes containing anticoagulants like EDTA, Heparin, Sodium citrate or ACD by venipuncture and centrifuge it at 3000 g for 10-15 minutes to obtain Plasma.
  4. **Serum collection:** Collect Whole blood in the collection tubes without having any anticoagulants by venipuncture. Keep it in standing position for 30 minutes and centrifuge it at 3000 g for 10-15 minutes to obtain
  5. **Capillary whole blood specimen collection:**
    - ◆ Wear gloves and massage the fingertip gently. It will help to obtain a round drop of blood.
    - ◆ Wipe the complete fingertip with the alcohol swab provided and
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wait until the fingertip is dried completely.

- ◆ Do not use the auto safety lancet if the auto safety lancet found uncapped. Detach the protective cap of the auto safety lancet provided. Squeeze the fingertip then push gently at the lateral side (avoid callus) of the fingertip as shown in above figure. Safely dispose of the used auto safety lancet in sharps container immediately after use.
- ◆ Wipe the first drop of the blood using sterile gauze. Without pressing too hard, gently squeeze fingertip once again to obtain second drop of blood (~40-50 µl).
- ◆ Take the specimen transfer device provided and hold it vertically. Gently squeeze the bulb of specimen transfer device and immerse open end in the center of a blood drop and release the bulb slowly to draw up the blood up to the 20 µl marking line on the specimen transfer device.
- ◆ Do not use the specimen transfer device having no marking. After completion of specimen collection, take the sterile gauze and apply pressure to the wound site to stop the bleeding. Specimen transfer device is for single use only.

**Note:** Auto safety lancet is for single use only. Do not share used auto safety lancets with another person. Dispose of used auto safety lancets in sharp box and alcohol swab in biohazard waste container immediately after use.

Do not use expired auto safety lancet. Use of any expired lancet may cause infections at the punctured skin due to expiry of its sterility. Use new lancet, alcohol swab and specimen transfer device and choose a different puncture site, if another finger pricking is required.

### **Specimen Storage**

1. Venous whole blood specimens should be used for testing immediately (within 1hour) or shall be stored at 2-8°C for up to 72 hours (3 days). Do not use whole blood specimens stored for more than 3 days, it can cause a non-specific reaction. Do not freeze whole blood specimens.
2. Note: Mix the whole blood specimens in the tube by inverting the tube 3 or 4 times before use.
3. If serum or plasma specimens are not immediately tested, then they should be refrigerated at 2-8°C. For storage period greater than 72 hours (3 days), freezing at <-20°C is recommended up to 4 months.
4. Venous whole blood, serum and plasma specimens stored at 2-8°C must be

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brought to room temperature before use. Serum or plasma specimens stored at <-20 °C must be thawed at 15 to 25°C. Avoid more than 2 freeze-thaw cycles.

5. Serum or plasma specimens containing precipitate may yield inconsistent test results. Such specimens must be centrifuged at 5000 g for 10 minutes and then use clear supernatants for testing.
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### **Limitation**

1. The assay procedure and interpretation of assay result sections must be followed closely. Failure to follow the procedure may lead to inaccurate test results.
  2. First Response® HIV 1-2.0 Card Test (Ver. 2.0) is designed to detect antibodies to HIV-1 and HIV-2 in human serum, plasma, and whole blood. Other body fluids or pooled specimens may not give accurate results.
  3. First Response® HIV 1-2.0 Card Test (Ver. 2.0) rapid test is limited to the qualitative detection of HIV-1 or HIV-2 antibodies in human serum, plasma or whole blood. The intensity of the test line does not correlate with the antibody titer of the specimen.
  4. Haemolytic specimen may give reddish background even after end of test interpretation time.
  5. High lipaemic specimens/ turbid specimens must be centrifuged and use clear supernatant for testing.
  6. Interpret the purple colored faint line as a reactive line. Repeat the test in case of very faint test line or if have any doubt for test line.
  7. A non-reactive result for an individual subject indicates the absence of detectable HIV-1 or HIV-2 antibodies. However, a non-reactive result can occur if the quantity of the HIV-1 or HIV-2 antibodies present in the specimen is below the detection limits of the assay or the antibodies that are detected are not present during stage of the disease/condition (person on ART treatment, window period, immune collapse, Infected but non-seroconverted) in which a specimen is collected.
  8. All three lines (1,2 and C) may develop when tested with specimens containing high titers of HIV-1 and/or HIV -2 antibodies. The reactive test bands for both HIV-1 and HIV-2 may not always indicate mixed infection. The genomic structural similarity of HIV-1 and HIV-2 may give cross-reactivity. The western blot or PCR should be used to differentiate virus
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type or co-infection.

9. Heparin, EDTA, sodium citrate, and ACD anticoagulants have been validated for use with this test.
  10. False negative results may occur as a result of a very high antibody titre in a specimen". In such instances "Contact the manufacturer (or distributor) for further instruction.
  11. Although a reactive result may indicate infection with HIV-1 or HIV-2 virus, a diagnosis of HIV infection can only be made on clinical grounds, if an individual meets the case definition for AIDS established by the Centers for Disease Control. For specimens repeatedly tested reactive, more specific supplemental tests must be performed.
  12. Immunochromatographic testing alone cannot be used to diagnose HIV infection even if the antibodies against HIV-1/HIV-2 are present in a patient specimen. A negative result at any time does not preclude the possibility of HIV-1 or HIV-2 infection.
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<b>Safety Precautions</b>	Using universal persecution (gloves, lab coat, washing hands) when handling infectious materials refer to the national health and safety guideline for standard safety procedure
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Maintenance	Step	Action
		Daily Bench Cleaning

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Quality Control	Control	Stability	Frequency	Preparation (y/n)
	Internal kit control	Room temperature	Each run	N
	In house control	-20 °C or colder	At least Weekly, New batch started, new manipulator and result suspicious.	Y

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Procedure	Step	Action
	1	Ensure that the test device & other components are at room temperature (15°C to 30°C) before starting the procedure.
	2	Open the device pouch, take out the test device from aluminum pouch. Do not use the test device if the desiccant color has changed from orange to green.
	3	Label the test device with the patient identification number. Place the test device on a flat, clean and dry surface. Take out the specimen transfer device from the plastic bag provided inside the kit.
	4	Gently squeeze the bulb of specimen transfer device and immerse the open end in the specimen and release the bulb slowly to draw up the serum/plasma up to 10 µl marking line and for the capillary or venous whole blood up to 20 µl marking line on the specimen transfer device.
	5	Gently wipe away the excess specimen from the outer surface of the specimen transfer device with tissue paper before dispensing the specimen into the specimen well.
	6	Gently squeeze the bulb of specimen transfer device to add 20 µl of whole blood or 10 µl of serum/ plasma to the specimen well by gently touching the tips of the specimen transfer device to the sample pad. Caution: Dispose of used specimen transfer device and tissue paper as biohazard waste immediately after use.
	7	Hold the assay buffer bottle vertically and add one drop of assay buffer to the specimen well.
	8	Observe for development of purple colored lines in the results window. Interpret test results at 15 minutes after adding assay buffer to the specimen well.
	9	Do not interpret the test result after 25 minutes.

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**Caution**

- ◆ Add exactly 1 drop of assay buffer. Adding more than 1 drop of assay buffer may cause over flooding or reverse migration phenomenon, which may lead to inaccurate results of the test.
  - ◆ Do not read the test results after 25 minutes. Reading the results after 25 minutes window may give inaccurate results. After recording the results, dispose of used test device as a biohazard waste.
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**Result Interpretation****Reactive result**

- ◆ If two purple colored lines appear, one at the control line 'C' and other at the test line HIV-1 '1' as in the figure, then the specimen is reactive for antibodies to HIV-1. Interpret purple colored faint line as a reactive line.
- ◆ If two purple colored lines appear, one at the control line 'C' and other at the test line HIV-2 '2' as in the figure, then the specimen is reactive for antibodies to HIV-2. Interpret purple colored faint line as a reactive line. .
- ◆ If all three purple colored lines appear, one at the control line 'C' and other two at the test lines HIV-1 '1' and HIV-2 '2' as in the figure, then the specimen is reactive for antibodies to HIV-1 and 2. Interpret purple colored faint line as a reactive line.
- ◆ **Non-Reactive result** If only a single purple colored line appears, at the control line 'C' as in the figure, then the specimen is non-reactive for antibodies to HIV-1 and 2.

**Invalid result**

- ◆ No presence of purple colored control line 'C' in the results window (irrespective of presence of test lines) indicates an invalid result.

**Note: The Invalid test results should be retested with new test device.**

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**Reference**

4. PREMIER MeDICAL CORPORATION Ltd. FIRST RESPONSE® HIV 1 2.0 CARD TEST Rapid Immunochromatographic Card Test for the detection of Antibodies to HIV 1 & 2 in Human Whole Blood/Serum/Plasma. March 2020.
  5. WHO. Consolidated guidelines on HIV testing services. December 2019.
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## Annex I: Standard Operating Procedure for Uni Gold™ HIV screening test

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**Purpose** To provide guidelines on procedures to perform rapid HIV screening test using Uni Gold™ HIV.

**Applicability** For all HTC providers/testers/ including laboratory technicians, laboratory technologists, nurses, midwives and community counselors

**Principle**

Uni-Gold™ HIV is a rapid immunoassay based on the immunochromatographic sandwich principle. Recombinant proteins representing the immunodominant regions of the envelope proteins of HIV-1 and HIV-2, glycoprotein gp41, gp120 (HIV-1) and glycoprotein gp36 (HIV-2) respectively, are immobilized at the test region of the nitrocellulose strip. These proteins are also linked to colloidal gold and impregnated below the test region of the device. A narrow band of the nitrocellulose membrane is also sensitized as a control region.

During testing, two drops of serum, plasma or whole blood is applied to the sample port, followed by two drops of Wash Solution and allowed to react. Antibodies of any immunoglobulin class, specific to the recombinant HIV-1 or HIV-2 proteins will react with the colloidal gold linked antigens. The antibody protein colloidal gold complex moves chromatographically along the membrane to the test and control regions of the test device.

Excess conjugate forms a second pink/red band in the control region of the device. The appearance of this band indicates proper performance of the reagents in the kit.

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**Abbreviations**

**HIV** .....human immunodeficiency virus

**AIDS** ..... Acquired immune deficiency syndrome

**ELISA** ..... Enzyme linked immunosorbent assay

**C**..... control

**T**..... Test

**Ags** ..... Antigens

**Abs** ..... Antibodies

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<b>Materials</b>	<b>Material provided</b>
	<ul style="list-style-type: none"> <li>◆ Test Device with sample Pipette and desiccant (Test device enclosed nitrocellulose test strip on which test and control lines are coated)</li> <li>◆ Wash solution</li> <li>◆ Alcohol swab</li> <li>◆ Sterile lancets</li> </ul> <p><b>Reagents, stability and storage:</b> should be stored at 2-27 °C.</p>
	<b>Supplies and Materials not provided</b>
	<ul style="list-style-type: none"> <li>◆ New pair of disposable gloves and face mask for each test conducted/specimen collected by fingerstick.</li> <li>◆ Sterile gauze pad and tissue paper.</li> <li>◆ Permanent marker pen and timer.</li> <li>◆ Extra sterile twist lancets, alcohol swabs and specimen transfer device, if needed.</li> <li>◆ Sharp disposable box and biohazardous waste container.</li> <li>◆ Venipuncture blood collection kit (if whole blood is collected by venipuncture).</li> </ul>

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### Specimen collection

#### Specimen Collection and Storage

#### 6. Whole Blood Venipuncture Serum and Plasma:

Using standard phlebotomy procedures collect a venipuncture whole blood specimen using a blood collection tube containing either EDTA, acid citrate dextran (ACD) or heparin. This whole blood can be used directly on the device, or stored at 2-8°C for up to 3 days, or preferably, the sample should be centrifuged and the plasma retained for further testing. Do not freeze whole blood.

**Serum:** If a whole blood sample is collected without anticoagulant and has started to clot, do not remix before testing, in such instances, the clear serum should be pipetted off the clotted specimen and used for analysis.

**Plasma:** Using standard phlebotomy procedures collect a venipuncture whole blood specimen using a blood collection tube. If collecting plasma use a blood collection tube containing either EDTA, acid citrate dextran (ACD) or heparin. Plasma must be generated within 8 hours of blood

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draw. Following collection, centrifuge the tube of blood (1000-1300 x g) for approximately 5 minutes (no refrigeration required) to separate the cells from the plasma. Carefully uncap the tube by gently rocking the stopper towards you so that it vents away from you. Specimens may be tested immediately or stored between 2 to 8°C for up to 5 days to allow testing. Specimens must be stored at -20°C or below if storage is necessary for more than 5 days. Grossly hemolysed or lipemic samples should not be used. Avoid multiple freeze thaw cycles.

**Capillary whole blood specimen collection:** Use whole blood samples collected by fingerstick immediately on the Uni-Gold™ HIV device.

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**Limitation**

1. Uni-Gold™ HIV test procedure and interpretation of results must be followed when testing for the presence of HIV antibodies in serum, plasma or whole blood.
  2. Uni-Gold™ HIV has not been validated for use with other body fluids. Testing with Uni-Gold™ HIV must not be performed with such fluids as results derived may not be accurate.
  3. Uni-Gold™ HIV test is intended for the testing of undiluted samples only. Do not dilute samples before testing.
  4. For venipuncture whole blood and plasma, EDTA, acid citrate dextran (ACD) or heparin should be used as the anticoagulant. Other anticoagulants have not been tested and may give incorrect results.
  5. Immunosuppressed or immunocompromised individuals infected with HIV-1 or HIV-2 may not produce antibodies to the virus. Testing with any kit designed to detect antibodies may give negative results and would not be a reliable test method for such patients.
  6. Infants may receive antibodies from an infected mother or they may not produce antibodies in response to an infection. Therefore, it is necessary to exercise great care in interpreting their results.
  7. The intensity of a pink/red line at the "T" (test) region is not an indication of the level of antibody in the specimen.
  8. A reactive result by Uni-Gold™ HIV suggests the presence of anti-HIV antibodies in the specimen. Uni-Gold™ HIV is intended as an aid in the diagnosis of infection with HIV. AIDS and AIDS related conditions are clinical symptoms and their diagnosis can only be established clinically.
  9. Reading test results earlier than 10 minutes or later than 12 minutes may give incorrect results.
  10. A negative result with Uni-Gold™ HIV does not exclude the possibility of infection with HIV. A false negative result can occur in the following circumstances:
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- ◆ Recent infection. Antibody response to a recent exposure may take several months to reach detectable levels. For negative results, repeat testing after 6 months is recommended to confirm negative status.
- ◆ The test procedure has not been correctly followed.
- ◆ Antibodies to a variant strain of HIV in the patient that do not react with specific antigens utilized in the assay configuration.
- ◆ Improper specimen handling.
- ◆ Failure to add sample.
- ◆ Failure to allow kits to come to room temperature prior to use may impact results.

**Safety Precautions** Using universal persecution (gloves, lab coat, washing hands) when handling infectious materials refer to the national health and safety guideline for standard safety procedure

Maintenance	Step	Action

**Quality Control**

Control	Stability	Frequency	Preparation (y/n)
Internal kit control	Room temperature	Each run	N
In house control	-20 °C or colder	At least Weekly, New batch started, new manipulator and result suspicious.	Y

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## Test Procedure for Whole Blood Fingertick

### Procedure

- ◆ Wear gloves and massage the fingertip gently. It will help to obtain a round drop of blood.
- ◆ Wipe the complete fingertip with the alcohol swab provided and wait until the fingertip is dried completely.
- ◆ Do not use the auto safety lancet if the auto safety lancet found uncapped. Detach the protective cap of the auto safety lancet provided. Squeeze the fingertip then push gently at the lateral side (avoid callus) of the fingertip as shown in above figure. Safely dispose of the used auto safety lancet in sharps container immediately after use.
- ◆ Wipe the first drop of the blood using sterile gauze. Without pressing too hard, gently squeeze fingertip once again to obtain second drop of blood (~60 µl).
- ◆ To collect the blood into the fingertick disposable pipette, gently press the pipette bulb, hold the pipette horizontal to the sample (Figure 5). This is important, as the specimen may not be adequate if the pipette is held in a vertical position. Slowly release pressure on the bulb to draw up the sample.
- ◆ Hold the pipette vertically above the sample port, squeeze the bulb and discharge two (2) drops of whole blood onto the sample pad (Figure 6). Allow the sample to fully absorb. Ensure there are no air bubbles in the sample port. Failure to hold the pipette in a vertical position may lead to erroneous test results. Do not touch the sample pad with the disposable pipette. Dispose of the pipette into biohazard waste.
- ◆ Hold the Wash Solution dropper bottle vertically over the sample port; add two (2) drops of Wash Solution to the sample port (Figure 7). Time the assay from this point. Ensure no air bubbles are introduced into the sample port. Failure to hold the bottle in a vertical position may lead to erroneous test results. Do not touch the sample pad with the dropper bottle tip.
- ◆ Read test results after 10 minutes but no later than 12 minutes incubation time.

### Test Procedure for Venipuncture Whole Blood, Serum and Plasma

1. Allow the kit (unopened devices and Wash Solution) to reach room temperature if previously stored in the refrigerator. Once at room temperature remove the required number of Uni-Gold™ HIV devices from their pouches. Devices must be used within 20 minutes of opening the foil pouch.
  1. Perform no more than 10 tests at one time.
  2. Lay the devices on a clean flat surface.



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3. Label each device with the appropriate patient information / ID.
  4. Fill the disposable pipette included in the kit with sample. Ensure there are no air bubbles. Use only the pipette included in the kit and do not reuse.
  5. Hold the pipette vertically over the sample port, squeeze the bulb and discharge two (2) drops of plasma/serum/whole blood onto the sample pad. Allow the sample to fully absorb. Ensure air bubbles are not introduced into the sample port. Do not touch the sample pad with the disposable pipette. Failure to hold the pipette in a vertical position may lead to erroneous test results.
  6. Dispose of the pipette in biohazard waste.
  7. Holding the dropper bottle of Wash Solution in a vertical position and above the sample port, add two (2) drops of Wash Solution to the sample port. Time the assay from this point. Ensure no air bubbles are introduced into the sample port. Failure to hold the bottle in a vertical position may lead to erroneous test results. Do not touch the sample pad with the dropper bottle tip.
  8. Read test results after 10 minutes but no later than 12 minutes incubation time.
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**Caution**

9. Do not use if the kit box safety seal is absent, damaged or broken.
  10. Do not use any device if the pouches have been perforated.
  11. Each device is for single use only.
  12. Do not mix Wash Solution/test devices from different kit lots.
  13. Do not use the kit past the expiration date (this date is printed on the kit box).
  14. Adequate lighting is required to read the test results.
  15. The result should be read immediately after the end of the 10-minute incubation time following the addition of Wash Solution. Do not read results beyond 12 minutes.
  16. Lancets should be placed in a puncture resistant container prior to disposal.
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**Result Interpretation**

**Reactive result**

- Two pink/red lines of any intensity in the device window, the first adjacent to letter "T" (test) and the second adjacent to "C" (control).

**Non-Reactive result**

- A pink/red line of any intensity adjacent to the letter "C" (control), but no pink/red line adjacent to "T" (test).

**Invalid result**

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- No pink/red line appears in the device window adjacent to the letter “C” control) irrespective of whether or not a pink/red line appears in the device window adjacent to “T” (test).

**Note: The Invalid test results should be retested with new test device.**

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## Reference

6. PREMIER MeDICAL CORPORATION Ltd. FIRST RESPONSE® HIV 1 2.0 CARD TEST Rapid Immunochromatographic Card Test for the detection of Antibodies to HIV 1 & 2 in Human Whole Blood/Serum/Plasma. March 2020.
  7. WHO. Consolidated guidelines on HIV testing services. December 2019.
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## Annex J: HIV Rapid Testing Quality Control Log Sheet

**NAME OF FACILITY:** \_\_\_\_\_

**MONTH:** \_\_\_\_\_

WEEK	Operator Name	DATE TESTED	Quality Control	Name of Test 1: _____			Name of Test 2: _____			Name of Test 3: _____					
				Kit information <i>(Provide information for each week)</i>	Result <i>(Circle one)</i>			Kit information <i>(Provide information for each week)</i>	Result <i>(Circle one)</i>			Kit information <i>(Provide information for each week)</i>	Result <i>(Circle one)</i>		
1			Positive	Lot No _____	POS	NEG	INV	Lot No _____	POS	NEG	INV	Lot No _____	POS	NEG	INV
			Negative	Expiry Date _____ <i>(yyyy/mm/dd)</i>	POS	NEG	INV	Expiry Date _____ <i>(yyyy/mm/dd)</i>	POS	NEG	INV	Expiry Date _____ <i>(yyyy/mm/dd)</i>	POS	NEG	INV
2			Positive	Lot No _____	POS	NEG	INV	Lot No _____	POS	NEG	INV	Lot No _____	POS	NEG	INV
			Negative	Expiry Date _____ <i>(yyyy/mm/dd)</i>	POS	NEG	INV	Expiry Date _____ <i>(yyyy/mm/dd)</i>	POS	NEG	INV	Expiry Date _____ <i>(yyyy/mm/dd)</i>	POS	NEG	INV
3			Positive	Lot No _____	POS	NEG	INV	Lot No _____	POS	NEG	INV	Lot No _____	POS	NEG	INV
			Negative	Expiry Date _____ <i>(yyyy/mm/dd)</i>	POS	NEG	INV	Expiry Date _____ <i>(yyyy/mm/dd)</i>	POS	NEG	INV	Expiry Date _____ <i>(yyyy/mm/dd)</i>	POS	NEG	INV
4			Positive	Lot No _____	POS	NEG	INV	Lot No _____	POS	NEG	INV	Lot No _____	POS	NEG	INV
			Negative	Expiry Date _____ <i>(yyyy/mm/dd)</i>	POS	NEG	INV	Expiry Date _____ <i>(yyyy/mm/dd)</i>	POS	NEG	INV	Expiry Date _____ <i>(yyyy/mm/dd)</i>	POS	NEG	INV
5			Positive	Lot No _____	POS	NEG	INV	Lot No _____	POS	NEG	INV	Lot No _____	POS	NEG	INV
			Negative	Expiry Date _____ <i>(yyyy/mm/dd)</i>	POS	NEG	INV	Expiry Date _____ <i>(yyyy/mm/dd)</i>	POS	NEG	INV	Expiry Date _____ <i>(yyyy/mm/dd)</i>	POS	NEG	INV

**KEY: NR-Non Reactive R- Reactive INV- Invalid NEG- Negative POS-Positive**

**Annex K: HIV Rapid Testing Logbook Template**



Federal Ministry of Health

# **HIV Rapid Testing Register**

**Region: \_\_\_\_\_ Zone/Sub City: \_\_\_\_\_ Woreda: \_\_\_\_\_ Start Date: \_\_\_/\_\_\_/\_\_\_**

**End Date: \_\_\_/\_\_\_/\_\_\_**

**Testing Center: \_\_\_\_\_ Testing Point Name: \_\_\_\_\_ Logbook Number: \_\_\_\_\_**

## Instructions for Using Standardized HIV Rapid Tests Register.

### Introduction and Background

This Register is being tested as a tool to streamline the work process. Appropriate and consistent use of this logbook make testers' workload lighter and more efficient. Additionally, this log book is critical to improve the quality of data recorded during HIV testing.

For example, never use "white-out" if a mistake is made. Instead, put a single line through the mistake and initialize and date for Quality Assurance purposes. For example, ~~this is a mistake and should be crossed out~~. Everyone makes mistakes. Knowing where mistakes occur most often will help improve systems. **Count** at the bottom of each page will be used to evaluate the performance of individual Test kits. When the test kit is changed (either of Test kit -1, Test kit-2, and Test kit-3), please start a new page so that Count of the PAGE are restricted to one test kit. Please use black or blue ink. Please do not record data with a pencil. Guidelines/instruction are provided below for each of the data fields (columns) in the logbook. The guidelines for interpretation of results are representative of most kits, but please be aware of differences in kits and follow manufacturer guidelines completely. Close the remaining row and Start a new page at the beginning of each month.

### Columns in the Logbook

Column no	Data Element	Description
1	Serial Number	Write sequential serial number for each row. Each row is used for one patient/client. Some patients/clients might have data recorded in more than one row. For example, if one of the tests is invalid (INV) and repeat testing needs to be performed. In this case, a note is made in the Remark Column and results of the repeat test are recorded on a subsequent row – ideally the very next row.
2	MRN (Medical Record Number) or Client/Patient Code	Write Unique individual identifier / Medical Record Number used on medical information folder, for HC and Hospital. Transfer medical record number or client code in case of VCT. Most sites have intake registration forms with specific medical record number that contain patient information. If possible, please avoid writing patient names on this Rapid Test logbook for confidentiality reasons.
3	Couple code	Write unique couple code for those clients who came as couple
4	Counselor Code	<b>Write unique code for counselor</b>



13	<b>HIV Test-3* (NR/R/INV)</b>	<p>Write the <b>kit name</b>, lot <b>number</b>, and <b>Expiry date</b> in the space provided at top of the Page. When the same kit cannot be used, please start a new page so that PAGE TOTALS are restricted to one test kit. Keeping track of this information is critical for Quality Assurance.</p> <p><b>Test-3 Results</b> Record results of the THIRD test performed according to the test-3 kit instructions.</p> <ul style="list-style-type: none"> <li>• For <b>NON-REACTIVE</b> result, Write NR.</li> <li>• For <b>REACTIVE</b> result, Write <b>R</b>.</li> <li>• For <b>INVALID</b> result, Write <b>INV</b>.</li> </ul>																																				
14	<b>Final Results** (NEG/POS/IND)</b>	<p><b>Final Results.</b> If the first and second tests are the same as the previous result (i.e., the FIRST is <b>REACTIVE</b> and the SECOND is <b>NON-REACTIVE</b>) not need to perform third test and proceed to section on <b>Final Results</b> and circle <b>NEG</b>. If results of the FIRST and SECOND test are equal (i.e., both are <b>NON-REACTIVE</b>), no need to perform THIRD test and proceed to section on <b>Final Results</b> and circle <b>NEG</b>. If results of the FIRST and SECOND test are <b>REACTIVE</b>, a <i>different</i> THIRD test must be done immediately (those results are recorded in the Test-3)</p> <p><b>1. Final Results</b> Use the following table as a guide for interpreting Final Results:</p> <table border="1" data-bbox="531 719 1948 982"> <thead> <tr> <th>SERIAL Scenario</th> <th>Test-1</th> <th>Test-2</th> <th>Repeat Test-1</th> <th>Test-3</th> <th>Final Results</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>NR</td> <td>Not Needed</td> <td>Not Needed</td> <td>Not Needed</td> <td><b>NEG</b></td> </tr> <tr> <td>2</td> <td>R</td> <td>NR</td> <td>R</td> <td>Not Needed</td> <td><b>IND</b></td> </tr> <tr> <td>3</td> <td>R</td> <td>NR</td> <td>NR</td> <td>Not Needed</td> <td><b>NEG</b></td> </tr> <tr> <td>4</td> <td>R</td> <td>R</td> <td>Not Needed</td> <td>R</td> <td><b>POS</b></td> </tr> <tr> <td>5</td> <td>R</td> <td>R</td> <td>Not Needed</td> <td>NR</td> <td><b>IND</b></td> </tr> </tbody> </table> <p><b>Note: Always follow the national HIV rapid testing algorithm.</b></p>	SERIAL Scenario	Test-1	Test-2	Repeat Test-1	Test-3	Final Results	1	NR	Not Needed	Not Needed	Not Needed	<b>NEG</b>	2	R	NR	R	Not Needed	<b>IND</b>	3	R	NR	NR	Not Needed	<b>NEG</b>	4	R	R	Not Needed	R	<b>POS</b>	5	R	R	Not Needed	NR	<b>IND</b>
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3	R	NR	NR	Not Needed	<b>NEG</b>																																	
4	R	R	Not Needed	R	<b>POS</b>																																	
5	R	R	Not Needed	NR	<b>IND</b>																																	
15	<b>Referred to:</b>	<p>Write the code where the client is referred to <b>from the list at the bottom of the page</b> e.g. if the client/patient is referred to ART unit, write "A" in the column, write "B" if referred to laboratory if initial and retest is discordant</p> <p><b>Referred to:</b>  <b>A – ART</b> <span style="margin-left: 200px;"><b>C - Nearby facility/lab</b></span>  <b>B – Laboratory (initial and retest is discordant)</b> <span style="margin-left: 100px;"><b>D - Others (Specify)</b></span></p>																																				
16	<b>Target population Category*:</b>	<p><b>Target population Category*:</b> col 17  <b>A= FSW</b>    <b>C=Prisoner</b>    <b>E= OVC/Children of PLHIV</b>    <b>G= General population</b>  <b>B=Long distance truck drivers</b>    <b>D=Mobile Worker/Daily laborer</b>    <b>F=Other MARPS</b></p>																																				
17	<b>Tester Initials</b>	<b>Write Tester Initial name performing this test. (Abebe Kebede as AK)</b>																																				
18	<b>Remark</b>	<b>Use this section for recording additional information. Examples of frequent Remark: kit expired and opened</b>																																				





## TESTING INSTRUCTIONS

1. Controls should be performed by each individual who are performing are client testing
2. The positive control and Negative control are run at the same time.
3. Test both positive and negative controls on HIV rapid tests 1, 2 and 3 (if applicable).
4. When the controls give unexpected results (Positive control being negative/invalid or negative control being positive/invalid) the necessary investigations should be carried out before commencement of client testing.
5. Record the quality control results in the table above (circle the correct results).
6. The facility shall order Quality Control supplies as need arises from their supervisor.

**Supervisor Signature:** \_\_\_\_\_

# **Module 7**

## **Monitoring and Evaluation of HTS**

## Chapter 1: Monitoring and Evaluation of HTS.

**Learning objectives:** By the end of this session the participants will be able to:

- ◆ Discuss record keeping and reporting needs of HTS.
- ◆ Practice recording and reporting on HTS data and reports.
- ◆ Describe the quality assurance in counselling.
- ◆ Describe HTS programs monitoring and evaluation.

### CONTENTS

- ◆ Introduction
- ◆ Basics of M&E
- ◆ Challenges in HTS M&E
- ◆ Records and practice of recording
- ◆ HTS recording & reporting.
- ◆ HTS routine program monitoring
  - Quality assurance for counseling
- ◆ Indicators for HTS
- ◆ Monitoring and evaluation of the HTC service at each level of the health care system
- ◆ Data quality assurance procedures & Data use at different levels
- ◆ Evaluation of the HTC program

### **Introduction**

Expanding HIV testing and counselling (HTC) services has been a key step taken by our national program towards achieving universal access to prevention, treatment and care. As services are scaled up and more resources are invested in HTC, programs must be able to establish standards, and ensure the quality of and coverage with HTC services among populations with the greatest need. An effective HTC program will result in a larger number of people with HIV receiving an early diagnosis of, and care and treatment for, HIV .

Focusing HTC services on those who are most vulnerable to acquiring HIV also presents an important opportunity for prevention counselling and referral to prevention services. As in any program, achieving these objectives requires a minimum, reliable set of data to guide the efficiency and effectiveness of service implementation.

### **Basics of Monitoring and evaluation.**

Monitoring and evaluation (M&E) are the techniques we use to find out how well our health program is achieving what it set out to do. M&E can highlight whether the program is still on

the right road, how far it has travelled, and it still will go. Generally, it plays an important role in the management of health programs to ensure resources are appropriately utilized, services are accessed, activities occur in a timely manner, and expected results are achieved. This management function facilitates the most effective and efficient use of human and financial resources for the achievement of 1<sup>st</sup> 95 targets which is especially relevant in areas where resources are limited.

Monitoring is the use of assessment techniques to measure the performance of an organization, person or specific intervention (e.g., HTS intervention) in order to:

- ◆ Make improvements or changes by identifying those aspects that are working according to plan and those that are in need of mid-course corrections.
- ◆ Track progress toward the performance standards that were set.
- ◆ Monitoring of program activities is a critical function. Data from monitoring activities can be used for a variety of purposes.
- ◆ Data from monitoring help clinics know and document what they have done. For example, how many clients did the clinic test for HIV this month?
- ◆ Data from monitoring help clinics know how well they are achieving program objectives. For example, did a lot of clients decline?
- ◆ Data from monitoring help with program management. For example, by monitoring the number of clients tested, clinics will know how many HIV test kits need to be ordered each month.
- ◆ Data from monitoring help determine the impact of programs on the health of clients. For example, by monitoring the number of people tested at the clinic, they can measure the success of HIV testing programs.

Evaluation will help:

- ◆ What works well and what could be improved in a program or initiative.
- ◆ Enhancing the chance that the initiative's goals and objectives are being achieved.
- ◆ Determining value for money (i.e., allocated resources are yielding the greatest benefit for clients and stakeholders)
- ◆ Identifying what components of an initiative work/do not work and why.

Challenges to HTS M&E

- ◆ Slow, manual M&E systems
- ◆ Relatively weak health systems
- ◆ Competing priorities
- ◆ Weak (information) infrastructure
- ◆ Gaps in information use
- ◆ Limited capacity for analysis and use of data (esp. at facility level where it is most

important)

### Strategies to address challenges in HTS M&E

- ◆ One agreed monitoring and evaluation system
- ◆ Standardized data collection and reporting tools with instructions
- ◆ Implementing data quality assurance systems
- ◆ Dedicating M&E personnel & resources for the program
- ◆ Proper training of service providers and data clerks

### Definition of Records

Records are generated when written instructions are followed. In other words, after data, information or results are recorded onto a form, label, etc., and then it becomes a record. Documents and records may be found as paper or electronic.

Examples of documents include: country testing algorithm, IPC manual, SOPs for an approved HIV rapid test, manufacturer test kit inserts, temperature log (blank form) and quality control record (blank form).

Examples of records that needs to be completed include: client test results, daily maintenance log book, stock cards and stock book, EQA specimen transfer log book, quality control record format, summary of findings from onsite evaluation visit and report of recommended corrective actions.

### Practice of Recording

Keeping accurate records of critical medical information is an important function of the clinic staff. The records are used for tracking clients' clinical care, public health surveillance purposes and evaluating program performance.

Currently, most clinics record data about each client visit using client record card. Some clinics use logbooks or registers to record client information and others use both. Information about HTC and other HIV activities needs to be added to client record cards as well as logbooks/registers.

The best method for assuring accurate information at woreda, zonal, regional or national level is to supply preprinted logbooks with labeled columns for each required data item and also periodic monthly or quarterly report forms.

In the absence of these preprinted logbooks, clinics will need to determine how they will record the additional information. As with all client information, clinic staff must do their best to ensure complete confidentiality of client cards and logbooks—particularly with the inclusion of HIV-related information that could prove harmful to clients if improperly released.

## HIV Testing Services Recording & Reporting

Documents are written policies, process descriptions and procedures used to communicate information. They provide written instructions for HOW to do a specific task.

Records are generated when written instructions are followed. In other words, after data, information or results are recorded onto a form, label, etc., and then it becomes a record. Documents and records may be paper or electronic.

Verbal instructions often are not heard, misunderstood, quickly forgotten and ignored. Policies, standards, processes and procedures must be written down, approved and communicated to all concerned.

Types of information captured on test records when testing is requested by different units include Client/Client MR number, Date of test, Results from Test 1, Test 2 and Test 3, Repeat results, HIV status, Kit name and lot number, Person performing test.

Storage of logbooks and records should be kept in a manner that will minimize deterioration. Although many sites use paper-based logbooks and records, they should be indexed so that they will be accessible while they are needed.

There are a number of items that need to be recorded and reported on a regular basis, daily or monthly. Here are some tips for good record-keeping:

- ◆ Understand the information to be collected. Before you record any information, make sure that you understand what is to be collected.
- ◆ Record the information every time. Record on the appropriate form each time you perform a procedure.
- ◆ Record all the information. Make sure you have provided all the information requested on a form.
- ◆ Record the information the same way every time. Be consistent.

The health facility providing HTS need to assign responsible persons at different service points for the following:

- ◆ Making sure logbooks are being filled out correctly.
- ◆ Making sure all posters are in place and not worn out.
- ◆ Checking supply of brochures.
- ◆ Checking the supply of condoms.
- ◆ Making sure that all providers are using a private space for discussion with clients.
- ◆ Checking with providers to see how things are going. (Discuss any problems.).

Table: Recording tools for HTS			
HTS Modality	Registers	Tally sheets	Remark
VCT	HTS logbook	HTS tally	
PITC	HTS logbook, OPD abstract register	HTS tally	
ICT	ICT register	ICT tally	
HIVST	HIVST register		

### HTS routine program monitoring

The HCT activities will be monitored through the national Health Management Information System (HMIS) using various facility-based patient records, registers, and reporting formats. Other key program information can be monitored using administrative records at different level. Routine HTS monitoring includes tracking of all HIV testing modalities such as: VCT, PITC, ICT, HIVST & SNS.

The national HTC routine monitoring system includes:

- ◆ Clearly defined indicators (as per HMIS) data collection and reporting procedure
- ◆ Standard data capturing tools.
- ◆ Descriptions of data flow and responsibilities at each level of the health-care system
- ◆ Data use at different levels (unit/department, facility, woreda, regional and national)
- ◆ Data quality assurance procedures

### Quality assurance on counseling

Quality assurance (QA) is the activities that ensure processes are adequate for a system to achieve its objectives.

Sample monthly quality assurance checklist

Name of person completing this form: _____	Date: _____
Are all registers and logbooks being filled out correctly?	
Are all posters, HTC protocols in place and not worn out?	
Is there a sufficient supply of brochures?	
Is there a sufficient supply of condoms?	
Are all providers using a private space for discussion with clients and use cue cards?	
Are providers comfortable with the way things are going?	

### Purposes of HTS Quality Assurance

- ◆ Ensure consistent and disciplined delivery of the intervention components.
- ◆ Enhance HTS providers skills in delivering the intervention.
- ◆ Provide feedback and support to HTS counselors.
- ◆ Create a collaborative and competent counseling team.
- ◆ Recommended HTS quality assurance measures.

The following are essential HTS Quality Assurance Activities:

- ◆ Use HTC Session Guide Cue Cards
- ◆ Observe HTC Session and Provide Feedback
- ◆ The counselor obtains permission from the client. The counselor explains to the client that the supervisor is assisting the counselor in enhancing the quality of services he or she provides.
- ◆ The supervisor sits where he or she can observe the counselor but can avoid obstructing the client-counselor interaction.
- ◆ Counselor/providers should be supervised at least every month, and the supervisor does not participate in the session. He or she quietly observes the session and takes brief notes on the “VCT Session Quality Assurance Guide.”

### **Indicators**

To assess different types of achievements of a program, we define a set of standard indicators. An indicator is a quantitative or qualitative measure that helps to determine how well a system or program performs and progresses towards meeting its objectives. Useful indicators are those which are: SMART, i.e., Specific, Measurable, Achievable, Realistic and Time bound.

### **Indicators for HTS in the HMIS**

Indicators: are data items that are being monitored. In many cases, the woreda, zonal health office or the regional health bureau request the clinic to report indicators on a regular basis (monthly or quarterly). Below is a list of HTS related indicators included in the national HMIS.

- ◆ Percentage of people living with HIV who know their status.
- ◆ Number of individuals HIV self-test kits distributed.
- ◆ Number of newly identified HIV positive adults and children clients linked to treatment and care

HTS _ List of Data elements (DHIS2)	
HTC_ Modalities	DHIS2 Indicators
VCT	Clients receiving HIV test results (at VCT)
	Clients testing positive for HIV (at VCT)
PITC	Clients receiving HIV test results (at PITC)
	Clients testing positive for HIV (at PITC)
ICT	Number of index cases offered
	Number of contacts elicited
	Number of contacts tested
	Number of contacts by test result
	New positive (contacts)
	Known positive (contacts)
HIVST	Number of Individual HIV self-test KIT distributed
	Directly assisted



	Unassisted
HTS Modalities -	Additional Recommended data elements
ICT_IPV / Adverse event monitoring	# Adult and adolescent Index cases who have elicited Partner/s
	# of adult& adolescent index case screened for IPV
	# of adult& adolescent index cases found high risk for IPV
	# index cases screened for the occurrence of adverse events after enrollment into ICT.
	# of index cases & their contacts who experienced Adverse Events as a result of their enrollment into ICT
	# index cases linked to IPV/GBV care services
HIVST	Number of test kits distributed
	# reported HIVST test result
	# reported reactive HIVST result
	# reported reactive HIVST result and Linked for confirmatory testing
	# reported reactive HIVST result and confirmed with conventional algorithm
	# ART Initiated
SNS	# Network members tested for HIV
	# Network members tested HIV positive
	# Network members tested HIV positive and initiated on ART

### **Monitoring & Evaluation of the HTS services at each level of the health care system**

Different responsibilities are given at each level of program management to ensure the proper flow of HTC monitoring and evaluation information (data) from the health facility to the National level and feedback from respective levels.

#### At health facility level

Trained health workers at health facilities will be responsible for recording HTS activities. Health facility management/MDT is responsible to conduct data quality assurance before reporting to the next level.

#### At the woreda level

The woreda HMIS coordinator/Performance monitoring Team (PMT) must work in collaboration with providers / data clerks to ensure that HTC information collected monthly from all health facilities on timely manner. The coordinators/PMT should check the report for completeness, accuracy, and its timely submission to the zonal /regional HIMS

coordinators. The Woreda is also expected to organize quarterly woreda level review meeting to assess the performances.

On a quarterly basis, the woreda focal person compile service utilization and coverage by comparing selected HTS indicators from different facilities to identify facilities with performance gaps, challenges, and barriers. Performance monitoring mechanisms like dashboard shall be used at woreda and at different levels of the health structure to ensure transparency and accountability for actions.

#### At the zonal level

Regional states that have zonal departments, intermediary between woreda and the respective regional office, ensure direct and smooth flow of HTC information collected monthly from the woredas. HMIS coordinators must work in collaboration with woreda HTS focal person and HMIS coordinator to ensure that HMIS reports are accurately compiled and submitted to regional health bureau's HMIS coordinator. On a quarterly basis, the Zonal HTS focal person compiles service utilization and coverage by comparing select HTS indicators from different woredas and/or facilities to identify facilities with performance gaps, challenges, and barriers. The Zone is also expected to organize quarterly Zonal level review meeting to assess the performances.

#### At Regional level

The regional health bureau is responsible for compiling, analyzing, aggregating, and sending all HCT reports to the MOH Policy and Planning Directorate. On a quarterly basis, the regional HCT focal person compiles service utilization and coverage by comparing selected HCT indicators from different zones/woredas/ facilities to identify performance gaps, challenges and barriers and take correction action. The region is also expected to organize quarterly regional level review meeting to assess the performances.

#### At National level

The national level has the overall responsibility for monitoring and evaluating the nation-wide HCT program. The FMOH/HTS case team conduct review meeting at the end of each quarter to share reports, analyze data and provide feedback to regions on the national program, regional achievements, and gaps of implementation. The analysis and coordination inform policy development, planning, and decision-making.

#### Data quality assurance procedures

Data quality assurance is one of the components of the M&E system. Once data are collected, the data are checked for any inaccuracies and obvious errors at every level. The data quality assurance (DQA) is done at two levels: facility level and administrative level (district health offices). At facility level, such a mechanism is the Lot Quality Assurance Sampling (LQAS) methodology which is done on monthly basis. In this procedure randomly selected data elements from the monthly reports are checked against the register or source of the report.

The findings are then compared to a standard Data Accuracy Table. The same procedure is done at district health offices on quarterly basis before the data are sent to the next higher reporting unit. Hence, in HMIS all reports are quality checked at every level, from the healthcare institution to the federal level. In addition, data quality assurance can be assessed using site supervision for verification and supportive supervisions. Findings from supportive supervision should be compiled and analyzed and feedback provided.

#### Data use at different levels

The effective use of data at different reporting levels ensures smooth running of the program. Data is used at different levels of program management to inform planning, decision making, advocacy, resource allocation, and accountability.

##### At the national level

The national office uses data to:

- ◆ Develop program plans and budgets.
- ◆ Provide feedback to regions to help identify and address problems to improve HCT services
- ◆ Ensure adequate coverage of HCT services and assure quality of services.
- ◆ Disseminate national program data with relevant stakeholders.

##### At Regional Health Bureau/Zone/Woreda level

Regional, zonal and woreda offices use data for a number of purposes:

- ◆ Inform program planning and budgeting.
- ◆ Ensure adequate coverage of HCT services within the area
- ◆ Report and exchange information with the national office

##### At Health facility level

Health care workers at HCT sites review the monthly reports to track program progress and gaps and improve implementation of HCT services. HMIS technicians conduct regular meetings with staff members to disseminate findings and review progress, problems, and challenges at health facility level. Data/information will be reviewed at performance monitoring team (PMT) Multi-disciplinary team (MDT) meetings if these are available and whenever possible.

##### Record keeping procedures.

All patient records, registers and necessary reporting formats and documents should be maintained to ensure they are accurately completed, stored securely to prevent damage, remain confidential and easily retrievable.

**HTS logbook:**

This Register is being tested as a tool to streamline the work process. Appropriate and consistent use of this logbook make testers' workload lighter and more efficient. Additionally, this logbook is critical to improve the quality of data recorded during HIV testing. This register is expected to be available and utilized at all service delivery points where PITC service provided including OPD, VCT, TB, ANC, L&D, and In-patient.

Count at the bottom of each page will be used to evaluate the performance of individual Test kits. When the test kit is changed (either of Test kit -1, Test kit-2, and Test kit-3), please start a new page so that Count of the PAGE are restricted to one test kit. The guidelines for interpretation of results are representative of most kits, but please be aware of differences in kits and follow manufacturer guidelines completely.

**HIV Rapid Testing Register**

HIV Test-1<sup>st</sup> Kit Name: \_\_\_\_\_ Lot No.: \_\_\_\_\_ Expiry Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 HIV Test-2<sup>nd</sup> Kit Name: \_\_\_\_\_ Lot No.: \_\_\_\_\_ Expiry Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 HIV Test-3<sup>rd</sup> Kit Name: \_\_\_\_\_ Lot No.: \_\_\_\_\_ Expiry Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

S.No	MFN	Client Code	Consent Code	Age	Sex(M/F)	Requesting Unit (see code)	Reason for Testing (see code)	Date Tested (dd/mm/yy)	HIV Test 1 <sup>st</sup> (R/R/INV)	HIV Test 2 <sup>nd</sup> (R/R/INV)	Repeat Test 3 <sup>rd</sup> (R/R/INV)	HIV Test 3 <sup>rd</sup> (Consistency)	Total Results** (NEG/POS/IND)	Referred to (see code)	Target population Category* (see code)	Tester Initials	Remarks
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
	004							/ /	NR R INV	NR R INV	NR R INV	NR R INV	NEG POS IND				
	004							/ /	NR R INV	NR R INV	NR R INV	NR R INV	NEG POS IND				

**Requesting Unit: Col 7**

A=VCT      G=Emergency  
 B=TB      H=ART  
 C=STI      I=L&D  
 D=ITD      J=ANC  
 E=OPD      K=ANC  
 F=PHUCT      L=KP  
 M=Others      E=elderly clinic

**Reason for Testing: Col 8**

1- Initial Testing  
 R- Reasoning for ongoing risk  
 C- Confirmation before ART initiation  
 V- Verification when divorce/happens  
 S- for confirmation following reactive HIV test  
 P- Follow up test for clients on PEP

**Total non-reactive/negative**

<b>Total Reactive/positive</b>					
<b>Total Invalid*</b>					
<b>Total Indeterminate**</b>					
<b>Total Tests</b>					

**Referred to: Col 15**

A- ART  
 B- Laboratory  
 C- Nearby Facility/Ref  
 D- Culture (Specify)

**Target population Category\*: col 16**

A- FSW  
 B- Long distance truck drivers  
 C- Prisoners  
 D- Mobile Workers/Day laborers  
 E- OVC  
 F- Other MAFHS  
 G- General population with risk  
 H- Sexual partner of index PLHIV  
 I- Biological parent of index children  
 J- Biological sibling of index children  
 K- 10 million of PLHIV  
 L- PWID  
 M- Sexual partner of PLHIV/PEW

**ICT register**

This register is exhaustive and contains information beginning with information on a confirmed HIV positive result. In addition, case-based surveillance, pre-exposure

prophylaxis, HIV self-testing, and services for IPV/GBV delivered to the index or its contacts  
are included.



# INDEX CASE TESTING REGISTER

Month \_\_\_\_\_ Year \_\_\_\_\_

Index Case Information & Service Provided									Elicited Contacts Information & Services Provided									
S.N	Name of the index case	Age	Prioritizing Criteria [1-7]	Date Tested HIV+	If newly diagnosed (1):			ICT service Offered (Y, N)	Name of Index Contacts Elicited	Age	Sex (M/F)	Contact category (code 1-4)	IPV Risk Assessment Conducted (Y, N)	IPV Risk Assessment Outcome (1-5)	If there is high risk of IPV, is s/he linked to PGBV care? (Y, N)	Has the index client already disclosed his/ her HIV status? (Y, N,)	Notification Plan/Method (Code 1-4)	Phone no. & Physical address
	Index MRN/UAN			Linked to care (Y/N)	is CRF completed (Y/N)	Tested for recency (Y/N)	Case Classification Status											
	Region /Zona	ART started (Y/N)	Date	Date	Write the Case Classification Result (C-1, C-2, C3)	Date accepted												
	Woreda/Town	CB5 ID	Recency testing result: Probable Recent (R), Long-term (LT), Inconclusive (IR)	if No, Indicate Why? (1-6)														
Kebela & House Number	Sex (M/F)	Target population group (1-7)	Date ART Started	Initial CBS ID	Eligible for Recency testing (E, NE)													
Phone No.			Linked to CBS (Y/N)															
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
				/ /				/ /										
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**4: Prioritizing Criteria for ICT services (write code) (Col. 4)**

- 1. Newly Diagnosed
- 2. PLHIV with HVL & Adult ART & Adult
- 3. PLHIV restart
- 4. PLHIV in Care with STI
- 5. Enrolled @ PMTCT
- 6. Key population (Female sex workers)
- 7. Other (Specify)

**Target population group (A-I): (Col. 4)**

- A-FSW
- B-Long distance truck drivers
- C-Prisoners
- D-Mobile Worker/Daily laborer
- E-CVC
- F-Partner of PLHIV
- G-Children of PLHIV
- H-Other MARPS (Widowed, Divorced, Separated, Re-Married)
- I-General Population

**If the client don't accept ICT services, write the reason: (Col. 9)**

- 1. No reason
- 2. No time for distation interview services are confidential (Fear of disclosure)
- 3. Do not believe
- 4. Afraid of intimate partner violence
- 5. Prefer to go to Other HP for this service
- 6. Other (Specify)

**Contact category (Col. 13)**

- 1. Sexual Partner
- 2. Child < 15 years
- 3. Parent of an index child
- 4. Siblings (If index is a child)

**Intimate Partner Violence (IPV) risk assessment Outcomes (Col. 14)**

- 1. Physical
- 2. Emotional
- 3. Sexual
- 4. No IPV
- 5. NA Child







### Evaluation of the HCT service at the facility and national level

Evaluation is the episodic assessment of results that can be attributed to program activities; it uses monitoring data and often indicators that are not collected through routine information systems. Evaluation allows exploration of the causes of failure to achieve expected results on schedule and the mid-course corrections that might be necessary. It assesses progress in program implementation and coverage and measure the effect of program activities on the target population.

The evaluation will therefore be used to understand if the interventions are working/ making a difference by measuring the degree to which the desired/ planned change has occurred. Evaluation of the HCT service can be done using different mechanisms. Facilities can conduct self-assessments for selected indicators and analyze the findings/ performance for planned intervention. The FMOH at national level can perform an assessment or study (evaluation) of the service performance through surveys and operational research.

The evaluation of the HCT shall be done periodically at all levels:

- ◆ At community level on awareness and service utilization,
- ◆ At health care delivery level on service quality, and performance,
- ◆ At Regional and national level on outcome and impact of the HCT service.

### **Case Scenarios for HTS Record / Report and (Monitoring and Evaluation)**

1. A 26 year old man, who worked as a long-distance driver, interested to check the HIV status of himself and his families. He has 4 children and visited the VCT clinic during the working hour. The care providers at clinic collected blood samples from six family members and performed the test following the manufacturer instruction. Finally, the care provider observed the following test results. What are the missing parts in each ID and interpretation of the final status of the clients?

Patient ID	One Step	First response	Repeat test	Uni Gold	Final status
ADDA1	Reactive	Non-Reactive			
ADDA2	Reactive	Reactive		Non-Reactive	
ADDA3	Non-reactive		NA		
ADDA4	Reactive	Reactive	NA	Reactive	
ADDA5	Reactive	Invalid			
ADDA6	Reactive	Non-reactive	Reactive		
ADDA7	Reactive	Non-reactive	Non-reactive		

2. Abebe, an AA resident, is 25 years old. His children from Hiwot, with whom he spent five years before divorcing last year, are three and five years old. He now resides with his new wife, Meselu. On March 19, 2022, he tested positive for HIV at the VCT clinic. The providers also completed a case-based surveillance form (CRF) for him and conducted a recency test on him the same day, with the results indicating a long-term infection. He was linked to an ART clinic, started ART and offered ICT service the same day. He accepted the ICT service and elicited his recent wife (meselu) and his two biological children. With his wife, he preferred the client referral method, and for his two biological children, he preferred to use the HIVST kit. He brought his wife on 25Mar2022 and tested negative. The provider counseled his wife and started providing PrEP services the same day. He also informed the provider on the same day that the HIVST results of his two children were non-reactive.
  
3. Selamawit, a 28-year-old financial officer from AA, visited your health center's OPD on January 19 with a health concern. She agreed to an HIV test from the provider, who was later diagnosed as HIV positive. She was linked to care, her CRF was completed, she underwent a recency test with the finding of a recent infection, and the same day she began ART. She accepted the provider's offer of ICT services that day and elicited three partners. She gave the provider their names—Abebe, age 29, Kebede, age 35, and Demeke, age 40—as well as their addresses and phone numbers. Kebede could be at high risk for IPV, according to the IPV screening, but not the other two. For all three of the partners, she also selected the provider referral notification method.. Abebe and Demeke visited the facility, was tested for HIV, and were informed by the provider that they were HIV negative on February 20th, 2018. Kebede arrived at the facility as well and underwent testing for HIV. He was found to be HIV positive and began ART on February 25th, 2018.
  
4. Daniel, a 27-year-old man, visited your facility's VCT clinic on December 17, 2020, to get his HIV status checked. When the counselor learned that he worked as a daily laborer, he offered to get HIVST kits for his coworkers because he knew they were at a high risk of contracting the virus. To his two friends, Daniel proposed giving them the HIVST kit. Daniel mentioned that his friends had both utilized the test kit and had reported non-reactive results after two weeks.

## Chapter 2: Overview of Client Referral and Linkage system

**Learning objectives:** By the end of this session the participants will be able to:

- ◆ Discuss what it means by referral.
- ◆ Explain the system of linkage in HIV testing service.
- ◆ Discuss the benefits of rapid linkage, referral, and ART initiation.
- ◆ Describe the good practices of linkage to care at site level.

### CONTENTS

- ◆ Definition of client referral and linkage
- ◆ Systems of linkage in HIV testing service
- ◆ Benefits of rapid linkage, referral and ART initiation.
- ◆ Good practices of linkage to care at site level.

#### Definition of Client referral

Client Referral: It is a process by which client's immediate need for care and support services are assessed and get helped to access services, such as setting up appointments or giving directions to facilities. Referral should include reasonable follow-up efforts to facilitate contact between service providers and solicit feedback to clients and service providers. Referral is also a process of sending HIV positive clients from the point of testing to care and treatment with referral form.

#### Linking People Diagnosed with HIV Infection

Linkage is defined as a process of actions and activities that support people testing for HIV and people diagnosed with HIV to engage with prevention, treatment, and care services as appropriate for their HIV status. For people with HIV, it refers to the period beginning with HIV diagnosis and ending with enrolment in care or treatment. It is critical for people living with HIV to enroll in care as early as possible. This enables timely initiation of ART as well as access to interventions to prevent the further transmission of HIV, prevent other infections and co-morbidities and thereby to minimize loss to follow-up.

Linkage to HIV treatment, prevention, care, support, and other relevant services is the primary responsibility of HIV testing services and the testers and providers delivering HIV testing services. Multiple factors may hinder successful linkage to care, including distance from services, transport costs, long waiting times and, for those testing positive, stigma and disclosure-related concerns at the facility.

Linkage to HIV care should be improved through interventions that support people in the initial steps in the continuum of care. Such interventions may vary based on the local

context, including: the health-care delivery systems, geography, and target population. A combination of interventions is needed to improve linkage to prevention, care, and treatment for specific groups at risk.

Post-test counselling messages remain key. They should be concise, addressing the needs of the client and focusing on supporting linkage to care. Post-test counselling messages need to be tailored to specific populations and their situations and whether their test results are HIV-positive, negative, inconclusive or they already know their status and need to engage, re-engage in care. Messages need to provide clients with the latest information, including:

The personal health benefits of early ART initiation: People living with HIV receiving ART who achieve and maintain Undetectable Viral Load result has minimum risk of transmission to their partners.

The benefits of voluntary provider-assisted referral for people living with HIV.

All people with HIV-positive diagnoses should be offered a package of support interventions that ensure timely linkage to care including ART initiation with in/outside the health facility, friendly and flexible services designed to suit specific population groups and digital platform. Providers should note that people who are HIV- negative but at ongoing risk also need to be linked to effective prevention services.

The following interventions have demonstrated benefit in improving timely linkage of PLHIV after an HIV diagnosis:

- ◆ Efficient interventions to reduce time between diagnosis and engagement in care, including support for HIV disclosure, tracing and training staff.
- ◆ Peer support and navigation approaches for linkage
- ◆ Quality improvement approaches using data to improve linkage.

Good practices of linkage to care at site level.

The recommended good practices to improve linkage of HIV positive person to care and treatment services after the person is found positive should be implemented at all sites.

Implement standardized service delivery system that will improve referral and linkage between HIV chronic care through:

- ◆ Prepare standard operating procedure (SOP) for inter- and intra- facility service outlets referral linkage system.
- ◆ Strengthen referral system between health facility and community by using SOP.
- ◆ Establish site level support groups to improve escorting/accompanied referral and feedback practices for intra-facility referral.
- ◆ Establish facility and catchments area level regular referral linkage auditing system to ensure that all new HIV infected clients are linked to ART.
- ◆ Map and establish network between available, chronic care, and other support services in the area (linkage service directory).

- ◆ Preparing, avail and utilize service directory which can be availed in soft copy or other forms.
- ◆ Ensure that a referring and accepting health care facilities or sites are accountable for assurance of the client's referral is successful.
- ◆ Strengthen Post-test counseling in such a way that the client understands the benefits of ART;
- ◆ Develop trust and confidence on the provider and reaches to informed decision on linkage.
- ◆ Promote health seeking behavior for service utilization.
- ◆ Educate clients on benefits of early ART initiation and related care.
- ◆ Call or text to the client and remind him/her for linkage service.

Standardized documentation, reporting system and feedback practice through:

- ◆ Ensure the availability and sustainability of recording and reporting formats.
- ◆ Ensure a referral and linkage feedback mechanism in health facility.
- ◆ Ensure standardization of guidelines and training materials on referral and linkages issues.
- ◆ Improve the engagement of Health Extension Workers (HEW), PLHIV in awareness creation activities:
- ◆ Support HEWs in their day-to-da information education and communication (IEC)/behavioral change communication (BCC) activities in relation to HIV.
- ◆ Establish and strengthen PLHIV associations and support groups to be involved in the facilitation of referral and linkage through escorting and other mechanisms.

Reduce stigma and discrimination through:

- ◆ Community involvement
- ◆ Identification and analysis of the root cause of stigma and discrimination.
- ◆ Development of IEC/BCC material and utilize media focusing on stigma and discrimination.
- ◆ Advocacy of gender inequality that predisposes to stigma and discrimination.
- ◆ Leadership role in community activities to address stigma and discrimination through contextual available values and norms of the community.
- ◆ Involvement of PLHIV to reduce stigma and discrimination and to be part of prevention and care services.

DISCUSSION POINTS

- ◆ Determine the process for contacting the ART clinic and who is responsible for contacting the ART clinic and setting up a meeting?

- ◆ Review the list of issues to be discussed at the meeting with the HIV care clinic and make any additions. (Prepare a sample list.)
- ◆ Where and how to get medications, the client is taking for other conditions
- ◆ Discuss the use of a referral note that the client will give to the HIV care provider. (See sample provided.)
- ◆ Review the sample referral note and make any necessary changes.
- ◆ Discuss possible list of support services that the client needs to get both in the facility and outside.
- ◆ Discuss possible list of support organizations and associations in the community that the client may be referred other than the HIV care clinic.

## **Module 7: Summary**

- ◆ Linkage to HIV treatment, prevention, care, support, and other relevant services is the primary responsibility of HIV testing services and the testers and providers delivering HIV testing services.
- ◆ Keeping accurate records of critical medical information is an important function of the clinic staff.
- ◆ Monitoring is the use of assessment techniques to measure the performance of an organization, person, or specific intervention.
- ◆ Evaluation is the process of using the data collected through monitoring activities to guide program improvement.
- ◆ Discussions with the HIV care clinic will be necessary to ensure that referrals of HIV-positive clients will be handled properly by the HIV care clinic.
- ◆ For clients who are referred, the HIV care clinic will need to know that an HIV test has been performed and is positive. The HIV clinic will also need to know the client's medications.
- ◆ HIV-positive clients, particularly when they become sick, need different support. Many clients also need support when they first learn that they are HIV-positive. They may need help in discussing their HIV status with their family and adjusting to the results.
- ◆ Although the clinic where the HIV testing is done may not be able to provide this support, the clinic needs to inform clients about services that are available in the community or connected with the HIV clinic.